PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2009–10

Melbourne — 12 May 2009

Members

Mr R. Dalla-Riva	Mr G. Rich-Phillips
Ms J. Huppert	Mr R. Scott
Ms J. Munt	Mr B. Stensholt
Mr W. Noonan	Dr W. Sykes
Ms S. Pennicuik	Mr K. Wells

Chair: Mr B. Stensholt
Deputy Chair: Mr K. Wells

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Witnesses

Mr D. Andrews, Minister for Health,

Ms F. Thorn, Secretary,

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

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

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

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the 2009–10 budget estimates for the portfolio of health.

On behalf of the committee I welcome Mr Daniel Andrews, Minister for Health; Ms Fran Thorn, Secretary of the Department of Human Services; Mr Alan Hall, executive director, financial and corporate services; Mr Lance Wallace, executive director, metropolitan health and aged care; and Dr Chris Brook, executive director, rural and regional health and aged care services, Department of Human Services. I also welcome 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 PAEC secretariat are to approach PAEC members. Departmental officers, as requested by the minister or his chief of staff, can approach the table during the hearing. Members of the media are also requested to observe the guidelines for filming or recording proceedings in the Legislative Council committee room.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. There is no need for evidence to be sworn. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript, to be verified and returned within two working days. In accordance with past practice, the transcripts and PowerPoint presentations will then be placed on the committee's website.

Following a presentation by the minister, committee members will ask questions relating to the budget estimates. Generally the procedure followed will be that relating to questions in the Legislative Assembly. I ask that all mobile telephones be turned off.

I now call on the minister to give a brief presentation of maybe 10 to 15 minutes, as his is a big department, on the more complex financial and performance information that relates to the budget estimates for the portfolio of Health.

Overheads shown.

Mr ANDREWS — Thank you, Chair, and I thank you for the opportunity to present to the Public Accounts and Estimates Committee on what is, again, a very strong budget for health. I want to go through some background, some of our challenges and the responses that the government has steadily maintained in relation to treating more patients and providing better care.

If you look at life expectancy as a reasonable measure of the health and wellbeing of the Victorian community, it is pleasing to see that for both men and women we rate consistently above the national life expectancy. I think that is a fair measure of the general health and wellbeing of our community, noting of course that there are areas of social disadvantage and health inequalities. Perhaps we will get an opportunity to talk about some of those matters later on.

In terms of challenges we face or changes in profiles, changes in terms of the number and types of patients that are presenting for care, demand is obviously something that challenges health planners and health service professionals the world over. To give you an example of that, this coming financial year we estimate that we will treat 660 000 more patients than was the case in 1999–2000. That gives you a sense of the growth in that particular category. Obviously Victoria is growing at a faster rate than other states and territories, and that is one driver, together with steady and welcome changes and advancements in relation to medical care. Basically we can do more for patients and we can do it for longer.

There is also a challenge and I suppose a trend in terms of that cohort within the community over the age of 65, who are bit more complex to deal with. They present with multiple and complex chronic illnesses, and they do present not only in and of themselves a great challenge but a growing challenge, given that that cohort itself is growing. You will see there a graphic representation of total admissions as opposed to treatments. That does give you a sense of the steady increase of the baseline of 1999–2000.

In terms of the way our health system performs, every single Victorian can be proud of the work that our doctors and nurses do. We do rate very highly against other states and territories and indeed other parts of the

world, whether it is in relation to emergency department performance, above the national average as rated by the commonwealth government, or median waiting time for elective surgery, again above the national average as determined by the commonwealth government. We run far and away Australia's most efficient health services, and one indicator of that is steady decreases in length of stay, making the best use of what are precious resources.

I have already mentioned that growth in the number of patients presenting for care is a real challenge for us and for health systems right across the world. Those numbers in the bottom left-hand corner of this overhead give you some sense of the growth pattern, the total additional effort that is needed this coming year compared to 1999 — for instance, 45 per cent more emergency department presentations. The profile of those patients is changing as well, and I will come to that in the next slide or perhaps the one after.

This gives you a global view of the current financial year and where we think we will finish up in relation to ED presentations, total admissions, outpatient appointments, emergency patient transports — obviously referring to Ambulance Victoria — screens for preventable illness, public dental services and also the total hours of care provided in our community health sector. Those numbers, by any measure, give you a sense of much increased activity right across the system.

I mentioned a moment ago some changes in the nature of patients presenting to emergency departments, what some perhaps a while ago would have referred to it as the front door of the health system. That is changing a bit, but we do see a different profile of patients presenting for care, and that throws out a challenge to us as well, both as planners and also in terms of funders. It is good news in some respects.

Fewer low acuity patients are presenting for care, and that in some way I think is an important validation of the measures we have taken both to substitute and to properly divert demand to less acute settings — for instance, our hospital admission risk program that I spoke to the committee about at length last year. I think there are now six GP co-located clinics with emergency departments — some of our busiest emergency departments. Those measures are working to give people who do not need emergency care, but nevertheless need care, proper alternatives.

In terms of urgency, if you look at the table there in the bottom right-hand corner, you have seen a complete switch — a split between 1 to 3 and 4 to 5 has gone from 3268 to 3862. That is a clear movement and demonstrates that we have not only more patients presenting but sicker patients are also presenting, so an increase in the total number of categories 1, 2 and 3, and that, as I said, throws out a challenge to us. A real challenge for us is to provide those more complex patients with the emergency care that they need and also to have configured behind the emergency department the bed stock and other services that are needed.

Inpatient activity: again that gives you a sense of what we did in 2007–08 across dialysis separations, cardiology, respiratory separations and others. It is important to note that we had an increase in the same-day procedures. These are same-day inpatients as opposed to multi-day inpatients. When we came to government about 48 per cent of the total inpatient experience was of a same-day nature. That is now 55 per cent, and that gives you a sense as well of the changing nature of the profile of the services we offer. I mentioned earlier on important improvements in the total length of stay, and you have got the numbers there, from 3.8 to 3.3 days.

In terms of what we are doing to meet these challenges and what we are doing to properly cater for the future, you can see there a very substantial increase — now a 130 per cent increase — in terms of acute health funding, from just over $3425 million to $7863 million, a very substantial increase. I would thought nobody could argue that that was anything other than a very, very substantial increase in the recurrent resources available to our system.

It is not just about ongoing funding, as important as that is; it is also about capital infrastructure and the asset program, about ensuring that the quality of our buildings matches the quality of care provided by our staff. You can see there, off a very low base in 1999–2000, building to substantial investments. The 2006–07 number there represents the Children's project being brought to book; 2009–10 represents a range of capital projects as well as the orange there, which is the state's important contribution of $426.1 million to the construction of the comprehensive cancer centre to be located on the former Royal Dental Hospital site in Parkville.

In terms of elective surgery, this is a very important area for us. It is important for patients the state over, and we are very keen to ensure that we continue to reduce long waits and that we continue to do more elective surgery.

It is not just about volume — again, that is very important — but it is about reforming the system. There are many different ways in which we have done that, whether it is the dedicated statewide elective surgery centre at the Alfred, whether it is the recently opened elective surgery centre at the Austin Repat campus, whether it is the soon-to-be-opened specialist orthopaedic elective surgery centre at St V's, or a range of other programs, like the OAHKS program here or the OWL program. I think I spoke to you last year about the orthopaedic waiting list program. It is all about ensuring that people get the most appropriate care. That can often mean that the elective surgery a person is listed for, they do not actually need that ultimately. They are important programs as well — the right care at the right time.

Last year, as you know, was a record year in terms of episodes of elective surgery. In partnership with the commonwealth government — there is $35 million from the commonwealth and $25 million from the Victorian government — we had a target of 9400, and we in fact exceeded that almost to 13 500 additional episodes of elective surgery, breaking the 140 000 barrier in a given year for the first time.

In terms of our workforce, obviously we are only as good as our staff and we need to always look to be employing more of them and to be properly rewarding them for the work that they do. These are well-known figures. There are almost 9000 extra nurses, and that is what the graph shows you there — from just over 21 000 EFT to just under 30 000 EFT in our time in government. Hospital doctors are up by 2500. I could quote also a whole range of allied health numbers, together with ambulance and paramedics nudging the 900 mark also. Again, I would have thought that on any fair measure that is a very, very substantial boost to the workforce that is so critical and so important to providing the very best care.

In terms of budget highlights this year, there is a $2.6 billion boost across health. It does not include the Parkville money I just spoke about a moment ago. Obviously there is a substantial and well-targeted asset program. There is also just under $826 million for boosting hospital services, whether it is in emergency departments, total inpatient growth or the 9000 elective surgery episodes I spoke about a moment ago, and of course the money that we announced just after the budget in partnership with the commonwealth government in terms of the PCCC.

In the coming year, as opposed to across the full estimates, there is a $220 million boost meeting additional demand and growing the capacity of the system and again boosting some of those important substitution programs I referred to earlier. There is also some additional money to commission new mental health services — $85 million — bringing to book the full effect of the beds package I announced last year. That is very, very important obviously in terms of patient flow and giving people the best care possible. There is the elective surgery boost I just mentioned, and there is a range of other programs totalling $8.3 million. There are some blood initiatives, issues around the reform of cardiac service delivery at the Royal Children's Hospital and some other matters that make up that $8.3 million.

In terms of our COAG commitments, there are many of these obviously in a portfolio as big as this affecting as many Victorians as it does. One example, and I think it is a shining example of what can be achieved in partnership with the commonwealth government, is the Closing the Gap indigenous health NP, which totals $56.1 million when you include a range of housing and other important programs. Our spend is $47.4 million over the next four years. That is real money, new money, and it represents without any shadow of a doubt the biggest boost in terms of indigenous health and wellbeing, or welfare services and programs, that this state has ever seen. We are proud as a government not only to sign the important charter last year to sign up to Closing the Gap, but then to deliver the money that is so central to that. That will be about smoking cessation, increased physical activity, a whole range of food and dietary issues — and, again, physical fitness is an important part of that as well.

Importantly, we are about training a culturally appropriate workforce to work not just for Koori communities but as part of Koori, Aboriginal-controlled health services, and those 35 additional workers will be trained as part of this package. There is also a million dollars to expand the very, very successful Koori maternity service at a further three sites. I hope I will get an opportunity to come back to this. There is a lot to be said in this space, and it is one great example of us doing what we need to do to meet the COAG commitments.

Just quickly, in terms of capital other than for the PCCC**,** the Alexandra hospital redevelopment is very important. That was a commitment made by Labor in 2003. This is obviously in an area that has been touched by the bushfires, and we are delighted to be able to provide, along with contributions from agencies, that

$19 million for a brand-new hospital and a co-located ambulance station. The Ballarat Health Service is a very important regional health service. There is a big boost there of $20 million not only to expand the special care nursery but also to bring a new range of heart care, coronary care, to the Ballarat area.

In regard to the Bendigo hospital, again, I am proud of our commitment there: $55 million for a range of works that are all about taking a step towards a new hospital. Additional capacity will be built at the Geelong hospital: a ward, a theatre upgrade and some additional mental health beds. At Warrnambool hospital we are undertaking one of country Victoria's biggest ever capital works projects in the health sector, and stage 1c is funded in this budget as well.

Finally, in terms of infrastructure more broadly, I have mentioned $426.1 million being our government's important contribution. That was matched by the commonwealth government, and we are very pleased to have been able to secure that additional funding to build what we hope will be one of the world's top 10 comprehensive cancer centres. That takes the total state and commonwealth government contribution to $852.2 million. There are other moneys involved in that, and if I get an opportunity I hope to speak in more detail around these issues.

I think the Premier may have had something to say yesterday about Box Hill Hospital. In any event a very clear statement was made on budget day around the fact that as a government we are committed to a further stage in the redevelopment of that hospital. We are committed to the redevelopment of the Box Hill Hospital; we always have been. But we do need to wait and see what sort of further support comes to the state Victoria — beyond the comprehensive cancer centre — in relation to health and hospitals funds. That may well be a subject of the budget which is to be brought down this evening.

Just in summary, I would say to you that this is a strong budget for health. Very substantial increases in terms of ongoing funding, the next important steps in terms of capital funding and some highlight projects like the Parkville comprehensive cancer centre, I think make this, by any measure, a very strong budget for us to continue to support our doctors and nurses, ambulance paramedics and others to treat more patients and indeed provide better care as we go forward.

The CHAIR — Thank you very much, Minister. Let me begin as I have begun with other ministers, by asking you to talk about federal grants, because they make up a very significant part of the state budget, and which ones you are receiving under your portfolio in your department and agencies, both in terms of output and asset issues. I would also like you to provide, perhaps on notice, a departmental list of the details of those grants and the accountability mechanisms which apply to them. But perhaps now you could talk more generally — be as specific as you like — about the grants that you get from the federal government.

Mr ANDREWS — Thank you, Chair. It is a very important question, and we might need to supplement the reply, given the sheer scale of our overall budget. The key part is obviously the national health-care agreement totalling $60 billion. It is the most important of those agreements signed with the commonwealth government. That comes into effect on 1 July 2009. Victoria obviously has a very substantial share of that.

In terms of, I suppose, other important agreements, I can give you some general comments, but again these are national partnership payments, and many of them — in fact, all of them — are the subject of implementation plans that are to be agreed between state and territory governments and the commonwealth. But to run through those broadly, the national health-care agreement is one of those; that is signed off. But in terms of the national partnership agreements for hospitals and the health workforce reform, the provision of extra money is very important to help train and support states in terms of additional undergraduate places, clinical placements and all the other supports that are necessary to train the workforce that we will need going forward.

There is also the national partnership agreement for important preventative health. As you would know, Rob Moodie, a great Victorian, has been chairing the national Preventative Health Task force. It has brought down at least one comprehensive report. It is due to do more work. Perhaps we will hear a bit more in tonight's federal budget about some of the recommendations it has made. That is the second of the major national partnership payments. Thirdly, the national partnership agreement for Closing the Gap, which I have already referred to, and our matching component is there and is a highlight of this year's budget.

Finally, we have the national partnership agreement for NEHTA — or the National E-Health Transition Authority — for the core functions of that body, as we move towards a seamless IT system, basically an

e-health system that links state-funded acute care and commonwealth-funded primary care, with all those wonderful benefits of your medical records following you rather than you having to tell your story a hundred times.

I can go through each of those in a bit more detail, but it may be best if we come back to you once the implementation plans have been signed off and give you further details. Obviously the commonwealth government and our government are very keenly aware that we are fundamentally accountable to the communities we serve in terms of the spending of that money and delivering outcomes against the important agreements that were struck at COAG last year.

Again we can probably give you a greater sense of the detail of those matters once the implementation plans have been signed off. Unless the secretary would like to supplement that answer, that gives you an overview of different areas in which additional effort will be made, and we are happy to come back to you with further details.

The CHAIR — That would be good. We are particularly interested in the accountability mechanisms. Of course you have a whole range of agencies — whatever the right word is — all the hospitals and — —

Mr ANDREWS — Funded agencies.

The CHAIR — Funded agencies, and they all have responsibilities, and we are interested in the accountability mechanisms that you put on them to achieve their outcomes.

Mr ANDREWS — We will be happy to come back to the committee with that.

Mr WELLS — Minister, I refer you to budget paper 3, page 90, outputs. I am very concerned about the accuracy of these numbers, something that you have a problem with — the accuracy of data. I am not sure if it is because you are incompetent or whether you are deliberately misleading Victorians — —

The CHAIR — I would like you to withdraw that. We said this morning we do not wish to use unparliamentary language.

Mr WELLS — I was just stating a fact. What are you talking about?

The CHAIR — So I urge you to take care in your language, please.

Mr WELLS — Which part of it was inaccurate?

The CHAIR — We are trying to not use language which causes offence.

Mr WELLS — Minister, I refer you to budget paper 3 page 90 and the accuracy of these figures. On 3 April this year Kathy Jackson, from the national secretariat of the health services union, claimed it was not true that you did not know about the issue of hospitals reporting incorrect data. She said that in a meeting with you in your office and your chief of staff in January 2008 she told you about inaccurate data reported by hospitals. She further said, 'But I did not really think I was telling the minister something he did not already know. On 5 May — —

Ms MUNT — Chair, I just seek clarification on whether this does relate to the budget estimates.

Mr WELLS — Hang on; I am getting to my question.

The CHAIR — Can you get to your question about the budget estimates fairly quickly?

Mr WELLS — On 5 May in Parliament you stated that the claims from Ms Jackson were incorrect; she was wrong. What is your version of the conversation you had with Kathy Jackson in your office in January 2008 and what impact did this conversation have on the figures that have been provided on page 90?

Ms MUNT — That is a fairly long bow to draw.

The CHAIR — I rule that question out of order and go to the next question. Ms Munt?

Ms MUNT — My question relates to the Parkville comprehensive cancer centre. Last Sunday a member for Southern Metropolitan Region and I walked in the Mother's Day Classic for cancer research. I think they were very excited about this wonderful new facility, as am I for all Victorians who unfortunately suffer from cancer. You mentioned in your introduction you would like to give some more details about that, and I am very interested in hearing a fuller explanation of the what the centre will be and will mean.

Mr ANDREWS — That is a very good question, Ms Munt. I am pleased to answer it. I am very pleased to illuminate the committee on our government's record investment in cancer and saving lives, a question about the outputs and a question about health. I am very pleased.

This investment needs to be seen in the context of the $150 million cancer action plan which we very proudly launched last year, the Premier and I. This is about supporting the growing number of Victorians who are diagnosed with cancer each and every day, sadly, and trying to do more in terms of the total number of people who sadly pass away from cancer each year — the $150 million of new money and a comprehensive action plan with hard targets around saving lives and improving outcomes between now and 2015.

It is also important that we have the capital infrastructure, the physical infrastructure to support the world-leading research and the advances in treatment, and that we build a centre where all that is good in cancer, all the great work that goes on across the cancer control community, can be brought together under one roof, and we can get the economies of scale and sort of efficiency dividends and benefits of that, and we can build what we hope will be one of the world's top 10 comprehensive cancer centres. This is only possible because of a partnership with the commonwealth government — $426 million each, together with some additional moneys. To give you some sense of the scale of this particular project, it will not just be Australia's biggest comprehensive cancer centre, it may well be the biggest in the Southern Hemisphere, and we are very proud to have been able to provide the record support needed for this important project.

In terms of the new facility, there will be 194 inpatient beds, 110 same-day treatment places, 8 medi-hotel beds as well, noting the increasingly ambulant nature of cancer care. There will also be — and this is very important linking back to some of the targets and the action within the Victorian cancer action plan — a dedicated, I think, if memory serves, 24-bed clinical trial space there as well, which is all about trying to do more to give more patients access to the latest therapies and the latest treatments, not just for their benefit but in an evidence-building way to, in an ongoing way, develop the cancer care that will save lives as we go forward.

In terms of growing the overall size of this particular facility, if we look at how much more work it will be able to do, it will have an important capacity to treat about 25 per cent more patients than are currently treated at the Peter MacCallum Cancer Centre or at the Royal Melbourne Hospital — from about 31 000 to a capacity of around 46 500. That again is an important boost in terms of giving our cancer doctors, nurses and others the physical space that they need to treat a growing number of cancer patients looking forward.

It is also about important cancer research. An important point to note is that there will be room, there will be the physical capacity to house up to 1400 cancer researchers — again making it Australia's biggest centre for important cancer research. So whether it is in terms of research, treatment and also training the workforce as necessary — so bringing those three important parts of cancer control together under the one roof — it is a truly unique and very important project, one we are proud to support and one where we are very grateful the commonwealth has entered into this partnership with us. It should be seen in the context of the Victorian cancer action plan.

Again this is for many in the cancer community a dream come true, something they have long wished for and worked very hard for. If I can take this opportunity, Chair, to thank all those involved at all those different agencies and the many others who, for so many years, have lobbied hard and worked hard to build the business case for this particular facility. It will be one that we can be proud of because it will be one that will be central to saving lives, both now and for many years to come.

The CHAIR — Mr Wells, have you had time to reconsider in light of Mr Dalla-Riva's — —

Mr WELLS — Mr Rich-Phillips will take the next question because it appears that this witness will receive the full protection of the Chair when it comes to questions from the opposition — —

The CHAIR — That statement is out of order.

Mr WELLS — It has been a waste of time.

The CHAIR — That statement is out of order. Mr Rich-Phillips

Mr RICH-PHILLIPS — Thank you, Chair. I do want to go to the issue of the accuracy of the emergency department and hospital data, which of course is the basis of a number of performance measures in the acute health output area. It was reported last May that as a consequence of the Australian College for Emergency Medicine survey you had undertaken to conduct a review of the performance data from emergency departments. It was then reported in August of last year in an article published in the *Age* that you would not set up an investigation because, to quote, you did 'not believe that this is happening' — being the issue of phantom wards. A month after that your department let a tender for an audit of emergency department data. My question is: firstly, did you undertake that review in May as reported; and secondly, what information came to you between your statement in August that you did not believe it was happening and September, when you commissioned the audit?

The CHAIR — Insofar as it relates to the forward estimates and the forward estimate targets and expected outcomes and actuals for the VEMD — —

Mr ANDREWS — Thank you, Chair. I think Mr Rich-Phillips confuses what is the audit of the Victorian emergency minimum dataset, or the VEMD audit, with the issues raised, which were many and varied — and I will come to them in a moment — from the college of emergency medicine. The VEMD audit does not come from issues raised by the college of emergency medicine — and I would have thought members of this committee would know this — it comes from not one, but in fact two reports of the Auditor-General. And the department and I felt that it was important, in an ongoing sense, and there has been much work done on this, to, as recommended by the Auditor-General, properly audit all data in the Victorian emergency minimum dataset — that is, all emergency department data right across the Victorian public health system. So the linkage is that it is not right to say that.

In terms of the integrity of data in emergency departments or anywhere else, I have made a range of important changes following issues at the Royal Women's and following issues that were outlined in the Auditor-General's report. They are separate in some respects to the college of emergency medicine's concerns.

The Department of Human Services — and Mr Wallace, who has direct dealings with the college in a broader sense, may want to supplement this — has always taken seriously issues raised by the college of emergency medicine. They relate to a whole range of different issues. Principally they relate to the way in which observation medicine units work — things like short-stay units — and much work has been done through our clinical network and through a range of different processes to deal with those important issues.

To bundle those issues together with the other issues raised that underpin the VMD audit is simply wrong. I have met with the college on a number of different occasions, and I will continue to do so. We take their concerns seriously, and we have acted to deal with the important concerns they have raised. I ask Mr Wallace if he wants to add to that.

Mr WALLACE — I just add that the college wrote to me about some issues of concern that they had. They were mainly about definitional issues and clarification of departmental policy positions. Some of those were issues like when does treatment commence under departmental policy. For example, if you are in an emergency department and you then get taken to a cubicle, does your treatment commence when you are taken to the cubicle or does your treatment commence when a nurse first comes to take some more information about diagnosis? Does your treatment commence when an ED physician actually starts some other procedures, whether or not it be medication of some form? There were those sorts of definitional issues that they were concerned about. There were also some definitional issues they were concerned about with short-stay units, which were a relatively new introduction during the 2000s when Victoria introduced those along with other states in Australia.

We had a process to work through with them. We established a process. I met with senior people from the college. We established a process with departmental officers to actually work through to clarify guidelines, to try to get better treatment protocols for a range of conditions, to define very accurately when treatment first commences and to try to get a more consistent application of departmental policy across our emergency departments.

Mr ANDREWS — Chair, can I just say that if you went to the college of emergency medicine and asked them whether they were happy with the response that the department has provided to the issues they have raised, I think they would say that they were. It is a matter for them, but I think they would say they were. We remain committed to working through issues that they raise. There were those that were raised in the past; there will be others raised in the future. We have a very good working relationship with the college, as we do with all learned colleges, and we will continue to work with them, because their aim is no different to ours — providing the very best care.

Mr RICH-PHILLIPS — When were those issues raised by the college resolved with the college — the issues that Mr Wallace spoke about?

Mr ANDREWS — There were a range of different issues. We have, for instance, put in place guidelines around the way short-stay units operate. Can I say to you — and it should come as no surprise — that perhaps the main concern at the college of emergency medicine was to see more beds funded. I was very proud, in addressing their concern before the end of last year, Mr Rich-Phillips, to announce $321.5 million worth of extra beds. I was very pleased to meet with the college and talk about that, and it would not be wrong for me to submit that they were pretty pleased about it too. That remains an ongoing concern of the college.

We work through issues that are raised by this college and other learned colleges each and every day, and obviously we will do that as we go forward.

Mr NOONAN — Minister, I want to ask about the dental package as part of this budget, and you made reference to it in your presentation. I refer you to budget paper 3, page 317, under 'Improving access to dental care', and I note some additional places there and better access, particularly in regional Victoria. I wonder whether you can outline for us what new funding exists in this budget and how access to dental care as part of this budget will be improved as part of that funding investment.

Mr ANDREWS — Thank you, Mr Noonan. That is a very good question and one that I know is of interest to you and your local community, and indeed to all of us, but certainly in the west of Melbourne the socioeconomic factors and other issues make oral health care even more important than it is perhaps across the board.

We have worked very hard as a government in partnership with our dentists, with the other health professionals who work in the oral health workforce and with Dental Health Services Victoria to grow the total amount of money we spend in terms of oral health. We have invested something like $1.1 billion in terms of oral health since we came to government in 1999. This year alone represents a $149 million investment, and, as you rightly point to, there is very important growth in terms of providing access to those patients who have waited longest in a number of different areas, and I will come to that in just a moment.

Again, as important as ongoing funding is, building the infrastructure is also important, and we proudly have increased the total number of chairs to 373 publicly funded dental chairs across the state; that is 110 more than was the case in 1999. We have also, importantly, supported a second dental school. The University of Melbourne does a fine job, but it has been the sole trader, if you like, in terms of training dentists and others. We have supported La Trobe University to grow its courses, and that is very important, particularly given that the majority of that training is in fact conducted in rural and regional areas.

The growth that you referred to relates to that. There are obviously a number of teaching clinics and teaching chairs that will have patient flow through them, and that represents around 14 400 additional treatments over the next two years. There is also a $3.5 million blitz, if you like, to provide just under 10 000 additional treatments — in fact 9600,r 9700, or around that mark — over the next two years in those areas where we have had the longest waits. I can confirm for you that includes Ballarat Health Service, Barwon as well, and Central Gippsland. The Knox Community Health Service will share in that as well, which I am sure will be of interest to those in the outer east, and the Latrobe Community Health Service in Moe. Frankston Hospital will also benefit, and so will Peninsula Health. Southern Health at Dandenong have got a very large clinic there, and they will benefit. Also in your own local community, Mr Noonan, the Western Region Health Centre at Footscray, which does a great job providing a range of different services and supports, often to some of the most vulnerable members in your area and indeed across the state, will benefit.

I will just go back to a point I made before about the second school or the second university being engaged in the training of our dental workforce. Many of the challenges we face around time to treatment and access are about putting the right workforce in place at the right time. Putting the second school in place and supporting that was the right thing to do.

That started both in terms of the bachelor of health science, dentistry and the master of dentistry at the Bendigo campus in 2008, with an initial intake of 50 students. We have also supported some of the critical training and treatment infrastructure in Mildura, in Wodonga and indeed in Melton. Last year's budget had $13 million in capital funding for those important satellite clinics, but also I very recently announced a 10-chair training clinic which is also a treatment clinic up in Bendigo.

Again, these initiatives are important and we should fully acknowledge that this will mean that more people will get access to the dental care that they need faster than they otherwise would have, but they should be seen again in the context of more than $1 billion worth of oral health care investment since we came to government. I acknowledge and the government acknowledges that we have more to do in this space, and this package is an important step forward.

Dr SYKES — My question relates to the provision of ambulance services in country Victoria, which can be comparable with the services provided to people in the metropolitan areas. I should say at the outset that I welcome the funding for Alexandra hospital and the co-location of the ambulance station there.

The situation in country Victoria is that there is a limited number of MICA-qualified ambos stationed in country Victoria, and they are often there without actually filling MICA positions. The word has gone around that those positions are now required in Melbourne, and so those MICA-qualified people feel under threat and see those MICA-qualified people who are in country Victoria, perhaps by default, being removed from the area.

There is a second issue of the reliance on community emergency response teams, known as CERTs, to meet primary response needs in growing communities such as Nagambie. My question is: what action are you taking to address this important issue of delivering equitable ambulance services to people who choose to live in country Victoria, I guess from a budget allocation point of view but I have also heard that there may be a review of service delivery going on out there?

Mr ANDREWS — Thank you, Dr Sykes. I acknowledge your long-term interest in ambulance services, and I think we had a bit to say about this last year. As you know, last year's budget had almost $186 million in additional funding, the biggest boost that ambulance services have ever seen. From a country point of view, very importantly, we brought together the three separate ambulance services to create one new Ambulance Victoria, so that every single Victorian could get access to the very best care. The planning, policy development and service delivery have been as consistent as possible, and having them driven by one agency is exactly the right way to go. I think that country communities, both large and small, have welcomed the move. We are rolling out services not just in the outer suburbs or interface communities but in regional cities and in small rural towns. A lot is happening in terms of ambulance services.

As I said, we are very pleased to have provided that funding last year. I am happy to come back to you on notice with some further details of rollouts in particular areas, but there were around 50 additional services provided, many of those in rural and regional Victoria. In terms of MICA, you have a situation where we are in the process and quite close to being able to roll out the single responder units, those rapid responder units, in Bendigo, Ballarat, the Barwon region and also in the Latrobe Valley. That is a model of care, if you like, that people in the inner city, in Melbourne, have had for years, since the mid-1990s. We are very keen to have that rolled out — I had a fair bit to say about this last year — and to be delivering that parity, if you like, the same access to the most rapid response for a mobile intensive-care ambulance paramedic in a car, not transporting patients but treating them. I think that is a great example of where our ambulance package and our efforts in ambulance are very much about ensuring that no matter where you live you get access to the best possible care. That MICA example is a very powerful one. I am happy to come back to you in more detail around our complete asset investment program and our additional paramedics.

You would remember that as part of trying to balance the workload, last year the former Rural Ambulance Victoria, now Ambulance Victoria, took a pool of money from overtime and determined to employ an additional 100 ambulance paramedics across rural and regional areas. That is very important for smaller towns.

They are progressing quite well with in excess of 80 — I think 88 of those 100 are in fact on the ground now. I can get you some more details around that and again provide you with some further details around the rollout of our ambulance package. Can I just say in terms of MICA paramedics — and I have met many MICA paramedics and I have nothing but praise for the work they do — it is my experience that MICA paramedics are very keen to work as a MICA ambulance paramedic; they are keen to do the work that they are trained for.

It may be that, for instance, as part of opening the new helicopter emergency medical service down at Warrnambool, a paramedic from another country community, a flight paramedic in this instance, might seek to go and work there to get access into that brand new service. It may be that MICA paramedics who are not doing a lot of MICA work now may move into one of these single-responder units. Again, this is a pretty dynamic workforce. It may well be also that having one service means that one barrier for metropolitan paramedics who, for lifestyle reasons, might want to go and work in country Victoria, is now gone. There is one employer; there is one service.

Again, I think there is a litany of examples where we are trying to make sure that no matter where you live you get the best possible pre-hospital emergency care and the transport services you need, whether it is through the retrieval chopper, the Warrnambool chopper, the MICA SRU rollout out in large regional centres, additional branches, additional vehicles — additional ambulance paramedics in the broad sense. I hope that gives you some comfort in terms of the issue. We are very committed to country communities, not just in relation to ambulance services but right across health care, and I think our record is a very strong one. I know that part of AV's charter, part of the clear guidance that I gave the board when we formed the single service was to ensure that we continued to provide first-class care in regional areas, and that if we could improve it, we did.

Dr SYKES — Is there any actual review of service delivery, given the concerns that there is a perceived contraction of the MICAs back to Melbourne? You have given an explanation, but is there any actual review or restructuring of service delivery over and above the larger regional communities that you have mentioned?

Mr ANDREWS — Again, there is no review that would see country communities with less ambulance paramedics or anything other than boosted services.

AV would do reviews on a whole range of different things almost each and every day. I would think that there would be review work going on around the transition from three services to one. We are coming up to the first anniversary of that. I am happy to come back to you. I am not aware of any review that would do anything other than boost services to rural and regional areas. Again that is my commitment, it is the government's commitment and I think AV are equally committed to doing that. But in terms of critically looking at the way we deploy services across the board, I am happy to come back to you on that. That is probably the best way to go.

The CHAIR — All right. We will take that on notice.

Ms HUPPERT — Minister, I am interested in the BreastScreen digital mammography rollout. As Ms Munt mentioned, she and I have an interest in improvements in the detection and treatment of breast cancer. I notice on page 321 of budget paper 3 there is a line that there will be $10 million TEI invested in that program. Can you outline how this initiative will enhance breast screening services in Victoria and improve the early detection of breast cancer?

Mr ANDREWS — That is a very important question and one that is important not only in terms of cancer care but also important to Victorian women in a broader sense. At the election in 2006 we committed to the $10 million to roll out digital technology for BreastScreen Victoria. They do a fantastic job and are very well trusted, very well thought of by Victorian women and have been so for many years.

Just in terms of background to this, this is a very important initiative but it comes on top of very strong support from our government. The BreastScreen Victoria budget has gone from somewhere around $19 million to $31 million since 1999, and we are proud to have done that, noting of course that breast cancer is the no. 1 cancer killer of women. Around 703 women will die this year in our state from breast cancer, and I think there is something in the order of 3200 to 3500 cases diagnosed newly each year. This is a very substantial challenge in a cancer sense, in a women's health sense, and indeed in terms of health and welfare for the community in a broader sense.

We should be pleased to note the five-year symptom-free rates, so five-year cancer survival rates of breast cancer have improved markedly in recent years from 74 per cent in 1990 to 87 per cent in 2004. We would hope to improve that going forward. The way in which you do that is to provide the screening to do that early diagnostic work and to provide care and support to women in an absolutely comprehensive way, and that is what the Victorian cancer action plan does.

Part of that is supporting the workforce to make the best use of the best skills and giving the staff at BreastScreen Victoria and at many private providers that will be linked to this digital technology — that is, the hardware through software we are going to fund for them — is all about making the best use of those best skills.

There are a number of sites: six major screening centres will be upgraded as well as the urban mobile screening van — we have two screening vans and they are Australia's only mobile screening vans for breast screening — St Vincent's at Fitzroy, Monash Moorabbin, Monash Casey, NorthWestern at Parkville, NorthWestern Moonee Ponds as well as Gippsland at the Latrobe Regional Hospital, and the urban van — although I note that it is better described as the second van given that it supports communities like Kyneton, Seymour, Belgrave and Cranbourne. They are all important.

As I also mentioned there will be a link through software to 20 private and other public screening services that will get supporting IT so they can link into the new digital BreastScreen service. What this essentially means is it is a great outcome for women in terms of getting their screens faster, far more detailed screens, the ability to change those images, contrast and enlarge images — things of that nature.

Obviously there is no longer a need to develop film. It is not just good for women, it is much easier and simpler. It is great for staff also; some of the very dangerous chemicals that are currently used to develop the old film will not need to be used or there will be less of them.

I think this is a win-win for everybody — the workforce and women. We are absolutely delighted to be able to provide this $10 million boost. There were some who had raised concerns about us delivering this commitment. We have always maintained that we would deliver this. We honour the commitments we make and that is what we have done here. I know BreastScreen Victoria is very pleased to have received this money, and I know women who will benefit from this high-quality service will also be very pleased with it.

Ms MUNT — Will that allow the onsite screening facilities to integrate with the local health services, too, in a digital manner?

Mr ANDREWS — That is a very good point, Ms Munt. Rather than having to develop films, send it physically via a courier or give it to the woman to take where it needed to go, which is not a 21st century way of doing things, at the press of a button, via broadband connections, through basically an internet connection, they will be able to send that image in all of its detail to whomever needs to view that.

So a radiographer in a regional centre or in the mobile van would take the shot; it is then emailed to the radiologist in Melbourne — it could be anywhere, in fact — to then read that image and make a determination about whether that woman needs further testing and indeed further care. It is all about efficiency. As I said, it is all about making the best use of the best skills noting that we do have some workforce challenges in this part of the health system. This is just about giving our dedicated professionals the tools that they need.

Ms MUNT — That is fabulous.

Ms PENNICUIK — Minister, I am looking through the big area of your portfolio, and there are some statements in the overview and throughout the budget paper regarding preventive health measures with public health and immunisation scattered through. Are you able to give us an idea as to the proportion of the public health dollar that is spent on preventive measures as opposed to treatment measures, and whether that is going to increase as we move through the years given that obviously preventive health is a good way of reducing the other cost?

Mr ANDREWS — That is a very good question.

Ms PENNICUIK — Are there benchmarks that your department looks at from around the world or anywhere?

Mr ANDREWS — I will definitely get Dr Brook to supplement this. This is very much his area but it is of equal importance to me, and the point you make is a very good one: that unless we invest more both in terms of money, time and policy effort as well in terms of preventing — and that is both primary prevention, so trying to stop people ever getting type 2 diabetes; let us use that example for instance — or secondary prevention which is about the effective management of type 2 diabetes. That is all about better outcomes for that person, their family, their workmates, their teammates, the community that they live in. But it also better for the overall health system. This is about, if you like, safeguarding the overall sustainability of the health system.

Ms PENNICUIK — I asked the question because it is a bit hard to tell from here where we are heading in that direction.

Mr ANDREWS — The public health output group will give you a sense of a number of different things that we do. I have just been talking about prevention. It is not quite linked to BreastScreen Victoria. That is more about screening and basically detecting breast cancer — it is about preventing death, if you like. But in terms of preventing illness, from a true health prevention point of view, there are a range of different things we do. If I can draw your attention to the Victorian Tobacco Control Strategy last year. There are some tobacco-related enforcement outputs here that are measured.

As part of the $150 million cancer plan we also announced the tobacco control strategy. That talks about a range of different changes. There are changes to the law around smoking in cars. There is a whole range of things we are doing. There is also a $10 million social marketing campaign — the biggest Quit campaign that Victoria has ever seen. That is directly about decreasing the adult rate of daily smoking from 17 per cent 14 per cent.

That is about saving lives, that is about prevention of cancer, respiratory illness, coronary disease and so forth. There are many different examples. We do as part of the national preventive health national partnership — the NP — there will be a new raft of different measures that we sign up to. There will be consistent accountability measures between each and every state. That is important as well. I am wondering whether Dr Brook wants to add to that answer. It is an important area. It is a very good question.

Dr BROOK — There is a methodological problem in trying to put a figure on who spends what on prevention. First of all, the state's responsibility in this area lies in several different parts of different output groups. For example, within the public health output group you could classify everything as prevention in one way — that would include immunisation and would include screening programs. They are really important early detection or secondary prevention issues.

But also there is a considerable amount of money but on a smaller scale which is spent on prevention research, such as the investment of $32 million a year into the Victorian Health Promotion Foundation, funding of initiatives like Life! for diabetes and funding of Go for Your Life.

The methodological problem is that the great majority of prevention and particularly secondary prevention spending actually occurs outside of the state health portfolio. If we look at the broader Go for Your Life program, where does one count bike paths or walking tracks in parks or beside roads? They are arguably far more important. Where does one count exercise and sport programs that are not counted in health?

The AIHW has been struggling with this for years. We sit on a group which is looking at national estimates of public health expenditure. All I can say of that is we would hope that we have better methodology next year, because no-one around the country seems to have been able to accurately estimate those elements of government expenditure outside of health which are genuinely part of improving health and improving socialisation.

You may look even within different portfolios of government, perhaps some unexpected. There is the $600 million committed for the WorkHealth initiative. That is a crucially important and very big initiative. You may also look to the COAG commitment of many hundreds of millions of dollars over a six-year time frame for the national prevention partnership, which will really not roll out at a state level until three years hence. But there will be commonwealth money going into social marketing campaigns regarding obesity, regarding child health and regarding smoking within the next year.

Having said that, you have also got to consider the non-government organisations, which are actually quite fundamental here, whether it is groups like the Cancer Council, which we sponsor for subsidiary activities, as it

were, in Quit or SunSmart; whether it is the National Heart Foundation; whether it is other organisations like that or whether it is in fact the common or garden media.

The direct answer to your question is: the best way to look at it is to include the whole of the public health output group within our portfolio — that is, about $250 million — and about one-third of community health expenditure which goes directly on health promotion.

Mr ANDREWS — Could I just add to that: obviously, Ms Pennicuik, if you look at pages 104 and 105 there is the health protection output group with 183.3 and then the health advancement output at 68.9. Perhaps if I was to write to the committee and to you with just a few further examples of our primary prevention, secondary prevention and the other behavioural change work that we are doing, together with some of the other diversion programs which sometimes do not make it into the basket or are not counted or called primary or secondary prevention.

They are more about demand management in the acute sector, but they do have some added benefits in terms of preventing the onset and preventing some of the really complicated and adverse impacts of multiple and chronic illness.

The CHAIR — Write to the committee, actually.

Mr ANDREWS — Yes, of course.

Ms PENNICUIK — Could I just clarify one thing quickly, Chair? Thank you, Dr Brook. I understand the methodological problems. This has been a long interest of mine, but I was prompted very much to ask it today, because I was listening to someone on Radio National this morning, a doctor who has come over from the UK who has done a lot of work on cardiac prevention. They have collected a lot of data and it is pretty well encapsulated in their health. Anyway, I will be interested to see what the minister writes.

Mr ANDREWS — I will be happy to write to the committee.

Mr SCOTT — My question is in regard to the Bendigo Hospital. In budget paper 3, page 322, the government has outlined an initiative to redevelop the Bendigo Hospital. What steps have been taken towards this project and how will it benefit the Bendigo community?

Mr ANDREWS — We are very pleased to provide support to the Bendigo Health Care Group. It is obviously a very large regional hospital, providing support and care not only to people in the Bendigo region but also right throughout north-west Victoria, as people in Swan Hill and other communities to the north-west of Bendigo look to Bendigo for the specialist care that they often need.

As you would know, as all members of the committee would know, we were — the Labor Party, that is — the only party in 2006 to commit to a new hospital for Bendigo. We proudly made that commitment. We committed firstly to provide, I think, around $2 million in planning money. In the very first budget after the election we delivered that. That planning work was done. It identified the top priority for Bendigo Health Care Group was just under $10 million for an expanded emergency department. We funded that in the very next budget after the planning work had been done.

We are now into the third budget of this term, and we have provided $55 million, an important boost. We have basically determined the site of a new Bendigo Hospital.

We have provided the moneys within that $55 million to relocate an ambulance station that currently sits within that site. There are other enabling works, but there is also an important boost that will help to maintain, expand and improve the current fabric of what I hope will soon become the old Bendigo Hospital.

All of this has been met with the acclaim of the Bendigo community. I think the people in Bendigo, particularly at the health service — doctors, nurses, the other health service administrators there — are very pleased with this outcome. It is important to note that they have worked extremely hard over the last two and a half years and even going back before then, to make the case for this investment. It is a substantial investment.

As important as it is, I think it should be seen in the context of the support we have provided to Bendigo Health Care Group and the patients who turn to it for the care that they need. It is a very substantial boost of nearly

120 per cent more ongoing funding this 2008–09 year compared to 1999. It has gone from $58 million in the current support to $127 million. That is a very big boost. It is through that support that they are able to treat a growing number of patients.

This $55 million is not the only capital support we have provided. I have mentioned the $10 million for the emergency department. There is also $7.9 million for the Amcor redevelopment of a new 60-bed nursing home out at Eaglehawk. There was also — and this is a fantastic service in partnership with Peter MacCallum — the regional radiotherapy service, regional cancer service there. It is not just one linear accelerator and bunker; there are two providing care and support to a growing number of cancer patients right throughout the north-west.

On from that, in last year's budget I know Minister Neville was very pleased to secure $13.6 million for the Stella Anderson nursing home. That is about replacing that 60-bed nursing home adjacent to the existing one in Eaglehawk, together with a whole range of other important equipment — the tools, if you like, that our health service needs. I was very pleased to open the second linear accelerator in that second bunker.

One of the very first things I did when I became health minister was to travel to Bendigo to open that. The MRI machine, CT scanner, other equipment associated with elective surgery, the PAC (picture archiving and communication) system is about putting medical records online and some of the digital imaging we just spoke about in terms of breast screen. The list goes on.

There has been very strong support for the Bendigo Health Care Group, and that is the context of this $55 million going forward. When we do the policy and funding guidelines for the new financial year, they will again receive a funding boost, as every single health service across the state has in every single year. We are committed to the Bendigo Hospital, because we are committed to the community that looks to that hospital for the care that it needs, and it is no wonder that the community is pleased with this announcement, because it is about the next step towards a brand new hospital for that growing part of rural and regional Victoria.

Mr DALLA-RIVA — Minister, I refer you to budget paper 3, pages 89 and 90 — in particular at the top of page 90. It is under the performance measure of admitted services under acute health services, and in particular relating to elective surgery and the targets that are provided there.

I want some clarification that, given accusations about the secret waiting lists and particular issues about use of 'not ready for care' lists, which go back as far as October 2007, and further allegations raised over the ensuing year about data manipulation of waiting lists by public hospitals, can you inform the committee of the accuracy of the data provided in the forward estimates — in particular, where you are expecting targets of 90 per cent, 80 per cent and indeed 100 per cent — to ensure that those data figures are not being manipulated and, if they are and have been, can you explain what action you have taken to ensure that this does not occur in the future?

Mr ANDREWS — Thanks, Mr Dalla-Riva. This is aggregate data and the department stands by this aggregate data, as do I. Following issues at the Royal Women's Hospital and a report from the Auditor-General tabled in the Parliament a few weeks ago, I made a number of announcements, and if I can run through those for you, that will give you a sense of what I have done and what the department has done to ensure and to enhance community confidence about the integrity of the data that in so many ways represents the performance of our system.

I announced that we would do six unannounced spot audits. That work has already started, and we are well on the way to having those six spot audits completed, and I will come back to that in a moment. I announced that a director of data integrity would be appointed, a senior public servant, who would have but one role, and that was simply to oversee the audit of those six spot audits and other audit work.

That other audit work was the important completion of the VEMD data audit that Mr Rich-Phillips asked about earlier on, the full ESIS audit — that is, the elective surgery information system audit — so that is all the elective surgery data: six spot audits, ESIS audit, the VEMD audit and any other audits that we might need to do. That director of data integrity would be in charge of that process and would drive that process.

The Auditor-General's report also raised some issues at the Latrobe Regional Hospital, and Paxton Partners, if they have not already completed, are certainly in the process of completing an audit down there around those issues, and that will again go to the director of data integrity. They are the audit steps I have taken.

I have also announced a raft of measures that are important in terms of the administration at a local health service level. For instance, I have made it very clear to chairs that it is my expectation and the expectation of the community that hospitals record their data accurately and that they have systems and processes in place to ensure the robustness or efficacy of any and all data that they provide.

Around those issues I have made it clear that I will require each and every hospital and each and every health service to make a statement in their annual report tabled in the Parliament as to the sufficiency of their processes. I will also make issues of data integrity a key theme in the statement of priorities to be signed for the 2009-10 year.

That, I think, is a substantial suite of important measures, but there are more. I have also disbanded the roughly $40 million bonus pool because there was a perception among the community that people may have been acting inappropriately in order to secure additional funds. That bonus pool has gone.

A small matter but I think an important one is our change towards making sure that every health service, where a patient's status changes, that patient will receive a letter notifying them and asking them to note that their status has changed. That effectively makes each and every patient an auditor of their own care. On any fair reading of that, that is a comprehensive range of steps.

They are important. They are about making sure that the community can have complete confidence as to the integrity of the data. This is aggregate data. The department stands by it, and I stand by it. In terms of individual health services, as will be reported in the Your Hospitals report, I await the completion of those six spot audits under a certification from the director of data integrity about the results of those spot audits, and then we will make further announcements around the Your Hospitals report for the first two quarters of the current financial year.

I reject the premise of your question, and I stand by the data that is before you in terms of expected outcomes as reported on page 90 and right throughout the budget papers.

Mr DALLA-RIVA — You reject what I have said, and I understand what you have explained to me in terms of the process. The first thing is that it has taken a fair time to get it enacted but you have enacted a range of activities. The target outcomes for 2008–09 are 90 per cent, and in 2009–10 they are 90 per cent in terms of category 3 elective surgery. They are the same targets for category 2 and category 1.

What I am trying to get at is that the Auditor-General has identified a range of issues. Surely you are that confident that the target measures that you are achieving for 2009–10 — —

Mr ANDREWS — The Auditor-General has found an issue at one hospital, and that is the Latrobe Regional Hospital. That does not relate to elective surgery, it relates to emergency. It was not the Auditor-General but the women's hospital itself that found an issue which was then the subject of auditors appointed by me — —

Mr WELLS — So there are a number of issues that — —

Mr ANDREWS — The way this works is that you ask the questions, and I answer them. I am trying to get to answer your question but now you are talking over me.

Mr WELLS — The issue is the accuracy of the data.

The CHAIR — The minister is answering the question.

Mr ANDREWS — I am attempting to answer the question, Chair. Do I have the call?

The CHAIR — You have the call.

Mr ANDREWS — Very good, thank you. The women's hospital itself identified issues and auditors were appointed. So this notion that the Auditor-General has found inappropriate or manipulation in aggregate data is simply wrong; it is simply wrong.

Mr WELLS — He has found it.

Mr ANDREWS — Again, you have asked your question, and I will answer the question. It is simply wrong. The department stands by this data, I stand by this data. The auditors of the Royal Women's Hospital, Paxton Partners, found — and if I can quote:

> This understatement will not translate to a material misstatement of the statewide elective surgery information and indicators published in the DHS 'Your Hospitals' report.

Mr DALLA-RIVA — So there will be no not-ready-for-care lists floating anywhere?

Mr ANDREWS — I do not think you understand.

Mr WELLS — Answer the question.

Mr ANDREWS — I am answering the question.

Mr WELLS — Just answer it.

Mr ANDREWS — I am answering the question. Patients are made 'not ready for care' each and every day based on their clinical circumstances and based on their personal circumstances. They are not judgements that are made by me, they are judgements that are made by appropriately trained staff. People who are not ready for care at a local health service level may well be listed as 'not ready for care'. In the main that is a clinical judgement, or it is a reflection of personal circumstances experienced by that particular person. That is not something that I have any involvement in. I am not quite sure the link that you are drawing. I think I have answered the question.

The CHAIR — Okay. I think we have answered the question. We will have some other answers in the immediate future.

Minister, I refer you to page 22 of budget paper 3 where it talks about your key initiatives. They are further elaborated on in the appendix to budget paper 3. I am particularly interested in beds, both additional acute beds and new sub-acute beds. Can you tell us a bit more about that, including the recurrent funding for this going forward, because it is obviously pretty important when it comes to meeting the growing demand on public hospitals?

Mr ANDREWS — This is a really important issue. It is about growing the raw capacity of the system. Late last year as part of the, I think, fair and balanced resolution to the medical enterprise bargaining we also announced a very substantial boost to the overall capacity of our health system, $321.5 million over four years — a very substantial boost. That is to fund 276 additional beds: 100 additional acute beds and 170 additional sub-acute beds. That is the great strength of our system. No other state has the number of sub-acute beds that we have.

The CHAIR — That was 170?

Mr ANDREWS — It is 170; 100 in acute, 170 in sub-acute and 6 critical-care. It is a mixture of PICU, NICU and also adult intensive-care beds. That is a very big boost. That was a 'bring forward'. Basically, that money flowed from 1 January this year, and we bring that to book. That is why some of the numbers in the budget papers refer to the five-year effect of that beds package — basically, quarters three and four of the current financial year and then right across the forward estimates.

That is a substantial boost. It will allow us to treat many more patients, indeed up to 63 000 additional patients. In many respects it is the biggest single boost to hospital capacity that I can remember having been in and around this portfolio for a number of years, but it is a very substantial boost, certainly in dollar terms.

It is not just more beds in one part of the system. As I said, it is a balanced investment. There is a bit of policy thought gone into this as well. It is not just about growing the overall capacity, it is about models of care, driving efficiency, boosting each of the component parts of the inpatient experience, acute, sub-acute, critical and critical care, playing to our strengths if you like. I should also say there is some money around adult retrieval and also newborn emergency transport services as well funded out of this package.

If I can give you a couple of examples of what this means for local health services: if you look to Melbourne's north the Austin Hospital shares in just under $7.9 million. That opens 34 beds — 10 acute and 24 sub-acute. If you look at Eastern Health, which I am sure is of interest to some committee members, just under $3.2 million. That opens 18 beds — 4 acute and 14 sub-acute. In my local community, which I share with a number of committee members — Southern Health — it has the biggest boost across the system for our biggest health service with 51 beds. Some have been critical of this; I cannot think why you would be critical of this. The health service certainly is not in any way critical of this; they welcome it, they are delighted with it. There are 51 beds — just over $12.7 million with 23 and 28 sub-acute, and I think there may even be some additional capacity in terms of critical care.

Again, it is not just in metropolitan Melbourne. Our large regional health services have benefited in this as well. All of them: Barwon, Ballarat, Bendigo, Shepparton and Goulburn Valley and also the Latrobe Regional Hospital.

I will give you one example: Barwon Health, $4.4 million, 20 additional beds, 12 acute and 8 sub-acute. This is a package that grows the capacity of the system at each of our major metropolitan health services, not just in the centre of Melbourne but in the outer suburbs and at our big regional health services. It is about treating more patients, it is about better patient flow and it is about moving people through emergency departments by growing the bed stock that sits behind those emergency departments.

But it is not just more of the same. It is playing to our strengths, it is investing in the different component parts of the system. It is a big boost, it is the right thing to do, and it will mean better outcomes for patients both now and in the years to come, Chair. Thank you for the question. This is a very important boost.

Mr WELLS — Minister, I again refer you to budget paper 3, page 90, regarding the accuracy of figures. It was claimed in March of this year that — the minister said that the secretary of DHS would take legal advice on what action would be taken against those involved in data manipulation in Victoria's hospitals. What is the result of this advice? Has action been taken against any staff involved in data manipulation in Victoria's hospitals to ensure that the data provided on page 90 is accurate?

The CHAIR — As far as it relates to the estimates — I really think it needs to relate to the estimates.

Mr ANDREWS — It is pushing it, but I am happy to answer it.

Mr WELLS — He said he is happy to answer it, so let us see if we can get an answer.

The CHAIR — I really do think it is pushing it. You really need to be about the estimates.

Mr ANDREWS — I preface that by saying the question is pushing it, but let me say — —

Mr WELLS — Let us see if we can get an answer.

Mr ANDREWS — Have I got the call, Chair?

The CHAIR — As far as it relates to the estimates, Minister.

Mr ANDREWS — Thanks very much, Chair. I might ask the secretary to supplement this given that it is she who has sought legal advice. The advice is not on disciplinary action against any individual. We do not employ people who work in health services, Mr Wells. I would have thought you would know that. The health service employs people; we do not employ people in health services, and there is no allegation that any member of DHS staff has done anything other than act in a fully appropriate way in relation to data — just to clear that up.

As a matter of course, if any report comes to the Department of Human Services that has any issue of malfeasance or inappropriate behaviour, it is as I understand it rudimentary, it is simply custom and practice that the secretary would forward it to Victoria Police or get legal advice, if you like, and then take appropriate steps. I would ask the secretary to supplement that.

Ms THORN — If I can add to that, the health service in question is undertaking a very detailed review of what happened, and its board will consider the findings of that review and whatever action it needs to take in

consequence of that. I did seek legal advice about: was their any reason for me to make a reference to Victoria Police because of fraud or any other activity?

The advice I have received says that in order for anyone to prove fraud, you have to prove that someone, an individual, has individually benefited from the actions. There is no reason for any of us to believe that anyone has individually benefited from the actions, and indeed the Paxton report that the minister referred to before makes it very clear that there was in fact no benefit from the actions that were undertaken.

On that basis and given the action that has already been taken by the minister both in respect of broader issues around data and about that health service, I have made a decision that there is no need to refer this to Victoria Police, because my legal advice tells me it will not pass a test of fraud.

The CHAIR — In relation to the — —

Mr WELLS — Hang on, this is my question. Do you want me to ask a follow-up?

The CHAIR — I was just asking in relation to the forward estimates and the accuracy of the figures; you have not answered that, Minister.

Mr ANDREWS — I again stand by my comments earlier on. The department stands behind these figures, as does Paxton Partners in terms of making no link between issues of inappropriate behaviour at the women's and aggregate data. This is aggregate data. In terms of individual, health service by health service, data we await the findings of the six spot audits that I have set in place and a determination by the director of data integrity, appointed by the secretary, in coming weeks. Again I stand by the data, as does the department.

Mr WELLS — Just to pick up a point from the secretary, you are saying you are confident that no-one has personally benefited and as a result of that it would not be referred to Victoria Police on the legal advice that you received?

Ms THORN — On the legal advice I have received.

Mr WELLS — That is fine. The minister, though, has scrapped the $40 million bonus staff pool because — —

Mr ANDREWS — No, it is a pool to treat patients, Kim. It is not a staff pool. It is not a bonus pool for executives.

Mr WELLS — So there was no extra funding — —

Mr ANDREWS — No, it is to treat patients.

Mr WELLS — I am actually asking — — you the question about — —

Mr ANDREWS — It is a bonus pool for health services to treat additional patients. It is not a personal bonus pool.

The CHAIR — All right, I think you have answered that one.

Mr ANDREWS — Which I think you probably already knew.

Mr WELLS — I was just asking the question.

Mr ANDREWS — It is wonderful theatre, but I think you already know that.

Mr WELLS — I was just waiting for you to answer the question to make sure we were very clear about it all across the board.

Ms MUNT — Minister, could I refer you to page 104 of budget paper 3 under the heading of 'Health protection'. It is my understanding, and you can tell me if I am wrong, that the first confirmed case of H1N1 influenza has just been determined in Australia. Can you please advise me how you are addressing this particular issue; what measures are being put in place?

The CHAIR — And what measures are in the budget too, Minister?

Mr ANDREWS — Thanks, Chair, and thanks, Ms Munt, for the question. It is a very good question. This is a real public health challenge and one that has got a lot of media attention and a lot of policy attention as well in recent times, not just here in Australia but indeed right across the world. Ms Munt is correct to say that Australia now has its first confirmed case. A 28-year-old female who is actually a New South Wales resident travelling from Los Angeles to Brisbane was swabbed at the airport as part of the positive pratique process that has been put in place by the commonwealth government at each of our airports.

She was later found, using the good offices of the World Health Organisation collaborative at the Victorian infectious diseases reference lab, funded and supported by our government, to be positive for H1N1. It is what is called a weak positive — that is, she was no longer infectious. It is also believed that she was at no point infectious while she was on the plane, having been ill on or about 27 April, having flown and arrived on 7 May.

As I understand it, there was a range of contact tracing measures put in place. She was, if you like, quarantined to home, but now that order, or that process, has been lifted. So that is a great outcome for her. It is also great for public health more broadly. But it does show you that what has consistently been said by the chief health officer, Dr John Carnie, by the federal minister and by the federal chief medical officer, as that person is known, that this would ultimately arrive here, was in fact accurate.

There has been a whole range of processes and different pieces of work done and different arrangements put in place. First of all, the most important thing in dealing with these pandemic threats is to have the full cooperation of the Victorian public. The Victorian public has been fantastic in coming forward to get tested — those who had a relevant travel history and those who had flu-like systems — and that has been very important, and the full cooperation also of the Victorian community and the Australian community in terms of time delays at airports, the thermal scanning and all those different systems and processes that are time consuming. I think people have been very accommodating and have understood that this is a serious public health issue.

In terms of steps that we have taken at a Victorian level, the chief health officer has written to all general practitioners informing them of these issues and giving them a sense of what the processes and protocols are. He has also written to various health professionals who work in our health and hospital system. They have been updated regularly, either through circular or through the DHS website, www.health.vic.gov.au. There have been many detailed briefings. Of particular importance are briefings with senior clinical staff from the 16 designated hospitals that have got negative-pressure rooms and that have got other services and supports and protocols in place to deal with a pandemic.

We have also ensured that a proper protocol existed between private pathology providers, GPs and the Victorian Infectious Diseases Reference Laboratory so that we did not have samples going missing, it was a properly coordinated process and we could have an accurate picture at any one time of how many were being tested, how many were negative to H1N1 and how many were pending. As I have mentioned, we fully cooperated by providing public health nurses and other staff as part of those positive pratique arrangements at Melbourne Airport, and we have also been very keen to do all that we can to properly cooperate with the commonwealth government.

Politics ought not come into these matters, and it never does. These are issues for the whole Victorian community and the whole Australian community. We are very pleased to have been able to provide substantial support in past years around the Victorian health management plan for pandemic flu — things like the upgraded at VIDRL, things like our own $4.5 million stockpile of medical supplies, not to be confused with the national stockpile that has something like 8.7 million courses of Tamiflu and similar antivirals and other medical supplies, and also very substantial investments around negative-pressure rooms and other physical facilities that are important in terms of dealing with a potential pandemic threat such as this one. Again we are on high alert, if you like. We are at phase — Dr Brook?

Dr BROOK — We are at delay phase.

Mr ANDREWS — It is important that we continue to do the work we are doing, but what is really important is that if any Victorian has got a travel history and has symptoms: visit your doctor, visit the hospital, ring Nurse-On-Call, get tested and then we will provide you with the care that you need.

Ms THORN — If I could just add to that, as an example of the alertness, one of our very senior staff had occasion to take his very small daughter to the Children's yesterday with flu symptoms. In the course of the examination it emerged that she had probably caught the flu from the child of someone who had recently returned from the United States. She was automatically treated separately and differently — you might call it mystery shopping; he was not intending to do that. The hospitals are certainly on alert and keeping their eye on anyone who attends with symptoms and examining not just their immediate family but who they are in contact with.

The CHAIR — Thank you, Secretary.

Mr RICH-PHILLIPS — Minister, you spoke earlier about additional funding for BreastScreen Victoria. I would like to ask you about the targets on page 105 of BP 3, which show a reduction in the target population screened within the specified time frame for breast cancer. The target has been reduced from 60 per cent in 2008–09 to 56 per cent in 2009–10, and there is a footnote which states:

> (b) 2008–09 expected outcome reflects the higher demand for breast screening services and ongoing workforce pressures. 2009–10 target has been revised to align with the current national average.

My question is, firstly, what does the reference to 'workforce pressures' mean and why would you be reducing the target to a national average?

Mr ANDREWS — This is a good question. Obviously there are pressures in this system, and I did allude to those a moment ago, in terms of the radiologist and radiographer workforce and others that are involved in this. I will get Dr Brook to supplement this answer in just a moment. He is most expert in these matters.

That is why, can I say, the investment of $10 million in terms of digital is so important, as I said earlier, in making the best use of the workforce we have, together with a range of other initiatives. We spend $40 million a year on a whole range of different workforce programs. I announced very substantial boosts only a couple of weeks ago in terms of rural and urban specialist posts for the next couple of years. There is a lot of activity in terms of training not just the generalist medical workforce but the specialist workforce as well. That is not just our responsibility, it is also the commonwealth's, but there is no doubt that there are workforce pressures, together with the fact that we have a growing cohort of women — that is, the target group of women between the ages of 50 and 69 is getting bigger and bigger each year.

Whilst our funding as a state government has grown, as I said before, from around $19 million to $31 million and there have been things like digital and some service delivery changes like the two bands and things like that, the commonwealth's contribution has remained reasonably stable. We would like to see that perhaps go up over time. There is a challenge here. One of the ways you meet it is through things like digital, through the other workforce programs that we have put in place in a broad sense, but also the Victorian cancer action plan — although it is towards the end of these forward estimates — funds 20 000 additional breast screens. This is a very important area, but it is challenging because the cohort is getting bigger and bigger each year. There is a review, as I understand it, of mammography or breast screening services that is currently being run by the commonwealth government, and we will eagerly await that. I think that probably answers the question in broad terms. But I will ask Dr Brook to supplement that.

Dr BROOK — Thank you, Chair. There is an Australia-wide shortage of both radiographers and radiologists in providing this and a number of other like services. This is a very big program. Ideally, every woman between the ages of 50 and 69 is targeted for mammographic screening every second year. It dwarfs any other radiological program of its type. It is a very big program. Not all women wish to participate, so the national objective in this arena is in fact only 60 per cent participation because it is not anticipated that every woman will participate.

The minister's statement about the nature of what is happening here is absolutely correct: it is something of a squeeze play. The cohort of women who are reaching the target age range of 50 to 69 is growing considerably as the baby boomer group moves through, and the capacity of the system to be able to respond to that is in fact quite limited. Things that we are doing, along with other jurisdictions, include looking at different models of workforce provision, so that rather than relying only on radiographers, who are the biggest problem group, we can look at a differently trained workforce, a more specifically trained workforce, under supervision, to look at

better ways of using the available radiology — that is, the people who read the films — workforce. There are a number of ways that can be done.

That can be done through, and I think it has been discussed, using the benefits of modern technology and compressing data and being able to transfer images from one place to another where they can more easily be read. I do not think we should underestimate just how significant the provision of the first mobile digital service in Australia is. Using basically Telstra 3G — without the ad — we are able to transmit large packets of information such as have never been appreciated before and get a service performed in, say, Shepparton, read in, say, St Vincent's and almost instantly answered.

We are making use of that. There is a major review of what is called BreastScreen Australia, which is the overarching program, and we understand that the final report of that is with the commonwealth at this point in time, but it has not been publicly released. We are hoping that the reason for delay in its public release is because the commonwealth wishes to invest further in this area, but that is their call, and so we are not in a position to confirm that. We actually have some significant issues to work through ourselves to try and generate more services to meet the growth in population in this area.

Just to remind you, this is a screening program; this is a program for women who have no symptoms, who do not have a family history of or think that they have breast cancer — for them going to other services is recommended. This is for people who are entirely asymptomatic, so as long as we can get this sorted we hopefully lose very, very little. That would be the ideal — that there is very little slippage in the program.

Mr RICH-PHILLIPS — Can I conclude from both your answers that the decline in the expected outcome for the current year which was expected to be 55 per cent versus the 60 per cent target last year reflects a constraint in supply for breast screening services?

Mr ANDREWS — I think what has been alluded to is a constraint in supply of an appropriately trained workforce. There is no constraint in supply in terms of funding, for instance, that is provided to agencies.

Mr RICH-PHILLIPS — No, availability.

Mr ANDREWS — It is the availability of the staff we need in order to provide these services. I will just add this: Dr Brook mentioned the mobile van, and I recently had the opportunity to be briefed on that van going into a number of remote indigenous communities if we have such a thing. We probably do not, technically, but some communities in rural and regional Victoria have large numbers of indigenous women, and it is such a powerful example of where smart investment can really drive changes in culture, changes in outlook. That mobile van has now visited that particular community twice, and it is not just about breast screening; it is a whole range of health services, whether it is cervical screening, running tobacco cessation programs — all sorts of women's health programs now that run from that van. It is only possible because the van is there, so it should not be lost on anyone, the significance of that. It is a really important investment; we are really proud of it, and BreastScreen Victoria did a wonderful job with it. That is the rural one; there is also the urban one as well.

Mr NOONAN — My question follows on from the comments you have just made, because I wanted to ask a question about indigenous health on which you also presented us with some information in your overheads. I think you described it as the biggest boost the state has ever seen in this area. So with reference to budget paper 3, page 39, which outlines the National Partnership on Closing the Gap in Indigenous Health Outcomes, I wonder whether you can explain how the government is investing to achieve this outcome and what the government is expecting to achieve as a result of that significant investment.

Mr ANDREWS — That is a very good question, Mr Noonan. There are many fine words spoken about these issues, and words are important and it is important to say and to be clear about the fact that we all as a community are really concerned and fundamentally committed to closing the gap, the 17-year life expectancy gap, which is no different whether you are in Fitzroy Crossing or in downtown Fitzroy. These are as much issues for Victoria as they are for remote Western Australia, the Northern Territory or Queensland. It does not matter where you are in Australia, 17 years is the life expectancy gap. That is shameful, and again as I have said many times about many different issues, we can often be well measured by the way in which we provide for the most vulnerable — our Kooris, our indigenous men, women and children, can I say. With that life expectancy gap we do not measure up very well at all.

There are some good programs, and we are proud to have supported them, certainly during our time in government and I am sure there were equally good programs under the previous government. Whether it is the Koori maternity service or a range of other targeted programs to support indigenous citizens in terms of chronic disease, whether it is in general terms policies and programs that may make particularly our rural and regional health services but also our urban health services more culturally appropriate, I think there is a good story to tell here.

But fine words are one thing; good policy and good intent is one thing, but it is the funding that makes the real difference. I am really proud to be able to say that this year's budget delivers nearly $47.5 million as part of our contribution to the national partnership — concrete, important steps forward, whether it is in terms of smoking cessation, birth weight, diet, physical exercise, alcohol and other substance abuse; a whole range of different supports and programs that I think will pay dividends and will really empower indigenous citizens through improving their overall health status.

If I can just give you a couple of examples of programs we will be able to grow as a result of this additional funding before I talk about workforce to wrap up: this year — only very recently, a couple of weeks ago — I was pleased to go out to Dandenong North just outside my own local electorate and celebrate the 10th birthday of Koori Maternity Services. This is a really important program; one we are very proud of and one that is delivering results. It is about midwife and team-based care, where Koori women who were previously often getting no antenatal care at all and would present, for instance, to a metropolitan health service whilst in labour, are now getting access — a vastly higher number are now getting access — to the antenatal care, the birthing care that they need, and also importantly for their health and the life opportunities of their baby, the post-natal care that they need.

I will give you one practical example of what that means for Koori women and their babies. For participating mothers something like 85 per cent of babies born in this program have a birth weight of over 2500 grams. To compare that, it is a mere fraction of that if you do not participate. So this is all about really tangible outcomes, better outcomes for the mother, for the baby and indeed for indigenous communities in a broader sense. That is just one example. That has celebrated its 10th year. One million dollars of this money goes towards expanding that for a further three sites. That is literally, over a period of time, hundreds and hundreds of indigenous babies and their mothers better supported than they previously were.

I have spoken about smoking cessation. Just recently I announced outside these moneys — but, again, it is another example of our absolute commitment to these issues — $1.5 million over three years for two important demonstration projects that are about better integrating primary and other disease management care with a proper evidence base. All too often we do not have the evidence base we need in terms of indigenous health — what works, what will not work, how you make the case for further investment? Those demonstration projects are an important part of that, both the one at VAHS in Fitzroy and the one up in Mildura at the co-op there.

Again, as I said at the outset, words are one thing and they are important, but practical investment, effort and energy in partnership with the commonwealth government really is the key to closing that gap, to making a dent in that, to doing more to empower people. It is all about dignity, it is all about looking after the most vulnerable, and often our indigenous communities are the most vulnerable across our state.

I will just finish by saying in terms of workforce, as I said before, whether it is in terms of breast screening services or so many other parts of the health system, we are as good as the staff that we can recruit, and we are as good as the staff that we can keep in our system. So having the right staff in the right place is really very important — even more so when it comes to providing culturally appropriate care, not just for indigenous consumers but also those from a culturally and linguistically diverse background in many different ways, but certainly in terms of indigenous health care and providing culturally appropriate care, where there is trust, where there is support, where there is a bond and where there is a confidence to come forward and get the care that is necessary.

This package also supports the training of 35 of those staff to work in Aboriginal-controlled health organisations. That again should not be underestimated in terms of the power of that, again as we look to close the gap and provide better and far more appropriate care and, in turn, better outcomes for indigenous men and women and children across Victoria.

The CHAIR — Thank you for that, Minister.

Dr SYKES — Minister, my question relates to the tables on pages 89 and 90 of budget paper 3. It goes to the issue of areas of underperformance in achieving some targets and yet the preparedness of the government to commit more money to those sorts of programs. For example, on page 89 at the bottom of the page, you have 'Emergency patients transferred to ward within 8 hours'. For 2008–09 the target was 80 per cent and the expected outcome was 69 per cent. Similarly on the top of page 90, for 'Semi-urgent (category 2) elective surgery patients admitted within 90 days' the expected outcome was only 74 per cent compared with a target of 80 per cent. What is the situation there? You are getting underperformance compared with targets. Is that because of lack of money or is it because of lack of efficiency? In other words, is just throwing money at it going to solve the problem, or is there something else that needs to be addressed?

Mr ANDREWS — Dr Sykes, it is important to — —

The CHAIR — Minister.

Mr ANDREWS — Sorry. It is important, Chair, to acknowledge that we are faced with a situation where more people are presenting for the care that they need, increasingly. I spoke in my slides about the notion that that sort of acuity profile is changing. So sicker people are coming to us to get the care that they need. These targets are about trying to drive improvement. These targets are meaningful targets, but no-one has ever said that they are easy; no-one has ever said that they can be easily achieved. What I have always said is that my aim is to try to deliver improvement, to try to treat record numbers of additional patients and to treat them faster. That is not an easy thing; it is not an easy thing at all.

My real task, Dr Sykes, is to make sure that our doctors and nurses and the other dedicated professionals in the system have the resources that they need — and you alluded to money, and money is always important. That is why there is 130 per cent more money in the system today than on the very first day that we came to government. There is always more to do, there are always challenges, whether it is in relation to the workforce, in relation to the infrastructure, in relation to the — —

Mr WELLS — More to be done.

Mr ANDREWS — Yes, there is more to be done, with record funding from this government.

Mr DALLA-RIVA — More to do, more to be done — —

The CHAIR — Ignore the comments, Minister.

Mr ANDREWS — Dr Sykes has asked a very serious question.

The CHAIR — Please continue to answer it.

Mr ANDREWS — Dr Sykes, what I would say to you is: these targets are important; they are about trying to drive improvement. The two that you mentioned, for instance, if you look at — I think you referred to the bottom of page 89, which says 'Emergency patients transferred to ward within 8 hours'. If you look at the 2007–08 actual and the expected outcome in 2008–09, that is a 2 per cent increase — from 67 to 69 per cent. I fully admit that that is below the 80 per cent. But the other point to remember is, of course, that many more patients have been treated within the clinically appropriate time, given the total growth in the number of patients who are actually presenting for care. So there is more money, there is a real commitment — from the government, from the department, from individual health services and from the doctors and nurses who work in them — to achieve these targets and to bring about improvement. That indicator shows important improvement.

I think you also mentioned category 2 elective surgery and if you look at semi-urgent elective surgery, I think was the one you raised Dr Sykes, you look at the 2007–08 actual it is 70 per cent, the expected 2008–09 outcome is 74 per cent. Again, I fully acknowledge we have not met the 80 per cent target, but we are seeing improvement all the while we treat more patients in terms of elective surgery, record numbers of additional patients, as I alluded to in my presentation earlier.

Ms HUPPERT — I refer to the Nurse on Call program that you referred to in one of your previous answers. In budget paper 3 on page 89 we have been given the output for acute health services. We know that the Nurse

on Call program has been designed to assist particularly with lower acuitive patients. Minister, could you give the committee an update on how Nurse on Call is operating?

Mr ANDREWS — That is a very good question, Ms Huppert. We have, as you know, supported Nurse on Call and Nurse on Call today has taken more than 1 million calls. It is a trusted resource, a trusted source of health information and advice. What it means is that more people are ringing to get the advice and support that they need. That is all about empowering people, giving people the information in a timely way. That is important.

What is also important is that it effectively saves time, saves resources, saves effort in our emergency departments and in our public hospital system. Previously, before Nurse on Call it would be not uncommon, in fact many thousands of calls were made each and every month, each and every year, to local emergency departments, seeking the information, the advice, the assistance that Nurse on Call can provide now, discreet and separate from the emergency department.

It is a very trusted resource, a trusted service. I note that a recent customer satisfaction survey indicated that 99 per cent of those who responded were satisfied with the service they got, so it is very highly and well thought of, and that is important.

I mention again that there is an issue about saving time and saving resources; making best use of our hospital resources, in terms of them providing care rather than providing information to people. I am advised that since Nurse on Call first began, just under 21 700 hours have been saved that would otherwise have been nurse time, other emergency department staff, and other health service staff — that is 21 700 hours saved that they have not had to spend on the phone providing advice, they have been able to get on with providing care to people.

That represents just over 2700 days in terms of effective time. That is another way of looking at it. It is a great service for individuals, for families, but it is also a great service for the health system more broadly.

I think that was seen very clearly throughout the heatwave that we experienced earlier this year when Nurse on Call and other telephone-based diversionary programs, if you like, to substitute for acute health care and the misuse of those important resources, coped very well and was a great source of comfort and advice to people.

In terms of bushfires, not so much during bushfires, but in the weeks and months afterwards, Nurse on Call has been a powerful resource there as well and most notably, as I referred to earlier, the H1N1 issue, there have been many calls to Nurse on Call as well, seeking advice.

So whether it is about the individual, the family or the health system and the sustainability of the health system, Nurse on Call is doing very well and we are very pleased to celebrate its birthday recently, and to celebrate more than a million calls. In fact, I am advised, for the record, that there have been 1 072 725 calls at last count. It is working and it is working very well.

Ms PENNICUIK — Minister, I am wondering will the government be providing resources to implement the recommendations of the *Rural Directions for a Better State of Health* report in relation to maternity services? And are you expecting any more rural and regional obstetric units to close in 2009–10, and if so, which ones?

Mr ANDREWS — This is a very topical question. The commonwealth government is currently conducting a maternity services review that has been the subject of a lot of press attention and stakeholder attention. There has also been, in our own media, recent reports around one particular rural and regional service that had to temporarily close because of senior staff going, one to sit his fellowship exams and another one that was simply on annual leave.

What I would say to you is that individual health services make very difficult decisions about the services they offer in their local area. They are charged, as individual statutory authorities, with providing safe and relevant care. Sometimes there are shortages of relevant workforce, sometimes it is simply by the number of women seeking to birth at a given health service.

There is simply not enough demand to either retain the right staff or to give staff who are willing to continue to work there enough recency of practice and enough throughput, if you like, to keep their skills up. Those boards

do have to make, in those circumstances, very difficult decisions at a local community level, and some of those decisions have been made.

Again, I think every health service, both executive but also the board, takes those responsibilities very seriously. The safety of the patient has got to come first. It is only if you can provide appropriate and relevant care that you would seek to offer that care.

I will get Dr Brook to supplement this. This is an area of expertise for him, in terms of his responsibilities with Rural and Regional Health. Whether it is the rural maternity initiative, whether it is last year's baby-boom budget in terms of capital works across the states and in the outer suburbs but also the very substantial growth funding — I think, if memory serves, $40 million across the four years — in terms of additional capacity, we are providing more women with choice, albeit there are challenges in some communities, and safety has always got to drive those issues; and it has got to be the main consideration.

I think boards and their senior executives discharge those functions, which are very difficult, well, and they are today supported in record terms. Never before has a state government provided more support for rural maternity services than our government does. We can always do more and we are committed to doing that.

Dr Brook might be able to add, just in terms of any trends, and any other comments he might want to make.

Dr BROOK — We did have some discussion about this last year, as you may recall, but I think it is important always in discussions of rural maternity to have a context in which to place the picture of rural maternity services.

People talk a lot about closure of rural maternity services, but they do not talk about the 43 health services that continue to provide maternity services — that is, births — across rural Victoria, and the seven hospitals that, while not providing births, do actually provide antenatal and postnatal care in their local community and refer to a reasonably close hospital for antenatal care.

Whilst it is true that there are services which have over time, for demographic reasons almost exclusively, not continued with maternity services, I think we can take great pride in the preservation and enhancement of rural maternity services to the extent that we are able. In fact, 85 per cent of women giving birth in rural Victoria choose one of 17 bigger hospitals, so there is an element here of personal choice, not just whether a service is available or not.

The main determinant of whether a hospital can or should provide obstetric services is most often not doctors. I have made this point a number of times. It is actually the capacity of the hospital to field a team of midwives, and to do that properly you need to be able to have three shifts of midwives in continuity. Three shifts of midwives does not sound much, but if you are a very small community with a very small hospital, and if that community has a workforce profile which is itself ageing, then that becomes a major problem for it.

Of course you need to have doctors who provide care, and if you are going to provide any form of complex obstetrics, you need to have some form of anaesthetic coverage and an operating theatre and the like. None of those things is any use unless both doctors and nurses have appropriate recency of practice, especially midwives.

As the minister said, what we have done in relation to rural maternity services, quite unlike other jurisdictions, is rather than saying, 'Here is a number' or 'Here is a place', we say, 'We are prepared to offer you what the sort of capability requirements you need to think about are; and if you have those capabilities, then certainly we will support you in the provision of the services that are appropriate for your local community. But if you determine that you do not have those capabilities — and one of those capabilities might be, for example, can you cope with an emergency and how would you would deal with that emergency; if you determine that or if your doctors quite genuinely are struggling because they themselves are growing old and they cannot field an out-of-hours group — then there are all sorts of local issues that might determine whether somebody does or does not'.

But when it comes to the major regional hospitals; when it comes to the further 11 or 12 major sub-regional hospitals, all of them provide vibrant obstetric services. That is not to say that we have not had some times — for example, a brief period at Seymour, and most recently a very brief period at Portland — where the services

had to withdraw from low-level obstetrics for a period. We then try and offer all the support we can to recruit staff, whatever the case may be.

Mr ANDREWS — It is important to note, Chair, that the Seymour example is a very good one, where through a lot of hard work — and the department was involved in that — we have now got birthing services back at Seymour hospital, and that is very important.

What I would say is that I am happy to write to the committee around the rural maternity issue, which is a wonderful program that links women, and often small country health services, with larger country health services and with a medical and midwifery workforce in teams to provide choice and provide care.

There are a lot of really great examples, particularly in the Goulburn Valley, over in the far west of the state as well, where we have some very great outcomes where we have linked the hubs both ways, if you like — larger hospitals, which themselves are not big, with smaller health services, team-based care, obviously for low-risk pregnancies: that 70 per cent are low risk. It is not just a matter of reading some report written by somebody, and I am pleased to do it, it is speaking with mothers, speaking with midwives and with doctors in those communities, and they are very pleased with the outcome. Chair, we might provide you with an update on how the RMI is working.

The CHAIR — Thank you for that.

Ms PENNICUIK — My question was: were you expecting any to close? I accept the answer you have given, particularly Dr Brook's, but I would like to know: are you expecting any more to close?

Dr BROOK — Are you asking: are there any planned closures or restrictions? No, there are no planned closures. The only recent issue we had was at Hepburn health. That is a decision that hospital has made where it is very close indeed to other service providers. We do not have any program of closure of obstetric services at all — quite the reverse.

Mr ANDREWS — There were literally, in that example, a handful of women who were seeking to birth at Hepburn.

Mr SCOTT — My question is regarding palliative care, and I refer the minister to page 89 of budget paper 3, which indicates the output 'Palliative care bed days'. Can you outline how the government is supporting patients requiring palliative care through inpatient and home-based or community based care? I will declare a slight conflict of interest in that my mother has worked in this particular area with the mentally ill over a long number of years, but not in palliative care.

Mr ANDREWS — That is a very good interest to have to declare. That is a great question from Mr Scott, and I acknowledge his long-term interest in these matters. Providing dignified end-of-life care and support, not just to the consumer, the client or the patient but also their loved ones is all about empowering people. It is about giving people choice; it is about really supporting people at their most vulnerable, and there can be no time when you are more vulnerable than in those last weeks, months and years, even, of a terminal illness.

Cancer is often the focus of palliative care, but it is not just cancer, it is a range of other important conditions, and across the board we have been pleased to boost palliative care hours and palliative care bed days but also to support greater choice in terms of palliative care, whether it is inpatient or acute services or what is referred to as community palliative care.

There has been a substantial boost there as well. What we know from talking to consumers, from talking to their loved ones — from listening, basically — is that people want choice; they want to die in the place of their choice, and they want to be supported to do that. That is not an easy thing. That is a very big challenge, particularly in the outer suburbs and particularly in rural and regional areas. We have proudly supported that choice, whether it is through infrastructure investments — Wantirna Health in the member for Scoresby's electorate, or if not, very close to it — —

Mr WELLS — Very close to it.

Mr ANDREWS — The old Wantirna drive-in site, a fantastic facility — 50 per cent subacute beds for aged care, 50 per cent palliative care beds — with the co-location of outer eastern community palliative care, a

fantastic facility from the ground up. It is about choice; it is also about recognising the new model of the way palliative care is offered. It is often referred to — people will go in for a tune-up, if you like — as episodic care. It is not necessarily one block of care. People go in, get the care that they need, and that kind of sustains them for a period of time. There will come an end-of-life period, and that can be inpatient or at home.

What I am saying is more money, brand new and important facilities, more choice and innovative models of care, innovative ways of providing what really is so important to so many people. In terms of additional hours, there is an important boost in the budget this year. One example is $1.7 million for palliative care funding for Melbourne Health which will support in your own local community, Mr Scott, out in Melbourne's north, 10 new palliative care beds at Melbourne Health. That will provide around 3000 additional palliative care bed days. It is very substantial; many patients and their families will get the support they need through that model.

This year — in 2009–10 — we will invest around $80 million on palliative care across all different settings. It is not just about direct care; it is also about medical and nursing, often nurse practitioner consulting services, so putting in the expert workforce. This is a growing discipline and one where there are certain needs, and you need to have the skills and expertise to provide this care. It is a very challenging environment to work in and we are very grateful to a growing workforce. But those moneys include workforce strategies as well.

I did note that it is not just about cancer. There are many other conditions to which palliative care is important but the Victorian cancer action plan did provide a $3.6 million boost for these services as well as some workforce supports, particularly in rural and regional communities, noting that that is very important to providing care and to providing options.

Whether it is a fact that by 2011 we will provide a minimum of five medical palliative care trainee opportunities each year in accredited palliative care training facilities, or things like the nurse practitioner program which we have supported and will continue to, there are many different examples, many different ways in which we are supporting with not only additional funding but also additional training opportunities. We have the right workforce as well as capital works to grow these services because we know how important they are to people, often at the darkest hour in their lives.

Listening to the consumer voice is very important as well, and we do that to try to make sure that we build the best possible service system.

Can I say that it is not just in Melbourne or the outer suburbs, regional Victoria really has benefited not just in cancer, but that is a leader in it, in terms of additional effort around palliative care, and we remain committed to growing the overall funding that we offer, growing the workforce, growing the supports that we offer to both inpatient palliative care and also community-based palliative care.

As I said before, the most vulnerable and how you provide for them can sometimes be a fair measure. I think this is a good outcome but one where we can do more and indeed we are committed, through the VCAP and through other processes, whether it is in terms of paediatric palliative care, whether it is in terms of the overall palliative care framework which we are in the process of looking at, together with budget outcomes. I think there are some good stories here of providing support to people when they are at their most vulnerable but we can always improve; we can always drive better outcomes and we are committed to doing that.

The CHAIR — Thank you, Minister.

Mr DALLA-RIVA — I refer the minister to budget paper 2, page 49 and if I could have a look at the last PowerPoint slide.

Overhead 'Investment in health infrastructure' shown.

Mr DALLA-RIVA — Just in the last dot point, Minister, and budget paper 2. It relates to the use of cash resources and the application of cash resources, in particular the Box Hill Hospital redevelopment proposal. I understand from the Premier's presentation yesterday, in which there was reference to the Box Hill Hospital being a consideration, I want to get some clarification into the forward estimates.

There are two lines in terms of 'net investment in fixed assets' and 'expenditure on approved projects', which are $4.5 billion and $7.1 billion et cetera. Under that is 'capital provision approved but not yet allocated', and that is in the forward estimates of $262 million in 2010–11.

I am trying to get some clarification from you, given that you have said 'committed to a further stage'. I would assume you obviously have some money allocated. Where is it within the budget you are proposing it would come from? Is it from expenditure on approved projects or is it from capital provision approved but not yet allocated? Depending upon which one it is coming from, when do you expect the rollout of the Box Hill Hospital to proceed?

Mr ANDREWS — Can I say to you, Mr Dalla-Riva, that issues around the allocation of unallocated capital are not matters for me. They are matters for the Treasurer, and I think you had him before you for 3½ hours this morning; the Premier before you for about that time yesterday, and I understand there was a debate about these matters, as there usually is. It is not for me to unpack unallocated capital or to rebuild the budget for you. That is not my job. What is my job is to ensure that we have the best possible fabric, the best possible facilities right across the state.

Mr DALLA-RIVA — I am talking about Box Hill.

Mr ANDREWS — I will come to Box Hill. We have consistently said that we are committed to the redevelopment of the Box Hill Hospital. Stage 1 is funded — very important. In terms of further stages, as the slide shows there and as a media release not from me but from the Premier and me on budget day made very clear, we remain committed to a further stage of the redevelopment of the Box Hill Hospital.

Mr DALLA-RIVA — So it has not come out of — —

Mr ANDREWS — It is not for me — —

Mr DALLA-RIVA — It is not in the approved projects?

Mr ANDREWS — Hang on. Let us read the slide 'awaiting details of first round funding allocated by commonwealth government from the health and hospitals fund'. That is very clear. We are awaiting — and we will only have to wait a few more hours — in relation to the commonwealth budget to see not just whether there are allocations for this project. That point is making a broader point. What are the moneys that will come to our state for health?

Indeed it will not just be health that people wait on tonight; it will be a whole range of other important infrastructure projects — from the Building Australia Fund, from the education fund I think, from all manner of different funds that the commonwealth government has set up.

What is clear is that there can be no doubt that this government is committed to the redevelopment of the Box Hill Hospital.

Mr DALLA-RIVA — When?

Mr ANDREWS — There is no doubt about that.

Mr DALLA-RIVA — I have asked you pretty much — —

Mr ANDREWS — Would you like me to read the slide again?

Mr DALLA-RIVA — Yes, read it.

Mr ANDREWS — 'Awaiting details of first round funding'.

Mr DALLA-RIVA — That is great.

Mr ANDREWS — Could I be any clearer?

Mr DALLA-RIVA — But I have also given you the forward estimates on page 49 of budget paper 2, there are — —

Mr ANDREWS — And I have indicated to you that it is not for me to unpack those issues.

Mr DALLA-RIVA — So I gather from your statement, Minister, there is no state funding in the forward estimates for this statement here?

Mr ANDREWS — How can you gather that?

Mr DALLA-RIVA — Because I have just asked you the question! I have asked you the question about expenditure on approved projects. You said there is none for Box Hill and the provision — —

Mr ANDREWS — The allocation of unallocated capital is not a responsibility of the health minister. Can I put it to you with the greatest respect that that does not mean what you have just said it means.

Mr DALLA-RIVA — But you have not answered the question that I asked.

Mr ANDREWS — It is not a question for me to answer. It does not fall within my responsibility.

Mr DALLA-RIVA — So who should answer it?

Mr ANDREWS — The witness you had before you for 3½ hours this morning, Mr Dalla-Riva. If you did not have the presence of mind to ask him, that is not my responsibility.

Mr DALLA-RIVA — I guess there is more to be done in this committee. The realities are that Box Hill Hospital is not going to get developed.

Mr ANDREWS — You want to do a bit of work on your questions, because it is not for me to answer for the Treasurer. I have made that point.

Mr DALLA-RIVA — You have got all this money allocated and you are not going to do it, you are not going to build it. It is just more spin. There is no money. You are waiting for Rudd money again.

Mr ANDREWS — Where this has finished up, Chair, is where Mr Dalla-Riva always hoped it would — that is, him being able to make a claim that this government is not committed to the redevelopment of the Box Hill Hospital.

Mr DALLA-RIVA — You are not.

Mr ANDREWS — In saying that, he is wrong.

The CHAIR — I want to ask you about major trauma patients. I refer you to page 89 of budget paper 3. You will see there, under 'quality major outputs and deliverables', 'major trauma patients transferred to a major trauma service'. There are percentage targets there. I just want to ask you: what in the budget do you have to deliver that particular output and to support trauma services here in Victoria?

Mr ANDREWS — Thank you, Chair, that is a very good question. Can I say to you that I think all of us across the state are very proud of the work of our trauma surgeons, our other medical staff, nurses. But can I single out — sometimes it is unfair to do this — our ambulance paramedics, particularly our flight paramedics, both rotary and fixed wing. We are all proud of the work they do. We see it on television. There are many different TV shows that are dedicated to this really important part of the overall health care system. We can be very proud of the work that they do, but it is important to support them, and it is important as well to gather evidence and see what the outcomes of that investment mean.

There are about 2000 major trauma patients treated at one of the state's major trauma centres every year, noting we have three major trauma services — the Children's, the Royal Melbourne and the Alfred. On from that, though, under some work — to give credit where it is due — that was done by the previous government and implemented by our government under the RoTES review, there is an integrated system, a statewide system, where you get properly escalated levels of care.

The whole health system works together to provide you with the trauma care that you need no matter where in fact the injury occurs — noting that it is not just motor vehicle, it can be an industrial accident; it can be any manner of different issues.

The CHAIR — Bushfires.

Mr ANDREWS — Bushfires, indeed, and I will come to that in a moment. Great staff, the best trained in the world, very strong support, a proper service framework where the whole system does not operate as individual health services but truly as a system, including ambulance and really substantial outcomes, really important results. You see those numbers reported in the budget, as you referred to them.

The bushfires — there were around 800 fire-related emergency department presentations and about 130 fire-related admissions. Within that number there was a cohort of very seriously injured people. The Alfred, both in its capacity as one of the three statewide trauma services but also our burns centre and one of Australia's leading burns centres, provided care to 21 of those most critically injured patients — 9 in intensive care and 11 in the burns unit.

We saw the pictures of the Ambulance Victoria choppers landing on the helipad at the Alfred, transporting those critically ill patients. Ambulance Victoria was a very important part of that. That is just one example of the kind of support that the Alfred and its contemporaries can offer.

Importantly — and this bears out the example around the system working together — in order that the Alfred could focus on those burns patients, the Royal Melbourne Hospital stepped up and took much of the trauma load, the non-bushfire-related trauma load that the Alfred would normally have had to share. The Alfred stepped up in a true system-wide sense and created the room, if you like, for the Alfred, both the ICU and other services, to cater for those critically ill burns patients.

I am very pleased to note that, as announced in the budget, there is a $1.1 million boost— a modest boost, but it will be of real importance to the Alfred burns unit — to upgrade the very important facilities there. These are inpatient facilities up on the ward as distinct from the ICU. That is an important development around improving infection control. We know people who have got very severe burns are the most prone to infection. It is about improved patient amenities and also some support around rehabilitation facilities — their own dedicated gym, for instance.

We are very pleased to have supported trauma services, pleased to have implemented and supported in an ongoing way a really good policy framework — it is a great system — and also to give all the component parts of that system the support that they need.

To give you a couple of further examples, in due course we will open the biggest ever emergency department redevelopment in the state's history at Melbourne Health — one of our state trauma services. Earlier this year I was really pleased to officially open the new Alfred intensive care unit — $25 million; an absolutely magnificent facility with more space, three dedicated pods to do the cardiothoracic transplant work, trauma and the non-trauma work; so three discrete areas, a lot of preparation and a lot of research. It is a fantastic facility to work in and provide care to the most critically ill.

I have already mentioned in answer to Dr Sykes' question earlier around air ambulance services that there will be not one but two new emergency helicopters — one adult retrieval, neonatal and also paediatric — but also putting the additional chopper down at Warrnambool and also providing ongoing support for the fixed-wing fleet — nearly $46 million. The list goes on and on.

The beds package I spoke about before is also about growing our capacity. The budget papers again do not show investment but they show above-target outcomes and we are very pleased with that. The real credit belongs to our dedicated workforce across the spectrum of trauma care who work in such a high-pressure environment, such a personally challenging environment, providing care and saving lives.

Mr WELLS — In relation to the Royal Children's Hospital project, given the claim in March of this year by the project director that there would be an additional $150 million in extra design and construction costs and, further, that the Auditor-General raised a concern that a $35 million donation expected to come from the Royal Children's Hospital Foundation and underwritten by Babcock and Brown International has not been paid by the due date, can the minister show us where in the budget papers these funds have been accounted for?

Mr ANDREWS — Let me indicate that there are some who have a very long history of criticising this project.

Mr WELLS — Who are you referring to?

Mr ANDREWS — Nobody in the Labor Party.

Mr WELLS — Who are you referring to?

Mr ANDREWS — We have funded this project — —

Mr WELLS — Who are you referring to?

The CHAIR — Can you allow me to chair this, thank you very much.

Mr WELLS — Who are you referring to?

Mr ANDREWS — You know who I am referring to.

The CHAIR — The minister, to answer the question.

Mr WELLS — I have asked you a question. Just tell me who you are referring to.

The CHAIR — Please do not interrupt.

Mr ANDREWS — We are proud supporters of this project. This is an important project. Mr Wells quotes from the Auditor-General's report. He fails of course to mention that the Auditor-General made it very clear that this project is on time, is on budget, is a first-class project and represents best value for every single Victorian.

Mr WELLS — Are you going to start addressing the part of my question, please?

Mr ANDREWS — Again, you have asked your question and I will answer it — —

Mr WELLS — You have given me the spin and the rhetoric. What I want is an answer to my question.

Mr ANDREWS — I hardly think — —

The CHAIR — Just a second, Minister. Mr Wells, could you desist from interruption?

Mr WELLS — He made an accusation about who supported and did not support it, so you must expect interjections when the minister is going down that path. Are you going to bring him back to answering the question?

Mr ANDREWS — I am answering the question. If I can get a word in, I am answering the question.

The CHAIR — All you are doing is causing problems for Hansard and interrupting. The minister to answer the question please, without assistance?

Mr ANDREWS — Thank you, Chair. I hardly think the Auditor-General is into spin. I am quoting from the Auditor-General. I am referring to the Auditor-General.

Mr WELLS — No, I am accusing you of the spin.

Mr ANDREWS — I am referring to the Auditor-General who finds that this is a best-value project and is a first-class project and one that we as a government are absolutely proud to have been able to provide support for.

The premise of the question is that a payment from Babcock and Brown has fallen due. It has not fallen due. That is the advice I have. What is more, my department is working with the board of both the Royal Children's Hospital Foundation and the Royal Children's Hospital itself around these issues, and we are very confident that there will be no shortfall in relation to this project. The Auditor-General himself finds that the project is on time, is on budget and is a first-class project — and one we are delighted to support. Again, others have been critical of this project. I am not one of them. I am a proud supporter of it and the first-class paediatric care that it will offer.

Mr WELLS — With respect, the first part of the question was in relation to the blow-out in costs of $150 million in extra design and construction costs.

Mr ANDREWS — There is no blow-out. I have just indicated to you that the Auditor-General finds that it is on time and on budget. Could I be any clearer?

Mr WELLS — So you are saying that there is not a $150 million blow-out in extra design and construction costs?

Mr ANDREWS — What I am saying to you, Mr Wells — —

Mr WELLS — Is that a yes or a no?

The CHAIR — The minister to answer, please, without assistance.

Mr ANDREWS — Mr Wells, I can hardly be clearer. If you do not want to take my word for it, that is fine.

Mr WELLS — It is just that you have trouble with numbers. That is why I am querying you about it.

Mr ANDREWS — Do I? Tell us about the unallocated capital? How are you going with that? Have you got the capital on the car worked out yet?

The CHAIR — Thank you, Minister; that is unnecessary.

Mr ANDREWS — Let's be very clear about this.

Mr WELLS — What are you talking about? Unallocated capital? We have moved on from the Box Hill Hospital. Unallocated capital in regards to Box Hill Hospital — —

Mr ANDREWS — There is no $150 million.

The CHAIR — Mr Wells — —

Mr WELLS — He is asking me about unallocated capital. What has that got to do with $150 million for the Royal Children's Hospital?

Mr ANDREWS — Have you worked it out yet? There is no $150 million issue, as you describe it.

Mr WELLS — What are you on about?

Mr ANDREWS — Do you want an answer or don't you?

Mr WELLS — What's the $150 million?

The CHAIR — Mr Wells, thank you. I do not wish for any more assistance from you. The minister to concentrate on the answer, please, without any distraction.

Mr WELLS — Thank you. It is about time you brought him back to the question.

The CHAIR — Just a second. I have said six times in the last five minutes to you, Deputy Chair, stop interrupting, and as soon as I asked the minister to answer the question, you again interrupted, so I ask you once again to desist, please. The minister to answer.

Mr ANDREWS — Mr Wells has referred to, as he sees it, a $150 million shortfall. If he is not prepared to accept an assurance from me that that is not the case, then he need only read the Auditor-General's report that was tabled in the Parliament last week, which clearly he has not done. He has read only the bits that have been provided to him by the shadow minister. It is on time and on budget.

Mr WELLS — So are you saying — —

Mr ANDREWS — The Auditor-General is saying that.

Mr WELLS — So there is not a blow-out of $150 million. Are you saying that there is not a $150 million blow-out at the Royal Children's Hospital?

Mr ANDREWS — Read the report.

Mr WELLS — Are you saying — I am asking you the question.

The CHAIR — The minister has answered question.

Mr ANDREWS — I have answered the question.

Mr WELLS — Can you summarise what he said, then?

Mr ANDREWS — On time and on budget. That is my answer.

Mr WELLS — You are not very good at numbers; that is why I thought I would check it.

Ms MUNT — You have referred in passing to the ambulance services in Victoria. I would like to refer you to budget paper 3, page 93, that details a range of performance measures, outputs and deliverables. Can you please outline what the government is doing to ensure that Victorians continue to have access to the highest possible ambulance services?

Mr ANDREWS — Thanks very much, Ms Munt. This is an important question and these are important services, as we have already alluded to I think in the context of trauma and some other answers, particularly for rural communities, but right across the state. As you know, last year, the biggest ever boost of nearly $186 million, 258 extra paramedics, new and upgraded services right across the state, both in the air and on the ground. I have already referred to some of the air ambulance investments.

That additional money is very important and it is appropriate, given that our paramedics, the best paramedics in the world, are in fact responding to record numbers of cases — 706 000-odd last year. That is 29 500 up on the previous year. We have also seen that paramedics are spending more time in terms of case time with those they are caring for, and that is indicative of both an expanded scope of practice for our ambulance paramedics, but also people perhaps needing more care. There are many challenges across ambulance services, and it is not easy to provide the world's best pre-hospital emergency care and transport, but that is what our ambulance service does, with support from our government.

In terms of progress towards the rollout of those investments, I think it is fair to say we have made very good progress — that is, Ambulance Victoria has — with the additional funding that we have provided. Just topical today in relation to the air ambulance discussion we have been having, the important retrieval chopper for neo-nates, for paediatrics and adults, so linking people almost exclusively in regional Victoria with the specialist care that they need in Melbourne is up and running, is going, and is providing that service 24/7. It is the first time we have had a 24/7 statewide retrieval helicopter. That is hangared out at Essendon in a new $20 million-plus, purpose-built hangar out at the Essendon Airport. It is the fifth chopper. When we came to government there were but two, and there was a cloud over one of them. There are now five, or there will be by June, when Warrnambool comes on line. I was very pleased to be able to visit a little while ago the Warrnambool Airport to see progress on the hangar and the ambulance branch, and that will be a reality, thanks to this government's support, later this year.

Mr WELLS — If it wasn't for Napthine, you would have never done it. You were so opposed to it every step of the way.

The CHAIR — Without assistance.

Mr ANDREWS — Hot air does not build these things — from Mr Wells — it is investment — —

Mr WELLS — You were dragged kicking and screaming.

The CHAIR — Without assistance!

Mr ANDREWS — And it is only this government that has provided the money to make the south-west chopper a reality. On from that, I have mentioned fixed-wing upgrades as well. Also, in terms of road crews, we are making good progress against those 258 additional paramedics and the additional services that we promised last year.

There is also an important commitment around fatigue, managing workload, as well. The former Rural Ambulance Victoria had committed to 100 additional paramedics funded out of less overtime, if you like. We have made very good progress. As I referred to before, 88 of those 100 are now in stations, in branches, providing care and, if you like, better balancing the workload, particularly in rural and regional areas.

In terms of capital works our investment is second to none: new stations or improved stations right across rural Victoria and right across metropolitan Melbourne. I was pleased to be in your local community not that long ago to open a brand-new branch there. Again, there are literally too many for me to mention, Chair. In the electorate of almost every member of this committee there are substantial boosts in terms of either upgrades to existing ambulance stations or new branches being put in, and that is indicative of the record funding that we have provided to the now Ambulance Victoria to do that.

Can I just finish by saying that there is one other very important investment in the budget. Ambulance is a small component of it. This would not have escaped your attention, Chair. As you would know, there is $56.2 million for an upgrade to a second emergency services telecommunications authority, if you like a second ESTA; not just in Tally Ho in your local electorate, but there will be a second mirroring call-taking and dispatch centre in Ballarat. That is part of the $56.2 million and ambulance shares in that. That completes, or will complete, the upgrade of common call-taking and dispatch services between both metropolitan ambulance and rural and regional ambulance. That has been a very long process. This piece of infrastructure is central to that and, whilst ambulance is a small part of the overall $56 million, I think it will be to the benefit of consistency and to the benefit of patients who need emergency care in rural and regional areas. I suppose it also provides redundant capacity in the event that there is a need to supplement the Melbourne-based call-taking services that ESTA runs not just for us but for other emergency services as well.

I am very pleased, Ms Munt, to provide you with that update, a very consistent rollout of additional paramedics, additional services, new branches, vehicle replacement and air ambulance upgrades. We are getting in there and AV is doing the hard work to roll out the money, and that should be of comfort to all of us. This government has provided the funding, and AV as the service is wasting no time in delivering additional services and I think some forecast improvements in ambulance response times. I hope a further improvement in ambulance response times will be closely linked to the additional asset investments that we have made.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the funding for the HealthSMART platforms. I remember in the budget last year there was some output funding over four years for what was described as the rollout of the HealthSMART systems, as distinct from the installation or setup of them. Can you tell the committee, please, if hospitals and/or health services are being funded for the ongoing maintenance of those platforms and the training of their staff; and are all health services and/or hospitals implementing the HealthSMART platforms?

Mr ANDREWS — What do you mean by maintenance, ongoing operating costs or physical maintenance of hardware, or — —

Mr RICH-PHILLIPS — Essentially, ongoing operating costs.

Mr ANDREWS — Okay. I might provide some general comments and then Mr Wallace can perhaps supplement those in some detail. This is an important project. When we came to government there was very, very poor IT right across the health system. I am not making a point about it; I am simply saying it is a fact. It was very, very poor after a lot of underinvestment for a very long period of time. We made a decision that a common IT architecture was very important, and that the efficiencies that would come from that meant that substantial investment was the right thing to do.

I note that the Auditor-General brought down a report last year that made it very clear that whilst this project was over time it was within the budget that had been allocated, and he confirmed, I think, as do most fair-minded people — as I am sure you do, Mr Rich-Phillips — that this is a good project to be investing in. These services are very important in terms of modern and efficient health care.

In terms of support to health services, you are right; there were allocations last year. As you would understand, the rollout of HealthSMART is a complex process. I am happy to provide an update to you around each of the different HealthSMART applications, whether it is in relation to the Oracle finance and supply management information system that is operational in eight health agencies, or the rural and regional FMIS — if I can be permitted to abbreviate — which is operational at 15 campuses. If we go to PCMS, which is patient and client management system — the iSOFT system — it is operational in six health services, and four more are to be implemented. The implementations are under way. Just to be clear about the point I made a moment ago about the 15 campuses within the Gippsland region, it has been rolled out in those 15 campuses.

To go on to community health, the client management system, or Track Health, as it is known, is operational in 17 community health services; a further five stand-alone community health agencies are at various stages of the implementation. In terms of radiology and imaging, the PAC system I referred to in an earlier answer — the picture and archiving communications system — which is a very powerful tool, has been implemented in six health services. That is a very complex business, but it is important and powerful in terms of efficiency. Statewide-shared infrastructure is currently supporting over 28 000 users across 31 health agencies from an imaging and radiology point of view.

In terms of human resources, so payroll and rostering, the HR management system — Frontier, as it is known — is operational in seven health services and paying over 50 000 health workers each pay cycle. Similarly, rostering is embedded across a number of different health services as well and being further rolled out.

I can go on to ambulance and we can have a long and I hope informative discussion about the Victorian ambulance clinical information system, or VACIS, as it is known, replacing paper with a tablet where basically data is entered roadside, bedside, and so on and so forth.

There are other benefits in relation to dental. I can go on further around the rollout of this important program. We remain committed to it. It is a complex process and I have made it clear that this had my close attention in terms of meeting the milestones within the overall project, and I remain committed to that, as does the secretary. In terms of drilling down into individual supports for health services, and particularly in the context of last year, perhaps Mr Wallace can provide us with an update.

Mr WALLACE — The specific answer to the question, 'Are we funding health services for operating costs?', the simple answer is yes.

Mr RICH-PHILLIPS — And training?

Mr WALLACE — Training is usually involved as a project cost. Project costs involve the implementation team and training that goes on of health staff, so that is usually considered an implementation cost. The operating costs: we are running shared services for most of the applications, so there is additional funding that is going in to cover the costs of shared services. It was always a sharing arrangement, but the funds that were provided in the budget last year have been allocated to meet those costs.

Mr RICH-PHILLIPS — At the health service level?

Mr WALLACE — That is correct, at the health service level — with the understanding, with the shared service providers, sometimes the funding is going into the shared service provider because the health service is not incurring the costs, it is being incurred in the shared service provider.

Mr RICH-PHILLIPS — Is there an expectation that all health services will take up HealthSMART platforms?

Mr ANDREWS — Part of a common architecture is having that architecture common to as many participants as possible. There are some legacy that are ready to be replaced, there are others that are not. There are some investments that have been made quite recently. It is not a matter of replacing things that do not need replacing, but it is the mission of this project to have a common IT architecture in place. That is not easy; it is very challenging, but there is a good team in place, there is a sound budget and, as the auditor finds, worthy work that, whilst it has had its time challenges, is operating within the budget that was allocated.

Mr NOONAN — I want to ask a question about workforce investment. I note from your presentation literature overall numbers since 1999, but in budget paper 3, page 91, there is a list of outputs for the training and development of health workers. My question really goes to whether you can outline how the government will use the budget in order to recruit and retain health professionals and, in light of Dr Brook's earlier answer to Ms Pennicuik, perhaps with somewhat of a focus on country Victoria in your answer.

Mr ANDREWS — Thanks, Mr Noonan. I think this has been a bit of a theme today, that training the right workforce, employing them at appropriate rates and then keeping them in areas of need and deploying them as efficiently and effectively as possible really is a very large part of the story of providing modern health care. These are big challenges for us. I think it is important to acknowledge that we have a partner in the current commonwealth government toward meeting these challenges. Admittedly at the end of the previous federal government's term we did get some support around the Deakin medical school, but we had to take some pretty unusual steps ourselves as a state government to support that, which is pretty much an unheard of investment.

Workforce — can I say there is a big challenge across the board, not just in rural communities but in the outer suburbs often as well. To attract and retain the right profile staff is a challenge there also. So this budget provides a very substantial boost. In terms of clinical placement there is more than $70 million to support clinical placements of medical students, nursing students and also allied health students. That is very important. There are obviously costs involved in training the biggest undergraduate cohort across those three areas that we have ever had. It is an entirely good problem to have. We have got more medical students, for instance, then we have ever had, through the Melbourne-Monash consortium, the third school at Deakin and other programs, other growth.

Barwon, as the third medical school, is operating very well, and we know that a very substantial number of the undergraduate — sorry, they are actually postgraduate students there; it is a degree beyond their bachelor's degree — I think, from memory, around a third of those students are from rural and regional areas. All of them are having the majority of their training in rural and regional settings. As we know, if you train in the country, you are more likely to work in the country. If you then put the additional overlay of having been born and having lived in the country — if you are from the country — then almost certainly you will go back and practise in rural and regional areas.

So there is a big challenge, but I suppose we had an important win, if you like, in terms of securing the third school, and that was one challenge dealt with. Now that throws up additional challenges in terms of clinical placement and hours, in terms of recurrent funding and also capital. You have to have the physical space to be able to train those doctors, and so on and so forth. But they are all good challenges to have to meet, and there is a good, strong budget outcome this year with more than $70 million in terms of clinical placements.

There is also a whole range of other important measures that again are about building on our record. You do not recruit 9000 extra nurses unless you are committed to giving our health services the budgets they need to do that important work. You do not recruit 2500 extra hospital doctors if, again, you do not have a commitment to the patients they treat. There is a lot of money and a lot of numbers used in health, often to describe investments. That is a great way, I think, of describing where that money goes to: thousands more highly trained staff treating record numbers of patients and delivering better outcomes — and not just in the city but in the regions, in small communities right across the state. So the additional training places, the supports for those additional clinical placements, supporting 4500 med students, 12 000 nursing students, 600 dental students — I think I neglected to mention them a moment ago — and 6500 allied health students right across the state, that is a very substantial boost.

I did mention earlier on in another answer that last week I made some announcements around $21 million for strengthening medical specialist training posts. More than half those allocations are in the bush: 57 out of the total of 111, that I think goes to 113, are in fact in rural and regional areas, so half of those. That is a good outcome for country Victoria.

Again, there are many other things I could talk about around our consistent investment in workforce, particularly in rural and regional areas. We know it is a big challenge, we know it is important and we are committed to working with our partners, with those health services locally and with the commonwealth government, not just in health but in terms of education and training as well, to ensure we have the right

workforce in the right places, providing the right care, with all the other associated linkages that make that possible.

Whether it is HealthSMART and telemedicine or digital breast screening, as we spoke about, there are many different ways you can support clinicians to do their work in areas other than urban Melbourne, and we are committed to always looking for those. Dr Brook, did you want to add to that at all in terms of rural workforce strategies?

Dr BROOK — Thanks, Minister. The only comment I would make is that you made reference in your question to initiatives to support workforce in the areas — I do not know whether you actually referred to maternity, but you talked to our earlier matter.

Mr NOONAN — I just referred to your earlier answer, where you did make reference to maternity in particular.

Dr BROOK — The minister has talked very strongly about the initiatives that are occurring at the entry level, but there are a number of initiatives that are also occurring at the graduate level. I just draw your attention to two of them that are specific to maternity. As part of the rural maternity initiative $1.4 million is allocated this year, and it will continue, specifically to support maternity in-line training and continuity-of-care models — very important to maintain team-based approaches in the larger, particularly regional and subregional, hospitals. A total built up over a couple of years of $950 000 — just short of a million a year — now goes on specific postgraduate medical positions, which we have really tried to boost so that people training in obstetrics, whether they are specialists, of which there will be five posts, or general practitioners, of which there will be six posts, actually receive their training in rural Victoria for all the reasons described with the expectation that they will find the lifestyle very attractive and they will actually stay in rural communities, where certainly they are welcome.

The CHAIR — There is food for thought there for you.

Dr SYKES — Minister, my question relates to the collection of performance data. I apologise for having missed some of the session, and it is possible that you have covered in part the question I am about to ask.

I understand that hospitals are required to make performance data reports available to DHS in relation to their activity for the compilation of an integrated performance and activities report, which may form part of the budget papers — budget paper no. 3. I am asking if the minister can briefly explain the purpose of this report, the integrated performance and activities report, and make available to the committee the reports since July 2008 which have been produced and/or sent to hospital networks or other relevant stakeholders. It is about the exercise of pulling together the information to underpin your budget reports, discussing that and making some of it available.

Mr ANDREWS — Dr Sykes, there is a whole range of performance monitoring frameworks and other reports that are provided. I am happy to take some advice on that. There are obviously issues about audited performance and unaudited performance. We have annual reporting, we have *Your Hospitals*, we have the budget papers, we have any number of different reports that are about monitoring the performance of health services — and business units within health services even — and then they are pulled together to provide aggregated data.

Some of those are about recording performance, some of those are about driving improvements in performance and some of those are about finding outliers, if you like, to then go and work with them and, based on that evidence, to fix problems and provide additional supports. I will get some advice on that particular reporting framework. I would say to you that it is one of many. Again I am always loath to provide commentary on unaudited information. I would need to get some advice on whether I would be doing that in making any further commitments to you.

The CHAIR — Thank you. We have time for two more questions.

Ms HUPPERT — Minister, I have a question about immunisation. On page 104 of budget paper 3 there are a number of major outputs specified around the area of immunisation which indicate that Victoria's childhood

immunisation rates have consistently met targets. Can the minister advise the committee how the government will continue to be a national leader in this important area of public health?

Mr ANDREWS — This is a very good question, and I am very pleased to be able to provide the committee with an update. We did have a similar discussion last year. I am very pleased to be able to provide an update and say that we have continued our national leadership. We are the only jurisdiction Australia-wide to consistently record 90 per cent immunisation rates or above for the three key milestone vaccinations — 12 months, 2 years and 5 years. That is something we can all be very proud of.

In celebration of that milestone and also to commission a new statewide immunisation service at the Royal Children's Hospital, I was very pleased recently to be there with Sir Gus Nossal — not only Victoria's chief scientist, but a Nobel laureate and someone of great standing and someone who knows more about these issues and the clear public health benefits that come from an immunisation and vaccination program than perhaps anyone. About 5000 children are vaccinated there each year. This is part of a modern health system. This is part of protecting not just those children but protecting all of us. The lower the cohort of unvaccinated individuals at any age, the lower the risk of latent diseases, latent viruses and latent conditions coming back with quite catastrophic consequences. Whether it is in terms of whooping cough or measles, there are many and quite recent examples where we have had those two conditions — pertussis and also measles — on the rise. That is another example of why vaccination rates at this high level serve all of us well. People are free to make a choice, but I and others are free to make the case that this is a good thing to do. We are very pleased to say that more than 90 per cent of kids are getting those three milestone shots and all the public health benefits for them and for the rest of us that come from it.

I will give you another example of where we have seen really strong improvement. It is around meningococcal C. If you look back at 2001, very early on in our term of government, there were 88 cases in that year and 10 deaths that were notified and were directly attributable to meningococcal C. We put in place the statewide immunisation program. Across 2007 and 2008 — I think that is calendar years — there were only two reported cases, and pleasingly there were no adverse outcomes. Certainly there was no mortality recorded as a result of meningococcal C confirmed cases. That is just one example of the power of the these programs.

We are very keen to continue to work with our partners, the commonwealth, around this. This is perhaps the most cost-effective and important public health measure — and modern health-care measure — that any government could put in place. It perhaps picks up on some of the points that Ms Pennicuik was making before about the need to perhaps focus more on the prevention of ill health rather than just the treatment of illness.

Ms PENNICUIK — Minister, my question follows on from the question from Ms Munt on the ambulance service and the partial answer you gave, or a comment you made in your answer about fatigue. A longstanding issue of concern to me is the relationship between working hours, shift work, fatigue, and occupational health and safety. I know that in negotiations for its enterprise agreement the Ambulance Employees Association of Victoria wants to increase the rest break from 8 to 10 hours, bearing in mind that a break of 10 hours still means you have worked 14 hours, which is not recommended, particularly for night shift.

Mr ANDREWS — You are rostered on for 14 hours.

Ms PENNICUIK — You are rostered on for 14 hours, but you only get 10 off; but if you get 8 off, you are rostered on for 16. But given the research and the knowledge about fatigue and its effects on health and safety — and we know particularly that about 20 per cent, if not 25 per cent, of road accidents are attributed to fatigue — the government and Ambulance Victoria should be moving towards that longer rest break. I want to know what is happening there.

The CHAIR — As far as it relates to the estimates, of course.

Ms PENNICUIK — So far as it relates to the estimates.

Mr ANDREWS — It is a very good question. Its principal relationship to the estimates, Chair, is that the budget papers in many different ways chronicle the substantial investment that we have made. It is through extra paramedics, extra vehicles and extra services that you can better balance a growing workload. That is not to say the workload is not growing. I went through some numbers before that show very substantial growth not

just in code 1s and 2s but also some of the non-emergency work. Right across the board our paramedics are doing a fantastic job, with record support from us.

In terms of fatigue, there are a range of different approaches and policies and different measures that Ambulance Victoria has put in place. I am happy to take this on further notice, and I can give you a further answer, but I think you would be interested to learn that there are 24 teams with blended rosters. That is all about removing consecutive night shifts. In the main, ambulance paramedics work a 10-14 roster, and if you can break up the two consecutive night shifts, that is to everybody's benefit. Some progress has been made there.

There is the issue of additional operational staff, whether it is those already committed out of the 258, or the 88 out of the 100 in rural areas. That is again about sharing the workload as much as we can, albeit a growing workload. There is also an important measure introduced by Ambulance Victoria — formerly it was a MAS initiative — and that is the caller referral service, where those who have rung 000 for an ambulance, thinking that was the appropriate thing to do, but not needing an ambulance, are then referred off to the call referral service. They are referred a bit further than the Nurse on Call service; it is not just advice or information. They can be referred on to a medical locum service so that a doctor can visit them; they can be referred to RDNS; they can be referred to any number of drug and alcohol service providers or mental health service providers. That basically dealt with the best part of 30 000 cases last year. That is case load that otherwise, through an abundance of caution and through the dispatch grid, would have made it to an operational branch. It would have been a call-out, albeit one where, when the paramedic arrived, it would be clear at that point that it was not as coded. That is about removing — I will not call it unnecessary work — but it is about simply appropriately triaging and categorising calls. That is about lightening or sharing the workload, if you like, and making sure there is an appropriate response.

Education and training programs around forums to engage the staff around fatigue issues have been a feature in recent times. There have been some meal break management initiatives as well, including specific meal break cars; and some staggering around start and end times for rosters, and certainly start times, so you have more meal break windows, greater opportunities for meal breaks, and so on and so forth. I am happy to write to the committee, or perhaps have AV write to the committee around these issues.

We are committed to a fair, reasonable and balanced outcome with our ambulance paramedics. There have been many hours of talks. The industrial relations commission is perhaps the way to go. We are certainly urging the union to be involved in a mediation with the commission. It is unwilling to do that; that is a matter for it. But we have a proud record of supporting our paramedic workforce. This is but one of a number of issues that have been raised, and we will continue to support them.

The CHAIR — Thank you, Minister. That concludes consideration of budget estimates for the portfolio of health. I thank the minister and departmental officers for their attendance today. Where questions have been taken on notice, the committee will follow up with you in writing at a later date, and it requests that written responses to those matters be provided within 30 days.

Mr ANDREWS — Thank you, Chair.

Committee adjourned.