CHAPTER 4: DEPARTMENT OF HUMAN SERVICES

Transcript of Evidence

4.9 Children portfolio

The transcript for the hearing on this portfolio will be included in a future report of the Committee.

Transcript of Evidence

4.10 Community Services portfolio

VERIFIED TRANSCRIPT

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2007–08

Melbourne — 10 May 2007

Members

Mr G. Barber
Mr R. Dalla-Riva
Ms J. Graley
Ms J. Munt
Mr M. Pakula
Mr G. Rich-Phillips
Mr R. Scott
Mr B. Stensholt
Dr W. Sykes
Mr K. Wells

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

Staff

Business Support Officer: Ms J. Nathan

Witnesses

Mr G. Jennings, Minister for Community Services;

Ms F. Thorn, secretary;

Mr A. Hall, executive director, financial and corporate services;

Ms G. Callister, executive director, Office for Children;

Mr A. Rogers, executive director, disability services; and

Ms J. Herington, director, aged-care branch, Department of Human Services.

The CHAIR — I declare open the Public Accounts and Estimates Committee hearings on the budget estimates for the portfolios of community services and Aboriginal affairs. On behalf of the committee I welcome the Honourable Gavin Jennings, Minister for Community Services and Minister for Aboriginal Affairs; Ms Fran Thorn, secretary of the Department of Human Services; Ms Gill Callister, executive director — Office for Children; Mr Arthur Rogers, executive director — disability services; Ms Jane Herington, director — aged care; and Mr Alan Hall, executive director — financial and corporate services; departmental officers, members of the public and the media.

In accordance with the guidelines for public hearings I remind members of the public they cannot participate in the committee proceedings. Only officers of PAEC, the 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. Those guidelines are actually that you are only able to film the person who is speaking.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act, and it is protected from judicial review. There is no need for evidence to be sworn. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript, and the committee requests that verification be forwarded to the committee within two workings days of receiving the proof version. 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 related to the budget estimates. Generally the procedure followed will be that relating to questions in the Legislative Assembly. In other words, there are no supplementaries, but clarifications are in order. Before I call on the minister to give a brief presentation on the more complex financial and performance information relating to the budget estimates for the community services portfolio, I ask that all mobile phones be turned off.

Mr JENNINGS — Thank you, Chair and the committee, for that introduction, which has orientated us all and made us pretty clear about who is on my side of the table. I am pretty pleased to see, given my burgeoning responsibilities, that I have almost got as many members on my side of the table as you have on yours! Hopefully we can rise up to your expectations and respond to those issues.

The CHAIR — You have got about 10 minutes.

Mr WELLS — How many on your side from the audience?

Mr JENNINGS — I did not realise how interactive this was going to be! If it is this interactive, you actually probably will not get as much out of me as you might have wanted!

Overheads shown.

Mr JENNINGS — Having said that, the first slide has listed responsibilities — I know the committee will be talking shortly to Minister Neville, but I just wanted to make sure that the committee had their heads up in relation to the division of responsibility as it crosses over between particularly children's services and aged-care services, which may prove to be a slightly vexing issue for the committee. This matrix provides you with a reminder of the areas of my responsibility. In terms of children, they relate to child protection and other family services, juvenile justice, and youth services such as secondary school nursing.

In aged care, I continue to be responsible for public sector residential aged care facilities; supported residential services, the home and community care program, the aged care assessment program, carer support, and dementia services. I will leave Minister Neville to speak for her own responsibilities.

It is important to indicate that in the areas I am responsible for we are embarking upon a range of change programs that have been underpinned by legislative reform and significant budget commitments by our government. I am very happy to be in the situation where I have inherited significant reform and investment that has been outlined in previous budgets and continued within this one.

In the area of improving outcomes for vulnerable children, I want to point out to the committee that there continues to be a major increase over the life of the Bracks government of our investment in child protection, family services

and youth justice services budgets, which is indicated clearly by the bar graphs before the committee. In child protection we have achieved a 93 per cent increase in allocation; youth justice is up by 79 per cent; and there has been an overall increase of 90 per cent in the budget allocation since 1999–2000.

As I indicated to the committee, an extensive amount of work has been done in partnership with the sector and the community to try to ensure that we provide for the safety, security and wellbeing of Victorian children. There is a well-developed body of evidence and legislative framework that underpin our work. That overhead is a snapshot of those pieces of work, which I am sure the committee can apprise itself of at a later time.

In particular, the most recent reforms have been proclaimed in the Children, Youth and Families Act, which came into effect on 23 April. That has engaged people in countless hours, weeks, months and years — you probably can count the years — of deliberations in that work. Very importantly, it is matched by a commitment from the government to fund programs that underpin that important legislative reform: $225 million has been allocated from 2006–07 onwards into the forward estimates up to 2009–10.

I appreciate that the committee will understand that we are in a continuum of forward estimates from the 2006–07 budget forward over the life of the current forward estimates. I will give you an indication of the growth within those programs. The family support innovations program, which is designed to support families to stay resilient, strong and capable, in this current budget has $7.2 million and in the forward estimates period, increases to $11 million by 08–09. The Child First program, which is a coordination effort to ensure that we provide easy access for families to support the needs of their children, this year has $1.6 million and that increases over the life of the forward estimates to 3.2.

Our approach to actually deal and respond to the needs of those children who may have been sexually abused or at risk of sexual abuse increases significantly over the forward estimate period, as indeed does our commitment to provide for new forms of foster care arrangements to more adequately deal with and respond to the needs of those very vulnerable children who require intensive foster care and residential care support. Indeed, a hallmark of the legislation has been our commitment to ensure within the principles of the best interests of the child that we account for the needs of Aboriginal children who, history would say, have a disproportionate high incidence with child protection systems and which we are hoping to address in the future.

One of the ways we are wanting to do that is to increase our support to Aboriginal community organisations charged with responsibilities and to increase investment within Aboriginal services across the sector.

There is some good news in Victoria in relation to child abuse substantiations. This is basically the level of determination of the level of risk that Victorian children are currently experiencing. In fact, I think the most telling part of this bar graph that the committee has before it is the relatively flat nature of the child abuse substantiations that have occurred in Victoria.

I draw the committee's attention to the very stark difference in the jurisdiction we often compare ourselves with, New South Wales, where there has been extraordinary growth in child abuse substantiations that have occurred within that jurisdiction. From our perspective it actually demonstrates that we have been quite effective in intervening earlier in family support programs.

We also recognise that when children are out of care we have an obligation to provide support to foster carers, who do a great labour of love on behalf of this community each and every day. As you can see, there are significant caregiver payments — we as a community are obliged to provide some financial support for the out-of-pocket expenses and the costs of providing those foster care arrangements. As the committee can see, there has been significant investment provided for within this budget and going forward in relation to foster carer payments. We also recognise that there is a need to make sure we have appropriate residential facilities for when children need intensive residential care. There is a rolling program of capital investment within the residential sector.

Moving into the area of disability, the committee can actually see there has been continual growth during the life of our government for investing in services for people with disabilities and their carers and the service system that provides for those needs. There has been an 87 per cent increase during the life of the Bracks government to the size of disability services. Indeed, in this budget that the committee is currently considering there is $214 million over the life of the forward estimates period to deal with those needs into the future. They relate to $184 million of output initiatives and $30 million of asset initiatives.

To give the committee an indication of what those services cover, there is significant investment for individual support programs. The committee would realise that there is an important direction in disability services to provide for the individual care needs of those in our community with disabilities and trying to tailor specific programs to meet their needs. There is an increasing emphasis, both within the programs but in terms of the resource allocation, to provide for that individual care planning support.

We also recognise that there has been a load, a disproportionate load perhaps, carried by carers for their loved ones and those in their community that they provide care for and assistance. There is an additional $13.1 million over four years for additional episodes of respite care to provide some breathing space as a fillip to those carers who provide that important work each and every day. Indeed, we provide specific assistance for carers who may wish to re-enter the workforce and perhaps have felt hamstrung about their capacity to do that.

There is a significant investment in the technability program. I do not know whether we invented that word for this program — we might have! The notion of this is to try to ensure that we invest in information technologies and information services that provide for and cater for the breadth of needs of people with disabilities and that ensure that they can more effectively and efficiently access information and use information to empower them and fulfil them in their daily lives. There is $12.3 million provided over the life of the forward estimates to support people in our community with acquired brain injury, which I bring to the committee's attention.

We can also continue the important programs that have seen great results, including the Futures for Young Adults program, which I draw the committee's attention to, which provides for life planning for young people with disabilities leaving education. We recognise the need to provide support for community service organisations, because most — well, not most — a lot of the services in the disabilities sector are provided by the non-government sector. They can be the inevitable NGOs that have very low-cost structures and the not-for-profit organisations that we need to provide support to. Indeed there is also significant investment in capital initiatives that I have outlined in terms of the refurbishment of the residential sector.

In aged care, members of the committee would realise that we have had a significant increase over the life of our government in aged-care services, and indeed this year it has topped $1 billion when you include allocations for aged services within the aged-care program and the small rural services. That is a significant increase, and again this year we continue a trend of providing for new initiatives with significant investment in capital — which has been a hallmark of our government — and with a commitment to redevelop 45 residential aged-care facilities across Victoria, 43 of those being in rural areas.

There is significant investment in home and community care in terms of an output measure this year. We would hope to see 400 000 more hours of service reaching 6000 more clients during the life of the program. We want to make sure that home and community care reaches the people who may not readily get access to it, including people from diverse backgrounds and indigenous people who are underrepresented within the HACC community. We actually understand that people might feel vulnerable at home and need additional assistance, whether it be through personal alerts or through specific initiatives, to make sure that they can eat well by providing for dental care or dentures, and to make sure that people can see and get around their daily lives in comfort.

They are features of the initiatives in this year's budget, and, as I have indicated, we are continuing a trend of investing significantly in capital infrastructure across Victoria. It is a hallmark of our government that we have reinvested in aged-care facilities right across the state, the vast majority of these being in rural areas. That continues to be the case with the announcements made today. We are also facilitating new investment in aged-care facilities through innovative approaches such as the Land Bank.

That is pretty much the rapid-fire introduction to my areas of responsibility, but I welcome the committee's interest and questions about these portfolio matters.

The CHAIR — Thank you, Minister. I appreciate the introduction. I would like to begin by asking you, as I have asked every other minister: what impact will the portfolio spend be having on productivity, particularly new initiatives under your portfolio?

Mr JENNINGS — I thank the Chair for his concern about productivity, because obviously this is an issue about which all of the Victorian community beyond PAEC want to have some confidence that we are being innovative and that we are trying to make sure that we deliver services in a way that is cost effective and delivers the maximum result.

I want to draw to the committee's attention that with a lot of the work we do — I will outline a couple of initiatives that we are actually undertaking — it is very important to understand that, for instance, in child protection and family services, 70 per cent of that work is provided by the non-government sector. In terms of our drivers of reform, we actually have to understand that we are a funder of non-government services, and we seek, in partnership with them, to drive productivity reform.

We have done this in a variety of ways — for instance, using the Community Sector Investment Fund, which is trying to ensure that there are technological responses, that there is training that provides for efficient services and that there is an approach to continuous improvement. There are hundreds of hours that we would actually allocate to the field to provide for ongoing efficiencies in terms of understanding best practice and the need to have continual improvement. There is extensive work, as I indicated, in child services alone. There have been 265 training sessions over the last two years designed to support the capacity of organisations to undertake that work.

In terms of disability services, we have some reforms that try to ensure appropriate practice and efficiencies, and in fact there are some statutory obligations that apply in the disability field. For instance, we have a new disability services commissioner who is charged with the obligation of ensuring that services are provided in an efficient and effective fashion. We have established an Office of the Senior Practitioner who drills down into what the effective and appropriate treatment regime would be to ensure there is best practice being applied in that sector. We have confidence that those initiatives and statutory obligations will be met.

I am sure that the Chair, in the committee's conversation with the Minister for Health previously, knows that right across the Department of Human Services there is an integrated and coordinated approach in terms of driving savings and productivity. I will not go back over those unless the committee particularly wants me to, but we are part of that discipline and that approach within DHS.

The CHAIR — Thank you, Minister I hope you will continue with the Community Sector Investment Fund, to make it work and perhaps enhance it, because it offers a bit of microeconomic structural adjustment in the sector, which I am sure will deliver good dividends right across the state.

Mr WELLS — My question is in regard to child protection. It would be the expectation of the community that all vulnerable children who need a service would receive that immediately. My reference is to BP 3, page 95, which talks about child protection reports.

How many children were referred to protection by the child protection hotline in the last budget period? How much money will be spent on the child protection hotline in 07–08? How many child protection cases referred to the hotline were not allocated, and therefore what is the waiting list? I suppose the more disturbing question is: why was it that a child of 3 had to spend 5 hours at the Preston police station last week because for 5 hours no-one could access the child protection hotline? I refer to an article in which the Office for Children executive director blamed a staff shortage for that. I note also that you have asked for a full and detailed explanation of why this took place. Could you answer those in whichever order you choose?

Mr JENNINGS — You are relying on my cumulative memory, but I will do my best to respond to all the various questions embedded within that scoping.

The CHAIR — Particularly in the context of the estimates and the budget.

Mr JENNINGS — Excellent. I thank the committee Chair for keeping us on the straight and narrow. As an overall introduction to this question can I just say that the program that the Deputy Chair has referred to is the after-hours child protection information service that is funded to the level of $5.815 million in the current budget.

That relates to the ongoing operation of a 24-hour service that is available to members of the community. It receives a very large number of calls during the course of the year — 61 900 calls per year are received through that service. Those calls are taken, and those calls are responded to. So if we are starting from the premise that we are not delivering a service that is responding to Victorians' need, I start by saying that is a very large number of calls that are actively responded to — and actively responded to, in the main, in a very efficient and effective fashion.

Indeed, my understanding is that 97 per cent of the calls are responded to within 30 minutes. Indeed, whilst we would like to provide for all calls to be responded to within that period of time, we are pretty close to being able to provide that degree of support. When you consider that between 160 and 170 calls come in an hour, that would be an onerous — —

Ms CALLISTER — In a 24-hour period.

Mr JENNINGS — Yes, okay. The 160 to 170 calls actually occur within a day rather than an hour.

Mr WELLS — Hang on, we have cut from a 24-hour period — from per hour to per day.

Mr JENNINGS — No, I have given you a leg-up, because I know that you are now very excited about that. Go back — —

Mr WELLS — We just want the truth. We just want to try to get to the bottom of what happened to this poor kid last week. That is why we really want to get to the bottom of it.

The CHAIR — We are actually talking about the services; we are not interested in individual cases.

Mr WELLS — Yes, we are talking about the efficient service that you are referring to.

The CHAIR — That's fine.

Mr JENNINGS — There is no doubt about this, you do not have any difficulty about getting to the truth.

Mr WELLS — Yes?

Mr JENNINGS — The truth is that 61 000 calls are actually taken each year — in fact, 61 900 calls — and they are taken efficiently; 97 per cent of them are actually responded to within half an hour. My faux pas at the moment is getting the wrong denominator for when those calls come in. But the substantive point remains. There is a significant team that responds to the needs of Victorian families each and every day. They do it on a 24-hour basis. There are four unit managers who are funded within the $5.8 million, there are seven team leaders, there are four specialist infant protective workers, and there are 35 child protection workers who are employed within that service. And under normal circumstances, in the vast majority of cases — and as I indicated, 97 per cent of calls in that time — that they are very efficient and responsive to the needs of the Victorian community.

There were some difficulties on the night in question that the member referred to, on the basis of a shift shortage due to a work practice where a number of staff, who not only provide for outreach work from this service but in fact do follow-ups through the Children's Court, had been effectively rostered on to undertake to discharge their Children's Court responsibilities. That meant that there was an unusual shortage in the office at that period of time — and, as I indicated to you, a very unusual shortage that occurred during that period of time. Attempts to augment the number of staff that were in the office at that time were not successful. As you could understand, and anybody in the community could understand, at some point in time when the workers who are within the service are responding to the urgency of needs that are coming in to them, they make priority decisions about whether they respond to those calls coming in or whether they spend time on the phone trying to get other people to come in. That judgement call is actually something that we are going to be examining and reviewing in light of these operations.

The case in question — the good news in this story is that the child in question was in the custody of the police, as Mr Wells quite correctly indicates. The child went from the care of the police to the Royal Children's Hospital, and at no time from the intervention of the police was the child in question at risk. That is a very important thing for the committee to the understand and for the community to understand. Whether in fact it is a satisfactory arrangement for the police or the ambulance service to make calls to the after-hours service and in fact there be a delay — I volunteered immediately, I volunteer to the committee — not acceptable, will not be tolerated, and we will in fact ensure that it will not happen again.

Mr WELLS — Can I just clarify one point, Minister: are there no children who have been reported to the after-hours service who are on a wait list, waiting for a service? The point is that you are talking about the 97 per cent hit rate in regard to responding, so there is obviously the 3 per cent. Does that mean that there is a waiting list? What happens to the 3 per cent that are not being — —

The CHAIR — It is responded to within 30 minutes.

Mr JENNINGS — They are responded to outside of 30 minutes. The substantive issue that you are talking about crosses over into the way in which child protection works and the way in which decisions are made on the notifications that are received by child protection, and how they are prioritised in terms of the assessment that is made by child protection officers about the way in which those matters will either be investigated or substantiated. In that context there are some delays in some investigations, but in terms of the crossover question between your concern about the after-hours service and what happens with child protection, it happens the following day. All of those matters would be examined by the child protection officer within the region the following day.

Mr WELLS — So there would be no waiting list other than — —

Mr JENNINGS — They are all examined — —

Mr WELLS — The next day?

Mr JENNINGS — The subsequent issue is, after they are examined, there is determination about whether there are matters that are going to be investigated fully by a full investigation of the family, which may then lead to a substantiation of the issue.

Mr PAKULA — Minister, I refer you to page 97 of budget paper 3, to the Children, Youth and Families Act. I wonder if you could tell the committee how the implementation of that act will improve the wellbeing of vulnerable children and other young people?

Mr JENNINGS — Thank you for the question, Mr Pakula. You may or may not know that it has been a big couple of weeks in relation to the Children, Youth and Families Act. It was proclaimed on 23 April and will lead to a new common implementation of the best interests of the child principle that underpins this act. It will be a common template that sees all providers of care — the Children's Court and the agencies that become involved within the purview of providing a responsibility to provide for Victorian children — will have a very consistent and definite approach to the way in which they address child welfare issues and the capacities of families.

We will actually see that there will be a new service configuration that supports this approach. I think the committee would appreciate that in the past child protection issues have been all too often reactive. They have actually come in too late after lot of damage has been done and children have been exposed to excessive risk, and we are trying to provide some remedies well and truly after the damage has been done. The new service configuration is to try to prevent that damage from occurring and prevent risk factors in the lives of Victorian children; indeed, beyond just providing for a secure environment to deal with those risks, to provide for the developmental needs of children. That is a very important emphasis in the new legislation and the new regime.

Consistent with this we have funded in the last number of budgets, commitments to family support innovation programs that have been designed to be flexible and responsive to deal with the need to strengthen families to make them more resilient and robust, and there has been significant investment within the last few budgets to achieve that: $5.2 million allocated in 2006–07, rising to $11 million in the 09–10 budget, so, as we can see, this is an escalating effort over the life of the forward estimates to try to make families more resilient and to prevent those children being at risk.

Child First is a new innovation. I went to the Barwon region yesterday to kick-start the Child First program throughout Victoria. It is an effort to coordinate a range of community-based services on a sub-regional catchment basis, so something up from the local government area but not too much — two or three local government areas would come together to provide a catchment of providers to deal with the holistic needs of families. So what happens is that if a family recognises, or somebody puts a family in connection with a Child First service, after the initial assessment and interview process, then there would be a determination about the range of needs that family might have. The Child First service would then tap into that range of services. Rather than making a family in the traditional way go from pillar to post, from one service to the other, there will be the one central access point to make sure that those services are easily available and accessible and deal with the holistic needs of those families.

In fact, going back to Mr Stensholt's question about productivity, you can actually see this is a relatively light investment to achieve very big results, because in fact the Child First program itself at the moment is funded at

$1.6 million this year to introduce nine of those services, rising to 5.1 in the next two years. The extraordinary benefits that will be derived from efficiencies and integrated coordination of previously disparate and fragmented service configuration in the lives of these families will be a major benefit both in terms of results for families and their children, but a major, major investment in productivity and more efficiencies within the sector generally. I think the Public Accounts and Estimates Committee should be alive to that important dimension.

We would also realise, in the context of Mr Wells's question a minute ago, there has been significant investment in child protection services — an increase from November 2005 of 100 additional child protection workers that have been funded within the budget. We are providing support and encouragement to those people to undertake their important responsibilities and hopefully make child protection and family services a good place to work. I would actually hope that that is outcome, because quite often the only scrutiny these workers come under is either malevolent or mischievous interpretation about the capacity of their work. There is great work being done out there and we are hoping to cultivate that culture in the years to come.

The CHAIR — Thank you, Minister. I am sure Dr Sykes will ask about the country, where it is a good place to live, work and raise a family.

Mr DALLA-RIVA — Please — just one a day!

Dr SYKES — Minister, I have a question in relation to sexual abuse of children and the adequacy of funding for the development of appropriate policies and the correct application of those policies by staff. I wish to illustrate the basis of my question with two case studies.

One relates to an incident in a local special school where there was an alleged sexual assault by one student upon another student. Both the alleged perpetrator and the alleged victim remained at the school while the problem was investigated. The parent of the victim was very frustrated by the lack of information provided to her because of following apparently the policy. Secondly, she was frustrated or very concerned about the lack of protection provided to her and her child, the alleged victim. She actually successfully took out a intervention order on the perpetrator. Interestingly, when the mother of the victim took out an extension of the intervention order, DHS contested the extension of that intervention order on behalf of the alleged perpetrator.

The outcome of the whole episode was that the case was found proven; that there was a sexual offence committed and there was substantial criticism of the handling of the whole process. The issue in this case that I am raising is what appears to be an issue of policy to not fully inform parents of children with disability of alleged sexual assaults and inadequacy in the protection of the victim in this case.

A second example which I would quote to you, a very recent one, is where a child with an intellectual disability alleged that she had been sexually assaulted by her father. The action by the government agency involved was to telephone the mother and to advise her to immediately leave home with the child. Fortunately, after getting over the initial shock of that telephone call, the mother and father further investigated the issue, and they established that in fact that no sexual assault had occurred because the child's definition of her private parts included her whole torso. So there was no touching of the child's private sexual parts.

The agency involved is extremely apologetic for having caused this trauma to the family. It has done its best to correct the issue, the matter or the pain. But the issue in this case is where there appears to be, in this case, what we will say is a relatively simple failure to thoroughly investigate the allegation in the first instance by cross-questioning the child that made the allegation and verifying what she in fact meant by her 'private parts'.

In pulling those two case studies together, I come back to asking the question: does the budget provide for adequate funding to review policies where there are shortcomings identified; secondly, does it provide adequate training of staff to ensure that they implement the policies thoroughly and correctly with the minimum risk of these unfortunate consequences?

Mr JENNINGS — I share Dr Sykes' concern about the incidence of sexual abuse that occurs within our community, and I want to make sure that children are supported and empowered to deal with these matters and that their families feel appropriately supported as well.

If in fact you, Dr Sykes, stopped your question at the first example, you might have got a different answer to what you will actually get by giving me the second question. The two examples are actually very telling. They go from

either ends of the spectrum in relation to the range of issues. One is actually whether in fact we are overzealous in pursuing a case in one instance, when in fact it was not warranted, and the other example is in fact when we are under-zealous in relation to one where it was.

The range of issues and the assessments that underpin the real circumstance, the real risk and the real degree of danger that has been imminent is very complex. We have to have confidence in them, and the people who work in this area have to be able to tease out the relevant facts and to be able to provide the appropriate intervention. Quite often public commentary on these issues — and I am not accusing you of doing it, because I know that you have done it in a very sombre, appropriate and overly sensitive way — has a tabloid approach that does not get to the underlying complexities or does not actually appreciate the complex practice issues that are embedded within those issues that you have raised with me. I hope the Public Accounts and Estimates Committee, and certainly we, from our vantage point, appreciate the importance of that work.

We have provided within this budget for specific funding; an increase in funding is available within this budget — $6.5 million has been provided within the budget, that I am responsible for, for dealing with support for sexual assault services. In particular we are focusing on additional counselling and support for children and adults.

In particular you will be pleased to know that there is additional funding for rural crisis care services. We are wanting to make sure that beyond what might be the disclosures of children coming forward with either claims that might be real or perceived, we in fact recognise that there is a need to provide some additional almost pastoral care support to young people. Within the funding allocation this year, we have additional treatment programs for children who may be demonstrating behaviour that may be indicative of them being sexually abused or at risk of being sexually abused. So in fact we are trying to go further in relation to going in a pre-emptive way to try to make sure we provide that support for those children.

Indeed we understand that workforce development for this area is an emphasis of the work. We want to make sure that we have people who are capable of providing the most professional, responsive and respectful service. As I have indicated to you through the budget allocation, we actually understand that our rural and regional communities have every right to expect that quality of service being provided within their community.

In relation to the starting point of your question as it relates to special schools, you will understand that I am not responsible for special schools, but I am very happy to work in a collaborative way with my colleagues about that interconnection between the service that I am responsible for and those schools.

Mr SCOTT — The question I would like to ask relates to aged care services. In budget paper 3 on pages 293 and 294 is table A.6. I would be grateful if the minister could inform the committee of the state government's commitment to upgrade the facilities for aged-care services as outlined in that particular area of the budget papers.

Mr JENNINGS — I thank Mr Scott for his question, because this just reinforces Dr Sykes' question; this could have been seen as a regional question rather than the one that has come from a city-based member. But I think it is important for us to recognise that one of the hallmarks of our government has been to reinvest significantly over the life of our government, and more than $400 million has actually been allocated. Indeed $424 million has been allocated over the life of our government to redevelop 45 facilities; 43 of them in rural Victoria.

When I initially arrived in my responsibilities as Minister for Aged Care and beyond that as Minister for Community Services, I inherited a very large portfolio of projects that required redevelopment to make sure that they satisfied the 2008 accreditation requirements of the commonwealth. I am pleased to tell the committee, as I have told it before — Mr Rich-Phillips has asked me on two or three occasions whether in fact we are going to meet 2008 accreditation, so if he is going to ask that question again, I have front-footed it — that we are.

Indeed, in the budget papers and the asset investment program that Mr Scott referred to, this year we are adding to that series of commitments by redeveloping the Leongatha hospital campus — the nursing home there — which is a $10 million commitment. It is an important first stage in the redevelopment of the Leongatha hospital precinct. It will provide ongoing care with 36 beds for older members of the community who require assistance there. I am very pleased to say that when I visited that hospital last November they were pretty enthusiastic, so they cannot wait for that project to roll.

That is pretty much the case in Nathalia as well, where we will be developing 26 beds — 6 acute and 20 high-care residential beds — in an $18 million program, which demonstrates our ongoing commitment to ensure that when older people require it in this community, they can have residential aged care.

We also understand the importance of capital investment in those communities. This may not be very well understood by the Public Accounts and Estimates Committee but the projects that I have been responsible for have been a major driver of economic activity throughout many small, rural communities in the last four, going into five years, and indeed is a major ongoing employer for people who work within residential aged care.

Some places, and I am mindful of Rainbow in particular — and I think from memory about 700 or 800 people live in Rainbow, over 1000 people turned up for the event. The reason why they turned up for the event in that number when we opened the new residential aged care facility — —

Dr SYKES — It was a pot of gold at the end of the rainbow, Minister!

Mr JENNINGS — Pretty much. In fact it was the biggest thing that had happened there for 20 years, and indeed will continue to be. The hospital's aged care facility will continue to be the major employer in town. And that is how important it is to communities.

But we also recognise that there is a need to invest in metropolitan services, so there is major investment in Caulfield General Medical Centre, which will be providing allied health to the suite of services that are provided at Caulfield General. In fact I was out there earlier this week, in the nursing home that we funded during the life of our government, and this will add to the significant redevelopment of that service. Indeed there is some additional funding to allow for the reconfiguration and upgrade of Calvary Health Care Bethlehem, which is also in the same area.

So overall we are going to continue in the business of being a major provider of residential aged care. We provide about 16 per cent of all the beds in Victoria — about 6500 beds we provide. No other state in Australia is a provider of residential aged care. The Victorian government will continue with its commitment to residential aged care during the life of the forward estimates, and I am pleased to say whilst I continue to be responsible for it.

The CHAIR — Thank you, Minister. Yes, we are very unique in that regard, particularly looking after the country. I understand Mr Barber wants to concentrate on the Aboriginal affairs portfolio, so I call Mr Rich-Phillips.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the Victorian aids and equipment program. The budget papers note that this budget provides $30 million over five years to provide an additional 15 000 items through that program. You may be aware of a Melbourne Citymission report that was released in October last year that commented on the program and noted that:

> As a result of underinvestment, increasing demand, and inefficiencies in the program, access to aids and equipment is characterised by long waiting times for many people with disabilities: most families who participated in recent Melbourne Citymission research had experienced delays … The impact on individual health and wellbeing of unreasonable delays in meeting needs can be substantial for all those with disabilities, but especially for children.

That same report also noted the manner in which applications are categorised into:

> 'no waiting' for immediate needs, such as oxygen equipment, wheelchair repairs, continence aids.

> 'high urgency' where aids and equipment are issued as soon as funds are available to purchase items —

and —

> 'low urgent' where items are made available subject to budget, waiting period and clinical factors…

Can you tell the committee how many people are currently on waiting lists under those three categories? To what extent will the funding that is mentioned in the budget reduce those waiting lists, in terms of numbers, and to what extent will the funding reduce the waiting times for people who are on those waiting lists?

The CHAIR — I assume we are referring here to page 91?

Mr JENNINGS — Ninety-one, yes.

Mr RICH-PHILLIPS — No, page — —

The CHAIR — 'Clients accessing aids and equipment', is that correct?

Mr RICH-PHILLIPS — BP 3, page 16 was the reference I was making.

The CHAIR — I was looking also at the quantity — the numbers with the target for this year: 'expected outcome' — 31 000, et cetera. Minister, over to you.

Mr JENNINGS — Good, I am glad we have found where we were. I thought that was where we were. The good news — —

Mr RICH-PHILLIPS — I was referencing page 16 as well.

Mr JENNINGS — Yes. The good news for Mr Rich-Phillips and those in the community who are concerned about this is that my answer to the Public Accounts and Estimates Committee is fairly similar to what I went on the public record with in the Legislative Council only a week or so ago. I obviously did not make an impression on you there, so hopefully I will make an impression — —

Mr DALLA-RIVA — A bit more detail, Minister.

Mr JENNINGS — I do not think so — surely!

Mr DALLA-RIVA — We do not get detail in your answers to questions.

Mr JENNINGS — I do not know that is the case; I have never heard that complaint before.

Mr RICH-PHILLIPS — I did not say 'waffle' — lots of words but not much detail.

Mr JENNINGS — You do not hear this problem ever.

The CHAIR — Can we concentrate on the answer, please, rather than the interplay.

Mr JENNINGS — Okay. The good news is that there have been about 5000 people who have been on the waiting list, which is a figure that I volunteer, and in fact my best advice is 5138 people have been on the waiting list for this program, which is a significant reduction to what it had been a year or two before. So we have in fact taken nearly 2000 people off the waiting list during the life of 2004, 2005 and 2006. So it is consistently good news.

I think I might have volunteered the substantive nature of that detail to you in the Legislative Council, but I also indicated that there are about 6000 people who are going to be the beneficiary of the one-off payment that actually occurred at the end of the 2006-07 budget. So if you have a look at the budget paper on page 91, you will actually see that there is quite a — if you actually have a look at the life of the estimates period here, we started off with a target of 24 910 people receiving a service, and the outgoing expected outcome is 31 110. Now that spectacular increase — —

The CHAIR — A good result!

Mr JENNINGS — That spectacular increase is being directly attributed to a $9.5 million injection that was made in the outgoings of the 2006-07 budget. That will make significant inroads; as you can actually see, it is 6200 people — it is larger than the waiting list. In fact I do not know that we are actually chasing up an additional 800 people to get serviced, because in fact, as you would appreciate, there are a range of various service needs and those needs vary across the different needs of people who are waiting to receive a service.

As you can see, the report that you quoted from pre-dated that significant commitment and also pre-dated the commitment going forward. So beyond the $9.5 million there is another $20.3 million going forward in the forward estimates which is designed to address those waiting-list concerns, and there are many elements of the waiting list that we optimistically think will be removed — for instance, that those children who are waiting at the Royal Children's Hospital for aids and equipment through the fantastic services provided there, we think will be eliminated through this investment.

We are also adding to the program to provide for the aids and equipment needs of people who are on extended aged care at-home packages and community aged care packages, which is a commitment that we made at the last election which will open up access to this program to people who previously were not eligible for this program because they were receiving commonwealth-funded assistance. We are also opening up a program to provide for greater home modifications and, for the first time, vehicle modifications.

So we think that the story about waiting lists is that we are trying to remove them and in fact we have probably provided enough money to remove the existing waiting lists, but as anybody in public life will know, in fact there is a certain elasticity in the nature of these programs and we may expect more people who may currently not have applied, to apply in the future. So I may not be able to come back here in 12 months time and say there is no waiting list, but at the moment we have accounted, in cost terms, for the current waiting list.

Mr RICH-PHILLIPS — Are you able to break down — —

The CHAIR — You want the breakdown among the three areas, do you?

Mr RICH-PHILLIPS — Yes.

Mr JENNINGS — I have not got that before the committee at this moment, but we can probably track that down subsequently.

Mr RICH-PHILLIPS — As to the money, you mentioned $20.3 million in the estimates; can you reconcile that figure, please, with the $30 million that is mentioned on page 16, over five years?

Mr JENNINGS — Yes, I can. It is the $9.5 million going back in 2006–07 and it is 20.3 going forward; so add those two together.

Mr RICH-PHILLIPS — Right; okay.

Ms GRALEY — Minister, I think you probably understand that there is nothing more emotional for a local MP than have a family, usually a lone mother, in the office with children with a disability. I understand that the performance of the Victorian disability services system is linked with commonwealth negotiations on funding. I am hoping that the minister could provide us with an update on the development of the next CSTDA and how he thinks this will play out in the future.

Mr JENNINGS — I thank Ms Graley for her question and her concern, and hopefully I will give her a sense of optimism rather than pessimism, because in fact it is very important for all of us to have a sense that we can respond to the needs of any family that may come knocking on your door and may require assistance. So I would like to end on an optimistic note, but I have to indicate to the committee at the moment that the negotiations up until this point in time have not been very fruitful or satisfactory. The commonwealth-state territory disability agreement — of which there have been three previously — is about to run out at the end of June. In the last financial year what that meant for Victoria was that the Victorian budget allocated about $1.04 billion worth of services through that agreement.

The commonwealth provided $129 million worth of services. So, as we can tell, about 88 per cent of the commitment was funded through the Victorian government, and the commonwealth level of contribution, we contest, is not equitable in terms of Victoria's share of disability funding or equitable in the terms of the relative weight that the jurisdictions should carry in relation to this important area.

The federal Parliament Senate process did a lengthy examination of the needs of the disability sector, and came down with a report in February that indicated that there is a whole range of unmet needs that the commonwealth should invest in. It was a unanimous report from the Senate inquiry, so you would have actually thought that when the commonwealth minister came to negotiate with state and territory ministers in Brisbane at the beginning of April, that in fact we would have common ground to embark upon the fourth agreement.

Unfortunately that was not the case. The commonwealth is very committed to accountability measures and wanting to make sure that all states and territories obliged with accountability undertakings to it — which is fair enough, from Victoria's perspective; however, there was not a corresponding commitment to grow the program going forward, so there is no agreed growth formula between the states and the commonwealth. There is no agreement about the level of indexation that is appropriate to provide to the field. In fact the indexation rate that the

commonwealth wishes to apply to the price structures of the program is very low indeed — 1.8, which is at the very low end of the scale in relation to indexation factor. There was no particular agreement to any specific purpose payments outcomes, whether they be to mirror the younger people in nursing homes initiative.

I will go off at a tangent to actually say that is one of the successful models of engagement between the state and the commonwealth, so in fact it is within our wit and wherewithal to be able to find opportunities where we can actually agree on a certain direction. Indeed in younger people in nursing homes we allocated $30 million each — commonwealth and Victoria, going forward — to try to provide for more flexible and responsive needs for younger people who might otherwise live in nursing homes.

So we are capable of finding some common ground, and I am absolutely determined to find some common ground with the commonwealth in relation to this. In fact in the state of Victoria we think an 80:20 share going forward is something that we are happy to countenance. We are very happy to comply with accountability measures. We are very happy for us to have an agreed assessment about what projects we can jointly fund. So the offer is available from the state of Victoria. We actually hope that the commonwealth will respond. In fact we are waiting for the commonwealth to respond, but states and territories will be putting in a combined position to the commonwealth shortly hoping to recommence negotiations in June, because these issues are far too important for them to be shunted from one jurisdiction to the other, and we should be working on an agreed set of principles and priorities.

The CHAIR — I thank the minister on that important issue.

Mr DALLA-RIVA — Minister, I refer you to budget paper 3, page 91 again, in respect of disability services targeted services. In respect of vehicle modifications, as we know, they can cost in the vicinity of $20 000 plus. I note, minister, in your earlier response in respect of the clients accessing aids and equipment, that you have got an expected target of 26 210 clients accessing aids and equipment. How many vehicles would you expect will be modified in the forward estimates in the 2007–08 target period? I am referring to a comment you made in the *Age* on 27 April, where you mentioned:

> For the first time we recognise that mums and dads want to take their children out and about and have an active and full community life —

which I agree with.

The question is: in terms of the priority for vehicle modifications, will it be families with young children or adults who have been waiting for vehicle modifications for a period? Finally, in terms of the guarantee, will the total cost of each vehicle modification be met by the allocated funding? I guess there is a three-part link in terms of vehicle modifications.

Mr JENNINGS — It is a very good question. I have to volunteer that my answer that I give you at this point in time I do not think is going to be a great answer. The various issues that you outlined are a work in progress in terms of the particular allocation within the funding envelope for this purpose, what the demands may be, because at the moment we have not had a waiting list for this because the program has not been opened to this area. So in terms of what the demands may be coming on us, we are not quite sure. What in fact might be the best way that we can actually spread the investment to provide for the biggest range of people — whether we go to the greatest need, or whether in fact we try to provide for a range and spreading the resources as far as we possibly can, without necessarily the most expensive investment; these are the types of finetuning of this program that we are going to be doing during the life of 2007–08.

It is a terrific question in the sense that it goes to the heart of what our deliberative thinking is going to be over the next few months. I am very happy to come back and let you know, the community know, when in fact we have built those parameters of the system so I can meaningfully answer that question.

Mr DALLA-RIVA — So can we expect something perhaps provided on that? Is there a time frame you are expecting, given that we are — —

Mr JENNINGS — All of that deliberative work, all that scoping work — —

Mr DALLA-RIVA — I understand.

Mr JENNINGS — An example of it may be — just in terms of the efficiencies of being a purchaser of equipment, which we have not been previously — what is our purchasing power? We are not quite sure whether we go through the existing providers and the existing network — which I am sure we will do — about who does those vehicle modifications, because in fact there is a sub-industry that actually undertakes it. We actually have not quite worked out what is the most cost-effective and transparent way to enter into that market, because we do not want to disadvantage people from actually having access to participating in that market. It will take a few months. It is an imminent issue, but by the end of the year — —

The CHAIR — So we will not having anything in the next 30 days, but I am sure we will keep this under review, Minister.

Mr WELLS — Minister, I refer to budget paper 3, page 79, the aged care assessment relating to both the cost per assessment and the wait between the client registration and the ACAS community-based assessment. It is a three-part question but all related. Why is the cost per assessment over 9 per cent higher in 06–07 than what it was in 05–06, and why is the target of 15 days not being met? It seems to have been stuck on 20 days in terms of the wait between the client registration and the ACAS assessment. How do you expect to meet your target of 15 days, which is in the 07–08, at the same time as reducing the output cost per assessment?

Mr JENNINGS — That is accumulatively about the best question I have actually ever received in relation to the accounts, really, in all my time of appearing before the committee, because it actually relates to the budget paper and the output measures pretty comprehensively, doesn't it.

Mr WELLS — Thank you!

Mr JENNINGS — I must say, maybe under your chairmanship, Mr Stensholt, the committee is actually digging deeper into the — —

The CHAIR — We are, we definitely are — we have a whole lot of new members, Minister.

Mr JENNINGS — You are quite right to indicate that there has been a concern about the average waiting time for people who receive assessments in the community, and that is absolutely true. It is not disputed, and in fact this is actually something that we do not find acceptable either.

What we can say is that there have been major gains and major success in relation to assessments that are actually undertaken within hospital-based settings, which has in fact been a major problem for all of us. We see the system of integrating residential aged care, community care and acute hospital care as being a major problem. A major problem has been that people are staying inappropriately too long within hospital-based settings — acute hospital settings — which is not necessarily accounting for their needs, no. 1, and is a very high, extremely high cost structure.

In fact if we have erred in the emphasis within this program and what we have achieved, we have actually achieved great results in making sure that those assessments take place in a very timely fashion within hospital-based settings and within residential aged-care settings. That has been our emphasis and priority, and we have been very successful at that.

In terms of the staff and the support that has been provided for average waits in the community, we have been stretched, given the nature of some staff turnover and the difficulty of finding specialised staff who have expertise in this field. You would be aware that this is an issue that both the state and the commonwealth are particularly mindful of, and we share a responsibility of trying to ensure that there are better outcomes within this program. We have allocated significant one-off state investment to try to remedy this situation.

Indeed, the cost structures that you indicate relate to the recruitment and training of additional staff. The unintended consequences of where there may have been staff reductions is that in fact we need to invest to try to attract people to the field, to train them and to ensure that our capacity increases over time. Hopefully this will be something that the commonwealth and ourselves can agree on in future as being an area warranting joint attention and investment.

Mr WELLS — Minister, just to clarify, how many additional staff do you think you need in this program to be able to reach your target of 15 days?

Maybe we could get Ms Herington's microphone a bit closer!

The CHAIR — It is good to see a minister prepared to take advice.

Mr JENNINGS — Sure. I am sorry that I offend the committee and my colleagues at the table if in fact I am just such a precious pup that I have to answer all the questions myself. The nature of what I indicated to the committee about this needing to be a collaborative approach has been reinforced by my colleague here, who reminds me that there is a COAG-auspiced process to try to get to the nub of this problem.

To just re-emphasise that point: it is a collaborative effort, where we both have funding arrangements. That does relate to the budget allocation and the target figure that is indicated here. In fact our forward estimates remain flat and static without anticipating what the commonwealth level of investment may be, so we may have some variation to the program on the basis of some matched funding that may subsequently come into Victoria from the commonwealth.

On the question of the number of people that we may need to recruit, there is a certain degree of elasticity in that depending upon the regional variation and the needs of the program, and depending upon the skill mix and what the service configuration may be. There is not a one-size-fits-all response to this on the basis of what the various service configurations of a community may be, what the starting point of the ACAS may be. I cannot actually provide the committee with an estimate of the number of people, so I will pretty much stick to my substantive answer there.

The CHAIR — Thank you, Minister. I might note that in response to the questionnaire we sent around, the Department of Human Services was not able to provide us with data of estimates for June 2008. Perhaps this could be supplied — every other department seemed to be able to supply it.

Last year we saw the Disability Act, which I thought was a great hallmark in the work of the portfolio. I would like you to give us a report on the progress for that with particular reference to what is in the budget here and the estimates in order to implement that new act.

Mr JENNINGS — I thank Mr Stensholt for his question. In fact, as I indicated in my introduction, I have been the beneficiary of a number of great reform programs that will redesign and reconfigure our obligations and service capacity to Victorians. Certainly that is the case within the Disability Act, which will be coming on stream in its full implementation as of 1 July. It clearly outlines the state's obligations in terms of service provision.

There are within the budget papers a number of undertakings that we must fulfil. For example, the requirement for individual case planning is a requirement that is in the budget paper where we actually have to comply within 60 days for 100 per cent of people who require a plan to be developed — we are obliged to develop it in accordance with the act. That is one indication of the onerous nature of this for the state and the people who provide services for people with disabilities.

There are also a lot of support mechanisms and reinforcing mechanisms about best practice in capacity. We have appointed a disability services commissioner who is charged with statutory responsibilities for reporting to the Parliament about the capacity of the sector, will have a role in terms of providing for effective advocacy and education services being provided to the field about best practice, about what the standards of practice should be.

The office of the commissioner will be able to provide for mediation services so that people can exercise their rights. That applies to people with disabilities themselves in terms of the quality of service they are being provided with, or indeed there will be access for their carers, their loved ones to be able to have remedies through mediation and support through the office of the commissioner. We are establishing a council to provide advice to both the commissioner and me about the range of needs in the sector and the effectiveness of the implementation of the act.

We have also introduced a senior practitioner who is charged with the responsibility of making sure that we have best practice, in particular in relation to practices such as compulsory treatment orders and restrictive interventions and other actions that may be done by service providers in disability in the name of maintaining safety and security for the community. But very importantly, we have to be mindful of the human rights aspects to ensure that people who are in those forms of orders and in those forms of intervention do not adversely impact upon their quality of life and their freedoms as citizens of this state.

It is a very important balance to make sure that we as a community are confident about the behaviour of people who may have very volatile or disturbing behaviours but yet have absolute right to ensure that they are not being

inappropriately treated. The combination of the senior practitioner and the services commissioner, we think, will play an important role in trying to ensure that there is appropriate practice taking place. I can say to the committee that the sector generally is pretty enthusiastic about the bill. There have been very passionate debates that led to its establishment.

The CHAIR — Telmo Languiller did a lot of work as parliamentary secretary.

Mr JENNINGS — A lot of work. The parliamentary secretary was a very busy man in terms of community engagement. There has been a lot of community engagement about this bill. There are very high expectations from all in the sector and in the community about our achieving better outcomes for people with disabilities, and I am pretty confident that the combination of things within the Disability Act will enable that to be the case in the years to come.

The CHAIR — Thank you very much for that.

Mr RICH-PHILLIPS — Minister, I am sure you would be disappointed if I did not ask you about aged-care facilities.

Mr JENNINGS — Good on you!

The CHAIR — They are very good. They do very well.

Mr JENNINGS — Excellent.

Mr RICH-PHILLIPS — Perhaps as an aside you might tell the committee what proportion of the aged-care budget you are responsible for versus Minister Neville. My substantive question goes to the issue of the commitments made for the Bendigo Stella Anderson facility and the Trentham Nursing Home — commitments that were made during the election in November. Funding has not been provided in this year's budget for those two facilities, so can you please tell the committee why not, when redevelopment will commence and whether you are confident that those two facilities will meet the requirements for accreditation in 2008?

Mr JENNINGS — That is beautiful! Let me actually start with the end first. Yes; just in case you thought I was being disingenuous at the beginning of my presentation to the committee today, all the Victorian public sector residential aged-care facilities will actually achieve 2008 accreditation standards. That is the good news, to answer the question.

It is all good news, really, because the commitment to redevelop those two services — Bendigo and Trentham — will take place over the life of the government. Indeed in previous iterations of public accounts and estimates I was always asked about when the capital program was going to roll out to ensure compliance with 2008. I consistently came back and said we will actually deliver on our commitments over the life cycle of the government and indeed make sure that we meet those standards, and that is going to be my answer when I come back. If it is not the answer, I will let you know, but I am pretty confident it is going to be the answer. Those projects will be funded in coming budgets.

In answer to your first question, I am not privy to be able to tell you off the top of my head what aspects of the budget Minister Neville is responsible for, but I — as I indicated to you before, on the basis of what is in the aged-care program and the small rural services program — am responsible for outputs of $1.0216 billion of services related to aged care.

Mr RICH-PHILLIPS — That would suggest there is only about $10 million left for Minister Neville.

Mr JENNINGS — As I said to you, I do not know the number off the top of my head.

The CHAIR — We can pursue that with Minister Neville.

Mr PAKULA — Minister, could you inform the committee how the government's commitment to the home and community care program of $83 million over four years will improve and increase service provision? In asking the question I am referring specifically to pages 80, 84 and 85 of budget paper 3.

Mr JENNINGS — Thank you for the question. Yes; one of the good things that I have been responsible for over a number of years and continue to be responsible for is the home and community care program — a major provision of support to seniors in our community and people with disabilities who want to live independently at home but require some additional support. Whether it be nursing care, personal care, help around the home or Meals on Wheels, these are the types of programs that are funded through home and community care. As lingering members of PAEC will know, I have actually come to the committee and told you on a number of occasions that under normal circumstances home and community care around the country is a 60-40 program, where the commonwealth contributes 60 per cent and the states contribute 40 per cent.

That has not been the case in Victoria. Over the life of our government we have gone pretty close to a fifty-fifty match, and indeed in the current budget of $470 million in this year Victoria has funded $57 million beyond what our matching component is. It is a significant commitment we make to seniors and people in the community who require assistance. We recognise that in the forward estimates with $83 million in the next four years to try to keep that momentum and capacity going within the system. We estimate that will provide for about 400 000 hours additional service and that in the order of 6000 additional people will be able to receive access to that program.

We recognise there are some reasons for us to make sure there is appropriate accessibility within the programs, so in the last triennial funding round and going forward we will be trying to make sure we do a number of things. The first is that we provide for equity across the state so that regardless of where they live people have a reasonable probability of receiving that service. When I arrived in the portfolio there was a very unequal distribution of those funds, and to be honest there continues to be a bit of an unequal distribution of those funds. On a per capita basis there is a disproportion between rural areas and metropolitan areas. With the triennial funding arrangements we are trying to address that imbalance by allowing for ongoing quality of service and by not diminishing any funding that goes into regions and then subsequently into LGAs. We are trying to distribute growth money through the program to try to address those imbalances.

We are establishing a benchmark for funding across rural areas which is higher than the benchmark for metropolitan areas. Members of the committee would understand that is probably an appropriate thing to do, given the tyranny of distance factors and transport factors that may come into providing for people within the program who might be socially isolated and have additional transport costs in rural areas. It is very important within that two-tiered system of regional benchmarking and metropolitan benchmarking for us to allocate maximum funding to cater for growth. That is the first issue.

The second issue is in relation to accessibility for people from culturally and linguistically diverse backgrounds to make sure they receive service in accordance with their needs. We estimate that somewhere around one in five Victorian seniors speak another language at home and come from a background where English is not their first port of call in relation to language. There may also be some cultural impediments to the accessibility of the service, and we want to try to overcome those. We have embarked upon investment strategies to try to turn that around so we have a more representative and responsive service configuration.

Exactly the same theory applies to members of our indigenous community in terms of their access to the program. There has been significant investment made in the last three years, and indeed there will be going forward, to try to account for the home and community care needs of indigenous people within the program. They are the major emphases and drivers of this program in the years ahead.

The CHAIR — Thank you, Minister. That pretty much concludes our consideration of that portfolio. Just before we finish I note that I would appreciate it if we could get an answer from the Department of Human Services to question 9 of our questionnaire. I am happy that it be taken on notice and be provided within 30 days. We would appreciate that. We are also looking for a departmental indication of the costs involved for the portfolio department in regard to servicing the Public Accounts and Estimates Committee, both in terms of staffing and resources, that you expect to have next year on the basis of experience over the last few years. I thank all witnesses for their attendance.

Witnesses withdrew.

Transcript of Evidence

4.11 Health portfolio

VERIFIED TRANSCRIPT

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2007–08

Melbourne — 8 May 2007

Members

Mr G. Barber	Mr G. Rich-Phillips
Mr R. Dalla-Riva	Mr R. Scott
Ms J. Graley	Mr B. Stensholt
Ms J. Munt	Dr W. Sykes
Mr M. Pakula	Mr K. Wells

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

Staff

Business Support Officer: Ms J. Nathan

Witnesses

Ms B. Pike, Minister for Health;

Ms F. Thorn, secretary;

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

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

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

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the 2007–08 budget estimates for the health portfolio. On behalf of the committee I welcome the Honourable Bronwyn Pike, Minister for Health; Ms Fran Thorn, Secretary, Department of Human Services; Mr Lance Wallace, executive director, metropolitan health and aged care services; Dr Chris Brook, executive director, rural and regional health and aged care services; Mr Alan Hall, executive director, financial and corporate services; departmental officers; members of the public; and the media.

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

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. There is no need for evidence to be sworn. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript. The committee requests that verifications be forwarded to the committee within two working days of receiving the proof version. In accordance with past practice, the transcripts and 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, and questions should relate to the budget and the forward estimates. I ask that all mobile telephones be turned off.

I call upon the minister to give a brief presentation of no more than 10 minutes on the more complex financial and performance information that relates to the budget estimates for the health portfolio.

Overheads shown.

Ms PIKE — Thank you very much, Chair, and thank you to the Public Accounts and Estimates Committee. Good afternoon, and thank you for the opportunity to make a few brief comments to start with. I want to outline some of the current challenges facing the health system here in Victoria, how we are responding to these challenges and what we are achieving, and also outline the new investment that is in this budget so that we can continue with our work in responding to these challenges and building a world-class health system for all Victorians.

We know there are increasing demands on the health system, and that is not something that is unique to Victoria; it is a worldwide phenomenon, and health planners do need to find extra capacity within the system to treat more patients every year. The volume of that is quite extensive here in Victoria. We will admit more than 360 000 more patients in 2007–08 than we did in 1999. That is an extra 1000 patients every single day into our hospitals.

We know what the major drivers are, and that bottom graph gives you a breakdown of those drivers — and I know you have it before you. The population, of course, in Victoria is growing faster than the rest of Australia, and that is represented in the blue section. But it is also an ageing population, and, on top of that, that increases the proportion of older people in our community and those with chronic conditions, because they, of course, become more manifest in old age.

We also know that as technologies and clinical practice improve more patients can and will be treated, and with economic growth — and you can see on your graph that much larger section, in fact, is economic growth — and as the community does become richer, in a sense, there are greater expectations placed upon the health system, and all of those things will indicate a very, very large growth in demand. All advanced health systems are finding that health is absorbing a much greater proportion of their national and state output every year. This graph shows the ratio of health expenditure to GDP in Australia overall. So you can see that health is actually taking up a growing proportion of our expenditure at both state and commonwealth levels.

You will be aware that the Australian health care agreement provides the funding arrangement between the commonwealth and the states for the funding of our hospitals. And what was a fifty-fifty agreement — and you can see there in 98–99 it was much closer to fifty-fifty — is now changing dramatically with the commonwealth's share of the costs really diving. So we now have the commonwealth barely meeting 40 per cent of the costs in what is, as I said, a fifty-fifty funding agreement for our hospitals.

We are also facing challenges in workforce. That is partly because of a lot of different trends: the ageing of the health workforce; the reduction in working hours — particularly doctors are not following the old pattern of being available and working 24 hours a day, 7 days a week; we do face increased competition from private hospitals; and of course as long as the commonwealth continues to control the number of training places in our universities, we have to draw on a diminishing number of people in the workforce.

We are also restricted in some ways by the ways that we can deploy our workforce because of the traditional practices and professional cultures in different dimensions of the workforce. There is some good work going on nationally which is trying to address that. We are responding by continuing to invest the state's resources in building our system. You can see from that graph that the 2007-08 budget now brings us to a 96 per cent increase in acute health output funding since 1999-2000.

Likewise, we are continuing to boost our asset investment for health and also aged care. There has been a massive rebuilding and modernisation program within health over the last few years. This budget builds on that with about half a billion dollars of extra funding for health and aged care.

On top of investment, of course, there has been major innovation and reform, and that continues in the system. There have been over 40 service innovations implemented in the system to really make sure people are getting the right care in the most appropriate setting and making sure we make efficient use of every single dollar that we put into the health system. These innovations range from keeping people well — and obviously prevention is something that deserves a huge effort and is something we are very committed to; early detection and referral through things like Nurse-on-Call; targeted programs for people with chronic disease such as the HARP program; being much more effective and efficient in the way we deliver services in emergency departments through things like 'see and treat' and short-stay units and others; and then of course a greater use of IT and other enablers within the system.

We are achieving results. I said that we have seen a huge growth in the number of admissions and that top line in fact reflects that. The bottom line reflects the total number of people on waiting lists for elective surgery. As the number of admissions is rising and rising, our performance is improving, and in a sense the gap between those is the productivity that you are seeing in hospitals. They are getting more resources but they are increasingly more productive. You can see that we now have the second lowest waiting list in nine years. Just put that in perspective, since 1999, 920 000 Victorians have had elective surgery. So even though elective surgery only makes up about 15 per cent of the overall activity within the acute health system, it is a sector that is performing well in the context of a huge growth in admissions.

We are building the workforce, and you can see there the increase to now well over 7000 extra nurses. We are improving access to dental care and 70 000 more people are being treated annually now than there were in 2000-01.

But as we know the challenges are well before us and we have to continue to invest in our system. So this budget allocates additional resources to emergency and critical care; to treating more elective surgery patients sooner in not only a volumes sense but in a very strategic way; expanding our capacity through the development of more same-day services; specialist services in Craigieburn and Melton; extra funding for the HARP program and chronic disease management; targeted growth in things like dialysis, chemotherapy, radiotherapy, blood services — all of those extra things that are seeing huge growth in numbers in the system — and of course additional funds for inpatient maternity services because we know we are going through a bit of a boom in birthing here in Victoria.

We are also expanding outpatient services, as we committed, and also responding to the growth in the demand that will come from the national bowel screening program. There are a range of other initiatives — Nurse-on-Call, home support for children and all of our rural initiatives in maternity care and extra volume within the system.

We are building on the strength of our workforce, continuing of course the COAG workforce reforms by expanding training for specialists; establishing a national approach for international medical graduates, and that is very important as far as safety and quality is concerned; growing VET places; establishing a new national registration scheme and providing of course the clinical placements for additional medical and nursing undergraduate positions. We are also doing work on workforce redesign — and we are doing that in partnership with other states and the commonwealth at a national level — and we are strengthening our rural workforce with more training for obstetricians and GP proceduralists.

I spoke about health infrastructure. The asset investments again are considerable in health: Frankston Hospital redevelopment, stage 2 — that is the theatres, the ICU, the HTU — building, of course, on the initial bed capacity that was provided in stage 1; Western Hospital — some redevelopment work on the Footscray campus and then the beginning of what is a major redevelopment at Sunshine; Royal Melbourne Hospital brickwork rectification — that is absolutely essential for the continuing service delivery there but also for the capacity to put in the massive new emergency department that was funded in last year's budget; some work in community health at Peninsula; and, of course, the short-stay unit at Northern, which adds to the additional capacity in mental health that has also been added there. And there are a range of other metropolitan projects.

In rural health, we are continuing the massive redevelopment program there — and really you would have to go a long way to find a place in rural Victoria that has not been upgraded or rebuilt or redeveloped in the last nine years — this year with Stawell; Warrnambool hospital, a $90 million redevelopment was committed by the government in the election campaign, and we are getting that going with stage 1; Ballarat, Murtoa, Barwon Health, Bendigo health. And this year particularly in the budget, is a very significant amount of additional funding for medical equipment replacement for infrastructure renewal, which often does not get a headline — the pipes, the electricity, the roofs, and all of those things that keep hospitals going — MRI, additional work in emergency departments and in intensive care.

We also need to continue to upgrade ambulance services. This year we will expand ambulance services to ensure fast response times in Bacchus Marsh and Hastings, where we will go up to 24 hours, and in Melton and Sunbury next year; and there will be new peak period units at Whittlesea, Altona and Doncaster East, a new ambulance station at Lara and extra crews at Moe. We will also fund and/or refurbish stations in Geelong, Belmont, Norlane, Wonthaggi, Lismore, Stawell, Daylesford, Warragul, Yea and Lara, and provide extra shifts in Moe. We will also, of course, provide $8.3 million for a new fixed-wing facility to be funded jointly with the police and other emergency services at Essendon airport.

We are continuing to do our work in oral health, and I am very pleased that we are able to extend fluoridation. We have been on a significant program of providing additional fluoridation right across country Victoria, which was left behind — and we know, of course, how important fluoride is for the prevention of decay, particularly in young people. There is the new rural dental school in Bendigo and some additional services for older and disadvantaged Victorians.

Finally, I want to continue to talk about the Go for Your Life strategy, because, as I think members of PAEC will know, we face a huge challenge in our community with rising levels of obesity, and particularly childhood obesity. We know that if we do not address this as a whole community with a very broad range of initiatives to deal with what has become quite a culturally embedded challenge, then we will see the really quite large growth of the onset of type 2 diabetes at even earlier ages.

The lifestyle change program, which is one of the things that it is coming on stream this year, will see a specific, targeted program for 25 000 people who have been identified as at high risk for the development of type 2 diabetes. Of course the Department for Victorian Communities will receive $102 million over four years. So it is a broad, whole-of-government package with some components in the health area and some in other areas.

Finally, I want to make mention of some funding to continue to build on our counter-terrorism and disaster preparedness, which is something that we have a very important part to play in, in health, and we have certainly provided investment in over the last few years and we are continuing to do that.

So, Chair, as you can see, there are huge challenges in health. They are not just challenges that Victoria has. Every single state in Australia and every Western country around the world is seeing huge demand in the number of patients that are coming into our hospitals, huge growth in funding health — the cost of health-care delivery far outstrips CPI on every measure and in every jurisdiction. That is why you will see further investment here in this budget, building on the innovation and investment that has been the feature of our response to these challenges over the last seven years.

The CHAIR — Thank you very much, Minister, for that comprehensive outline. You touched on the issue of productivity. I am particularly interested in this one and would like to ask you to elaborate more on that in terms of what impact on productivity will portfolio spend have next year, particularly new budget initiatives?

Ms PIKE — Thank you, Chair. Just in recounting my last statement, what we have is the cost of delivering health care ranging from about 5 per cent up to about 8 or 9 per cent additional per annum. You can see that when the private health insurance funds come to the commonwealth government and ask for permission to actually put up their premiums, that it is within that range. So it is certainly acknowledged that the costs are rising.

We have also of course demonstrated that the number of people coming into the system through the ageing of the population, through the growth of the population, but of course more importantly and more significantly through the availability of new technologies, new medicines, new procedures, better ways of treating people, all mean that you have got growth in cost and growth in demand. By all nationally accepted indicators Victoria's hospitals are now the most efficient at actually meeting those challenges and those costs. We have a lower cost per casemix adjusted separation than the Australian average, and that has been case for the last five years. We have a lower average length of stay, and we have the best emergency department performance of any state and territory and the best elective performance of any state.

We also are improving in our quality — for example we have 127 sentinel events in 04–05 compared to 429 in the same period in New South Wales. Our adjusted mortality rates in cardiac surgery are well below the UK and the US benchmarks. How have we achieved these good results in the context of a massive increase in demand and cost? We have had a very multilayered strategy. We have cost-reduction strategies and things like Health Purchasing Victoria. The creation of nurse banks have seen services drive down costs where there is capacity to do so without affecting the quality of patient care.

We have introduced new models of care, and medi-hotels are a great example of this where people can have oversight before they have an operation, but they are not in a very high-expense acute bed because that is not necessary for them at that stage in their care. There are a whole range of other initiatives where we are moving people to a more appropriate level of care and a more effective and efficient level of care. The growth in sub-acute is another example of this.

Then clinical practice improvement; just in some of your most basic surgical areas, practices that used to keep people in hospital for 7, 8, 9 or 10 days are now same-day procedures in many of our hospitals, and that is because of the huge growth in expertise, but also, of course, the new treatment technologies, our use of imaging technology and all of those things that have made our hospitals and system just so much more effective.

So, as I said, these improvements and this productivity comes against the backdrop of the growing population of increasing co-morbidities. As people get older they come in with more complex issues. There is a growth in chronic disease prevalence, new technologies, a great rise in the cost of medical and surgical supplies — prosthetics, drugs and all of those sorts of things — and a very tight labour market. So when you put that all together it is a challenge, but we have really demonstrated significant productivity over the past few years.

Mr WELLS — Minister, I refer you to budget paper 4, page 66, table 2.2.1, especially 'Employee benefits'. What impact will the reported payout to Dr Rob Hall, the former chief health officer — which is estimated to be half a million dollars more than what his contract requires — have on the forward estimates? What proportion of that payout is actually hush money?

Ms PIKE — Dr Robert Hall's termination is in full compliance with all of the government guidelines and within the terms of his contract. Dr Hall will receive no more or no less than his contract stipulates.

Mr WELLS — So what impact will that have on the employee benefits? I mean, obviously there is going to be a cash payment up front which would not have been in the forward estimates, so when will that final termination take place on that?

Ms PIKE — The arrangements for the termination, as I have said, are within the terms of Dr Hall's contract, and all of this was effected within the terms of his contract. There are no additional payments that are being made. Obviously when the termination of a contract is brought forward, then the allowance has obviously been made for the full payment of that contract. So it will have no impact on the forward estimates because it is all within the terms of a fully funded contract that we anticipated paying.

Mr WELLS — Okay, so just to clarify that point — —

The CHAIR — Keep it to the estimates.

Mr WELLS — I am looking at the estimates. So in other words, he was not given any extra payment for time that he may have served? He was terminated on a particular date and received no other payment for any forward employment contracts other than his annual leave, superannuation and long service — —

Ms PIKE — No, there are conditions within standard contracts for public servants, like my colleagues here all have. They are governed by GSERP, an independent body. Dr Hall was paid according to the terms of his contract, which he signed, and there is no impact on the forward estimates. If you require the secretary of the department to elaborate, I am very happy for that to happen.

Mr WELLS — So he was not paid — —

Ms PIKE — He was not paid additional funding beyond those items that were determined within the contract when he first signed that contract to come and work within the Department of Human Services. That is exactly the same as for the other departmental officers who sit before you.

Ms MUNT — Minister, you touched briefly on elective surgery waiting lists in your presentation. I would like to refer you to budget paper 3, page 288, under 'Hospital futures', which talks about increased funding for elective surgery lists. I would you to please tell the committee what has been achieved so far by this allocation of extra resources to elective surgery, what further plans the government has to improve elective surgery access, and when will the two new elective surgery centres at St Vincent's Hospital and Austin Health Heidelberg repat be completed and operating?

Ms PIKE — The most recent *Your Hospitals* report, which reported the activity within the health system for July to December 2006, indicated that we have the second lowest elective surgery waiting lists in nine years. Since 1999, 920 000 Victorians have received elective surgery. Since the blitz, as we have described it, since a massive increase in funding for elective surgery, 202 000 Victorians have received elective surgery. We are very committed to ensuring timely treatment for people who need elective surgery, and in 2006–07 we have invested an additional $22 million to provide more surgery for patients and invested $6.2 million at the new Alfred Centre.

For the benefit of the committee, the Alfred Centre, which has been completed now and is in fact taking patients, is a dedicated elective surgery centre, which means that people can have their booking, and there should not be hospital-initiated postponements because it is separated from the emergency department. Of course, people understand that in a system like ours the sickest people always get treated first, so there are times when a very, very sick person comes into emergency — they might have been in a car accident or something like that — and there sometimes have to be postponements. But the new elective surgery centres will deal with that.

The Alfred Centre will treat 30 000 elective surgery patients over the next four years, including 1704 statewide patients just in 2006–07. When it is fully operational and it is completely up and going, that will be nearly 4000 people who will be treated.

As I said, the waiting list performance has improved since 1999, and when you look at that in the context of the increased admissions as a proportion of the additional people broadly in the system, it is even a greater improvement in percentage terms than the raw numbers would actually indicate.

As I said, our system is based on the fact that the sickest people get treatment first, and in Victoria 100 per cent of category 1 patients are treated within the recommended time of 30 days. In fact the average waiting time for category 1 patients is eight days in Victoria. The overall average waiting time across all categories for elective surgery in Victoria is 28 days. That is the average time. Within the varying categories there are different outcomes, but that is the average time.

As I said, a total of 22.1 million will also be provided in the budget to other health services to treat longer-waiting patients and to expand capacity. You asked specifically about the new elective surgery centres. St Vincent's Health will specifically focus on joints replacement; that of course is an area of high demand. Austin Health has received funding in this budget to do the refurbishment required so that it can also have specific elective surgery conducted there, again, on the Heidelberg site. It will not be adjacent to the emergency department, which of course is facing huge demand in the brand-new hospital there. It means that we can continue to have the work done there. As I said, both the St Vincent's and the Austin initiatives are funded in this budget. We expect the Austin to be up and running in 2008; we expect St Vincent's centre to be completed by 2009.

I do not want to diminish the fact that there are many people in Victoria requiring elective surgery. It is a huge and growing area of demand. We are working very hard to keep within the national targets. We, in elective surgery, are performing well above the Australian average in many categories and at the Australian average in category 2.

We know that there is a lot more work to be done, and we have a whole range of innovative strategies. It is not just about expanding the amount of dollars so that elective surgery can take place across right across the state, it is not just the dedicated elective surgery centres; it is also specialist funding for physiotherapy and some of those other support services that can often be of assistance to people who in the past may have found themselves on the elective surgery waiting list.

For example, the treatment of varicose veins has seen a fairly dramatic improvement, because not everyone who has a varicose vein problem needs drastic interventional surgery. The establishment of vein clinics and the use of medication and physiotherapy has been very effective. Similarly, in orthopaedics, not everyone requires a hip, a shoulder or a knee replacement. There is certainly a very great capacity for physiotherapy to be of assistance. I think everybody knows that if it is possible to avoid a highly interventionist procedure, then everything needs to be done to do that.

Elective surgery is about managing the community who are on the waiting list and making sure that they can have timely access to treatment, giving people good information about that through *Your Hospitals* report, investing in new treatment options, investing in dedicated elective surgery centres so that we have a robust system and we can continue to meet that demand that I described earlier.

Dr SYKES — Minister, I am interested in your addressing the shortage of health professionals in country Victoria. My understanding is that there are considerable federal funds available for the training of doctors, a lot of which is being spent at Deakin and Warrnambool for country-oriented doctors. It is also my understanding that there is limited money available for the training or placement of interns in country hospitals, with the result that a large number of the interns who have had training at Deakin or Warrnambool are in fact doing their internship at Box Hill.

If that is so, then the underlying objective of having health professionals train and live in a country community and therefore realise that country Victoria is a great place to live, work and raise a family, if that part of the equation is not being addressed, then we are not going to have those young people come to country Victoria. Can you please confirm whether my understanding is correct, and, if it is, what is being done about it?

Ms PIKE — As you will know, we were very successful in lobbying the commonwealth government for additional places in medical schools. In fact, Victoria does have 220 additional places. Both Deakin University and the Monash-Melbourne consortium to train people in country Victoria are yet to get up and running, but obviously the provision of appropriate clinical places for those students and then the provision of advanced places when they pursue that aspect of their course is something that we have already been planning for.

Deakin University, in fact, will not have any graduates for another five years, so this is something that is a way off, but we have begun to put money aside so that they can have access to appropriate training for that course. As you have rightly said, we want to make sure that as many doctors as possible have access to training in country Victoria so that we can attract them. Certainly the research shows that the longer time they spend in country Victoria, the more they will see that as a viable professional option for them in the future.

In the first raft of students there will be some who have a small part of their training at Box Hill, that is true. I can give you some numbers on that although I do not have them here before me. That is because the universities themselves require a level of supervision and obviously with around 27 per cent of health service delivery happening in the rural area and a very significant additional number of students, there is not complete capacity for that supervision within the whole rural community.

You are correct in identifying that there will be a part of their training at Box Hill for some students, but it certainly will not be all of their training, and they will have plenty of rural experience. But as capacity develops and supervision develops and as the course continues, then we will be working to make sure that we can have as much supervision as possible for this new cohort of people.

More broadly on the area of capacity within rural areas, this budget does see additional funding for specialist training. The group, of course, that you are talking about — it is going to be five years before they even graduate.

The issue of specialist training, of course, needs to be negotiated with the colleges and all of that sort of thing. In this budget we are providing $18.4 million over four years for specialist training.

We are also, as I said, growing the number of VET places. We are working with the commonwealth on a national accreditation and registration scheme. We are also providing extra funding for VMOs within country hospitals for their on-call allowances so that we can help to sustain the viability of emergency services within rural hospitals. We are providing funding for GPs to improve their procedural skills to become GP/anaesthetists, GP/obstetricians, other areas like pathology, paediatrics and other specialities. There is a whole raft of initiatives.

On top of that, until these 222 additional young doctors come through the scheme, we know that we do have a gap. That is why we have provided funding in the budget for a major recruitment campaign in the United Kingdom and other places overseas, which will see incentive grants paid to people who want to come to work in Victoria, and obviously the greatest area of need is country Victoria. It is a very comprehensive rural workforce program. We are looking forward very much to Deakin and the Melbourne-Monash initiative getting up and running, as well as the new dental school that will be developed in Bendigo for La Trobe University.

Mr PAKULA — In the presentation, at the start, you touched on the continuing demand pressures on the health system. I am broadly referring to pages 71 to 88 of budget paper 3, and I am wondering how the demand pressures have been reflected in health system performance and how you view it impacting over the forward estimates period and on any impacts that were outlined in the *Your Hospitals* report.

Ms PIKE — Thank you very much. We are very committed to improving access to our hospitals. We have set very challenging benchmarks for service delivery, and we make no apology for that. We think that we need to strive for excellence, we want to continually improve the work and the activity that is happening within our health system and we want to drive towards those benchmarks over time.

We do perform, however, very well when we compare the Victorian system to other states. In fact the most recent Australian Institute of Health and Welfare data shows, as I said, that the median waiting time for service delivery in an emergency department is 16 minutes. That is across all categories, from emergency right through to categories 4 and 5 — the primary-care type patients. It is a 16-minute average wait, and the national performance figure is 25 minutes, so Victoria is well ahead of other states and territories in access to emergency departments — and that is in spite, as I said, of the continuing growth in demand.

If you look at the last *Your Hospitals* report, you will see that between July and December last year there were 4525 more patients coming into our emergency departments and being admitted to a bed. That is not everyone coming in, that is just the ones who have been admitted; that is a 3.9 per cent increase. There are also an additional 36 371 admitted bed days, and, as I said, overall — including those patients who were admitted to a bed — there were 28 515 extra people coming into our emergency departments. They are people who were not coming in before, as a volume number.

We need to continue to meet this growing demand, and we have allocated $142 million to manage growing demand for acute services. On top of that, we are also providing more capacity: additional beds at Northern Hospital; the two new day hospitals at Melton and Craigieburn, which will just see thousands of additional patients who will have terrific services — one in your community — that in the past they would have had to have gone to a hospital for; and of course a new expanded emergency department at Monash, which is now up and running. We have also, as I have said, provided additional funding for elective surgery. I have outlined how we will be spending that money and what an impact that has been having in the system overall.

Broadly, though, on top of that extra resourcing to deal with the volume, it has been the hospital demand management strategy — a comprehensive multilayered strategy that supports system improvement and assists with dealing with service demand — that has really helped to deal with this issue. For example, the very successful hospital admissions risk program (HARP) will continue to be funded and rolled out. The HARP program is specifically designed for people who have chronic illnesses.

If you imagine someone with a chronic illness, such as a respiratory condition, before this program that kind of person would often deteriorate within the community to the point where they had bounced back into an emergency department — often unnecessarily — time after time after time. They came in, they put demand on the emergency department, they ended up having to go into a bed, and that was because their chronic disease was not being treated appropriately.

With the HARP program, for those people who are in the HARP cohort there has been an average of a 30 per cent reduction in avoidable hospital readmissions. So it is not just about providing more volume. It is about saying, 'This is a group of people, and we can treat and support these people better. It is better for them and it is better for the system as a whole'. Those kind of community-based options are intersectorial and they have been very, very successful.

We have also been mainstreaming different models of care — I spoke about medi-hotels — but medical assessment planning units, where people from different disciplines can round a patient, if you like, and actually plan in a comprehensive and interdisciplinary way the kind of care pathway that a person will have in a hospital so they do not just jump around the hospital not being dealt with appropriately.

Fast-tracking for people who come in with issues that really ought to be dealt with by a GP, except, of course, we have seen such a dramatic decline in after-hours and bulk-billing GPs; the care-coordination services in emergency departments; the psychiatric short-stay units; the general practice liaison program — making sure that when people leave hospital that they are connected back into general practice. These are all areas of service interface that are dealt with under the HDM (hospital demand management) strategy, which have helped us to not only drive efficiency and not only deal with that huge volume of people but also provide a better service for the people who are coming into the system.

So we are committed. We have had 40 different initiatives. We are certainly committed to continuing to find innovative ways to treat people, and I think that the report identifies where that has been successful and also identifies where we have more work to do.

The CHAIR — Thank you, Minister.

Mr SCOTT — My question relates to an issue which you touched upon briefly in response to a question that Mr Pakula raised in terms of the hospital system's performance on access to emergency departments, as reported in budget paper 3, page 72, I would be grateful if you could provide information to the committee on how this compares to other states, both in terms of historical performance but moving forward in the estimates period for this budget?

Ms PIKE — Thank you very much. I have spoken about the demand for emergency care, and, of course, that has dramatically increased. Just to give you a bit of historical perspective on that, there were 264 427 more emergency presentations and 77 000 more patients admitted to a ward bed in 2005-06 compared to 2001. So that is a very large number of extra people who are coming into our system. There is a whole range of reasons for this. I have talked about the growing ageing population.

I think there are a couple of other factors that really are worthy of mention here too. Obviously we have in certain places seen a very significant growth in the number of primary care-type patients. They are patients, usually around category 5, sometimes category 4, who really would much prefer — and it would be more appropriate for them — to have their services provided by a general practitioner. But we do know that through changes in work practices but also, of course, by diminished numbers of general practitioners, after-hours GPs are increasingly unavailable.

Let me give you the example of Werribee, where the Werribee Mercy Hospital has, for example, a very high proportion of its emergency presentations in that category. Werribee has the lowest per head of population ratio of doctors in Victoria. In other words, for a person moving into Werribee, most of the doctors, GPs, have closed off their lists. It is almost impossible for a person to have timely access to a GP — in fact to have access to a GP for an emergency condition is almost impossible. On top of that, we know that overall the level of bulk-billing remains low and that, of course, is a barrier for many people because they are not able to afford co-payments and, of course, free emergency care is found within an emergency department.

The other factor is that, quite frankly, the improved conditions within our emergency departments actually make them very attractive places for people to come, and there has been a huge increase, for example, in presentations at the Austin emergency department, after that new hospital was built. Similarly, I anticipate in Monash, where we have a brand-new emergency department and in Maroondah with the Angliss new facilities out there. When the Royal Melbourne $54 million brand-new emergency department is built I have no doubt at all that people will move into those facilities.

Now, we do know that the sickest patients are always given priority for care. I think people understand that — that when they come into an emergency department there will be people who go before them in the line, because they are sicker. Of course the whole emergency department is geared around that. But nevertheless we do continue to outperform every other state in all triage categories, with an average time of 16 minutes, with the national average of 25 minutes. At peak times, as I said, there might be times when people wait longer — non-urgent patients wait longer — but we do remain very committed to trying to move people through as quickly as possible and some of the work in fast-tracking has meant that we are able to stream patients more effectively.

Despite the growth in the number of patients requiring admission, 70 per cent are admitted — or have been, in the last report — to a bed within 8 hours, and that compares with 67 per cent in 2000–01. We have set a much tougher benchmark. It used to be a 12-hour indicator. We have made that an 8-hour indicator and we are working with hospitals to help them meet that indicator, because we think that that is a way of driving improved performance.

The other factor in emergency care has been the decrease in hospital bypass. That has fallen from around 6.7 per cent in 2000 to 1.8 per cent at the last report, and it certainly remains within target. We have a target of 3 per cent that emergency departments can be on bypass.

One thing that I think is really worth mentioning and that has been a real sea change in our emergency performance is the number of very long waits. I have to say it was very concerning in around the year 2000 that there were in fact 10 000 people in that reported period who waited longer than 24 hours in an emergency department. That number has now reduced dramatically, and I think that really shows that by focusing on a problem and introducing innovative strategies — a number of them were mental health patients, and the provision of additional care for people with mental illness in emergency departments has really improved that indicator.

As I said, there is a continuing demand. There is a lot more work to be done, and I am working very hard to strive towards greater improvement against all indicators, but when you consider our national performance and when you consider the volume of people that are coming in, I think we are on the right track.

The other thing is emergency care, and I will just conclude on this, Chair. We have also had a major project to improve the patient experience within emergency care. I think we all know people get excellent clinical treatment, and that is because of the wonderful doctors, nurses and allied health staff who are there in our emergency departments, but we have now moved to also get people to focus on the other aspects of experience in emergency departments — for example, the provision of standardised information, letting people know what the word 'triage' means, what it means to be in a category 1, 2, 3, 4 or 5, and what it means when someone goes in front of you.

We have also improved access to physical facilities, better physical facilities. So the overall patient experience and the improved performance in emergency care has been good. But, as I said, there is always a lot more work that has to be done in that area.

The CHAIR — Thank you, Minister. I should note that questions which are ruled out of order will not appear in the Hansard transcript.

Mr RICH-PHILLIPS — Minister, you have a health protection output group for which you are providing 245 million in funding this year, and the description is, 'protects the health of Victorians through a range of preventative programs including regulation, surveillance and the provision of statutory services'.

In that context I would like to ask you about the recent HIV debacle in which you sacked the chief health officer, Dr Hall. At that time you said one of the reasons for Dr Hall's sacking was that he did not inform you of the full extent of the department's knowledge of the matter. What did you mean by that?

Secondly, given at that stage the matter was a matter of public record and had been in the media — reports on a number of those cases — why had you as minister not sought advice from the department about the matter?

The CHAIR — Minister, if you can confine your answer to the estimates and the protocols which are operating within the department rather than past events.

Ms PIKE — Certainly I think it was a very broad question with some specific aspects to it, but you talked generally about the output in the budget paper regarding HIV services; in fact it was a much broader question. You talked about all of our work that happens in the public health area. Certainly that is a big part of our work, and it

does encompass everything from setting standards for food and water quality to working and empowering local government to fulfil its statutory obligations, dealing with issues like legionnaire's disease, rolling out the immunisation programs that are a requirement to roll out, and smoking cessation. The public health functions of the department are very, very broad, and that is of course why you identified the amount of funding that goes to that whole area.

The work in sexually transmitted diseases is one component of the overall work of the public health branch. In fact the program is a $14.7 million program which comprises $3.7 million in health promotion, money for community based support, and of course clinical and laboratory services, including the Melbourne Sexual Health Centre. On top of that, we provide $10 million to Bayside Health for Victoria's HIV/AIDS service.

We have allocated recently additional funding for our work in that area because we want to make sure that the people who are living with HIV/AIDS in our community receive the best possible service, and we want to make sure that Victorians have a good public health response so that we can limit the overall infection rates for the broader community from HIV/AIDS. A number of our new initiatives will continue our work in this area and provide additional funding for preventative care.

Now the area that you are specifically talking about is the management by the Department of Human Services of a small number of clients — a very, very small number of people — who do engage from time to time in risky behaviour when it comes to HIV. There are established protocols that have been put in place to deal with that group of people. The initial set of protocols were in fact developed on a national basis, and Victoria has in the first instance provided the benchmark, in fact, for performance in dealing with this very small group of people.

I have said quite clearly on the public record that when I became aware that the police were seeking the file of a particular client with our department, that the department notified me of that fact last year. At that time I said to the department, instructed the department, that a number of initiatives take place, that there be a complete review and strengthening of our own internal protocols. And that work in fact was undertaken and those strengthened protocols were put in place.

I also specifically asked that there be work done on the relationship between the Department of Human Services and the police, and that there was a very clear understanding of specific roles in this regard. That is very important, and it is very important because whilst there is a small number of people who engage in risky and sometimes illegal behaviour, there are also many other people in our community who are living with HIV/AIDS, and we have to be very certain that we have the right regime in place to provide for good public health outcomes that do not discriminate against people and do not discourage people from revealing their HIV status. That is internationally accepted best practice.

That is why we have to have the protocols right between the police and the Department of Human Services because each jurisdiction — each particular area, I should say — has a responsibility. The police, of course, need to deal with illegal behaviour; the department needs to deal with public health behaviour.

After I asked for that work to be done I then later found out, this year, that there had been more engagement by the department in the public health area with this small group of people than I had been made aware of. I was also made aware that the relationship with the police had not been dealt with to my own satisfaction and that the communication to my office had not also been to my satisfaction. So all of those matters were of grave concern to me. I had lost confidence in the capacity of the chief health officer to continue to monitor this program and to monitor this group of people and to effectively communicate to me the things that were important to me.

Mr RICH-PHILLIPS — Given the protocols you have now put in place, in future would Victoria Police have access to those files?

The CHAIR — I — —

Mr RICH-PHILLIPS — It is a fair question.

The CHAIR — Okay, right.

Ms PIKE — I am happy to answer that question. I have made it very clear that I have asked the previous deputy chief commissioner, Commissioner Bob Falconer from Western Australia, and also a person who will be

nominated by Graham Rouch to have a look at every single file that we have within the Department of Human Services on this small group of people who are at the attention of the department because they have come to our attention because of their risky behaviour.

The protocol between the police and the department is quite clear. If the police want access to those files because there is a particular matter of investigation regarding criminality, then of course they issue a warrant. That is agreed procedure between the police and the Department of Human Services. I have asked Bob Falconer and Professor Rouch's nominee to give me further advice on this. The head of my department, Ms Thorn, has already met with the chief commissioner as well and the deputy chief commissioner. We are certainly working very closely with the police.

We want to make sure that the different roles and functions are clear, that the protocols are clear, that we are complying with the protocols — both ourselves and the police — because we are all serving the best interest of the Victorian community here. If people are engaged in illegal activity, that is the role and function of the police. It is the role and function of the Department of Human Services in the public health area to deal with the health and wellbeing and public health of the community. This has been very good work; it has been very constructive work, and I expect that to continue, and I want it to continue.

Ms GRALEY — Minister, can I take you back to slide 9? I am particularly interested in health service innovation and reform. You have spoken briefly about HARP, and I am wondering if you can tell us more about the progress in some of the key innovations you mentioned, in particular Nurse on Call which is of keen interest in my electorate and how the 2007-08 budget intends to build on these initiatives.

Ms PIKE — Certainly, and thank you very much. As I said, there have been around 40 separate innovations projects that we have undertaken over the last few years. Those projects have been very successful in helping us to manage that huge and growing demand — 360 000 additional patients to be admitted into our hospitals this year compared to 1999 — a huge growth in emergency demand.

HARP has been one program that has had additional funding and has been rolled out over the last few years. It has in fact been independently evaluated. I sold myself short before when I said that the evaluation said there were 30 per cent fewer emergency department attendances; in fact it is 35 per cent fewer emergency department attendances for people who are in that particular cohort group; 52 per cent fewer emergency admissions and 41 per cent fewer days in hospital.

When you think about the volume of people that this represents, and if you actually put that back into the system — in other words, if HARP had never happened and was not being mainstreamed and rolled out within our service system — you would see a very different picture in our indicators. The reduced need for hospital services has been equivalent to one emergency department attendance, two emergency apartment admissions and six days spent in hospital for every single HARP participant. As I said, it is now embedded in the chronic disease management programs of our health system and we are now seeing that spread across 22 health services and we have invested $55.6 million in HARP and chronic disease management. That is the overall, with growth being included in that. So it does provide very integrated and effective chronic disease management for the target population.

I gave the illustration previously of someone with a respiratory illness. Cardiac care is something that also has benefited enormously through HARP. For example, the COACH program — a HARP program funded out of the St Vincent's Hospital, a simple day-to-day contact with people with chronic heart disease, giving them health advice, prompting them around the taking of medication, the engagement in moderate exercise, all of those things — has borne huge fruit and been a very successful program.

You mentioned Nurse-on-Call. Nurse-on-Call has just been enthusiastically embraced by the Victorian community, and there has been a much more rapid uptake in fact than any of us could have imagined. From June to December 235 600 calls were answered; from June to the end of March, 330 000. So it is just going up and up, and we expect the volume to settle, but the average number of calls per week in December, for example, was 8430.

Just to give you a bit of a breakdown of those calls, 71 per cent of calls were people really wanting triage information; in other words, 'What should I do next?'. You know that this is a very conservative health assist line. It is there to really give people information. Nine per cent of total calls answered were providing health education and 7 per cent were just other general kinds of information.

Now, many emergency departments had telephone access available to them. A lot of that is being diverted to Nurse-on-Call for general health advice, so that is really taking pressure off the staff in our emergency departments. Nurse-on-Call is very popular. It is a very clinically safe system; McKesson, who runs it, has had millions and millions of calls internationally, and as I said it has been very warmly received by the Victorian public.

Mr WELLS — Minister, where in Melbourne is it actually based?

Ms PIKE — The Nurse-on-Call centre is based in Richmond; it is still there, isn't it?

Dr BROOK — Yes.

Ms PIKE — It is based in Richmond in the Victoria Gardens complex.

Mr WELLS — Why is it not funded past 2007-08?

Ms PIKE — We anticipate full funding for all of our services beyond that, but the contractual arrangements are in place, so Dr Brook can add further information to that.

Dr BROOK — The contract in fact is a three-year contract and I am not sure which bit of the budget papers you are referring to — —

Mr WELLS — I am just looking at it on page 284, table A.5, budget paper 3.

Dr BROOK — I think that refers to additional funding of $1.5 million which is in fact the current funding that appears for the first time in this year's budget, so it builds on the basis of re-allocated funds and new funds which were allocated last year to pay for that service. This is an additional amount which will continue

Ms PIKE — For the demand.

Mr DALLA-RIVA — Minister, I refer you to budget paper 3, and in particularly to the same page we were just talking about, page 284 . At the top of the page is 'HIV and sexually transmitted infection prevention'. I noticed in Dr Brook's explanation that would be an additional $2 million for prevention funding. I note on page 288 in relation to that particular line item that the funding is provided to implement a range of initiatives to enhance HIV and STI prevention if it is in response to increasing rates of infection.

I refer back again to BP3, page 86, in relation to public health. Minister, I note that in the preamble in performance measures it talks about health protection, and that being to protect the health of Victorians through a range of prevention programs which I just indicated, including regulation, surveillance and the provision of statutory services.

Given that a huge of amount of money is spent, and if we look at the total output cost of $245.2 million in the next financial year, why would it be that your department would go to great lengths, and who made that decision in your department to block access by Victoria Police to files related to the alleged intentional spreading of HIV? Given there is so much effort on it in the budget papers, why would you go to the effort of having lawyers from your department, and who instructed those lawyers to stop access by the Victoria Police?

The CHAIR — I am not sure that question actually relates to the outputs.

Mr DALLA-RIVA — It relates very much to the outputs.

Mr BARBER — The output is less HIV.

Mr DALLA-RIVA — You have got performance measures which give you equivalent, not related but similar, infectious disease outbreaks responded to within 24 hours of 100 per cent. Some could quite easily argue that in fact the response time for the issue relating to the alleged intentional spreading of HIV was not 100 per cent, and what I am trying to work out is in relation to the amount of money — $245 million or one-quarter of a billion of Victorian taxpayers money — where you are saying through your outputs that you want to protect the health of Victorians, why would it be that you would end up engaging your lawyers to block access to Victoria Police who are actually trying to assist the department in protecting the health of Victorians?

Ms PIKE — I need to indicate that the amount of money in that output group covers a very broad range of responsibilities, including, for example, the new rollout of Gardasil, and including all the infant immunisation areas et cetera.

Mr DALLA-RIVA — I understand that, but I specifically asked about the $2 million for HIV — —

Ms PIKE — The $2 million — —

Mr DALLA-RIVA — Which I have noted.

Ms PIKE — Additional funding provided for in the budget — the actual allocation of that will be announced by the new group that we have established of people who represent leadership in this broad area.

Mr DALLA-RIVA — But it sends a mixed message. You have allocated money, Minister, yet on the other side of the ledger you have got — —

Ms PIKE — I made — —

Mr DALLA-RIVA — We have got your department stopping Victoria Police accessing files which in turn prevents the protection of Victorians. It just — —

The CHAIR — The minister — —

Ms PIKE — I am happy to answer that question.

Mr DALLA-RIVA — We are going on to other initiatives which I did not talk about. I have spoken specifically about HIV.

The CHAIR — That is fine.

Ms PIKE — Certainly. I explained very clearly that there are well-established protocols between the police, which we are seeking to strengthen, and the Department of Human Services. When the police believe that they want to access a particular file of a particular client because of a particular aspect of criminality, then, of course, they seek a warrant to obtain those files because patients files — as they are right across every aspect of health care — are governed by particular confidentialities. Now in this case additional files were taken and additional notes were amongst those files. So we have no problem with working with the police on following through with a warrant within the agreed protocols. In this case there was additional material taken and the department made a determination to seek the material that fell outside of the warrant to be returned.

Mr DALLA-RIVA — Do you not think the protection of Victorians is more important than one or two individuals?

Ms PIKE — No, I think doing what is in the law and doing what — —

Mr DALLA-RIVA — Then do not get your lawyers to block — —

Ms PIKE — Excuse me; I am speaking.

The CHAIR — Let the minister answer.

Ms PIKE — I think doing what is in the law and fulfilling different statutory obligations is more important. I do not really seek myself, as a minister, to be judge and jury on this kind of situation, and I would be surprised if any member of this committee sought to be judge and jury or to have greater knowledge than the police or our legal system — —

Mr DALLA-RIVA — So I gather you did not want to make that decision. You made the decision then to bring in the lawyers, I gather, because that was my initial question.

Ms PIKE — The decision was made by the department, and I am happy for Dr Brook to give further information, but these matters are before the courts and I do think that it is highly inappropriate for anybody to actually make a judgement. They are allegations at this point. As I said quite clearly, the warrant related to a file of

a particular individual. There were other files that were transferred from the department to the police, and the department made that decision — as is the normal practice — to have the notes that were associated with some of those files returned, because they identified other people who were not related to the particular file that the police were seeking by way of the warrant.

The CHAIR — Thank you, Minister. I might continue on in terms of acute health services, which is on pages 71 to 73 of budget paper 3. I am particularly interested in services in my local area, and indeed all around Victoria, in terms of renal dialysis services. Would you like to tell us what is in the budget in terms of renal dialysis services?

Ms PIKE — Thank you very much. There are, of course, many more aspects to the health care system than just what happens within hospitals. People within the community are requiring renal dialysis, and there has been a great growth in demand for dialysis services. So throughout 2006 and 2007 we have actually been reviewing the way our renal dialysis services are provided, and we are now rolling out significantly improved and grown renal dialysis services.

Obviously this is happening in lots of different places: Moorabbin Hospital has seen an expansion of 12 to 15 chairs; the Peter James Centre, in your area, 12 to 20 chairs; Rosebud Hospital, 3 to 9 chairs; Mildura hospital, 6 to 9 chairs; the Royal Melbourne Hospital, 5 new chairs; and of course the Craigieburn and Melton super-clinic, will have 6 new chairs respectively. In addition we are building another unit at Maroondah and another unit at Box Hill, and that will be an extra 28 chairs.

We also, of course, want to give people the opportunity to dialyse in their own homes. We have got home-based care — people can have haemodialysis services overnight, and a number of people, with support and a nurse coming in to visit them et cetera, can do that as well. In fact, home dialysis really is the optimal treatment. Not everyone can do it — not everyone's condition allows it — but it is the optimal treatment.

We now see in this budget more funding to expand services. Bendigo Health Care Group will become a regional node; eastern and western health will also become hub providers to support outplaced dialysis facilities and outplaced nocturnal haemodialysis. We believe that by having centres of excellence and then having them provide support, in a hub-and-spoke kind of model, that we will be able to even further improve the system.

We have a maintenance dialysis advisory committee that we have established within the department, and those people offer expert advice to us about how we roll out the additional funding that we are providing. We will continue to implement a number of additional initiatives for home dialysis and expanded services.

Mr WELLS — Minister, in relation to the regulation for the provision of statutory services quoted in the budget paper as the public health branch's primary role — BP3, page 86 — when did your office or the Department of Human Services inform the Premier's office, the Attorney-General's office and the minister for police that the police had raided the DHS, and when were those three offices contacted and made aware that lawyers were being briefed on behalf of the DHS to block access to the files from Victoria Police? Maybe your secretary or Dr Brook could answer that.

The CHAIR — Minister, you are free to answer these things, but really we are meant to be talking about the budget — —

Mr WELLS — We are trying to get to the bottom of this because it is a matter of accountability.

Ms PIKE — I do actually fail to see how it relates to the budget papers, Chair.

The CHAIR — You might want to rephrase it and see if you can relate more specifically to the estimates, otherwise I will have to rule it out of order.

Mr WELLS — The issue is very clear — that we put aside a certain amount of money for the HIV, and we want to ensure that that money is being well spent. We want to ensure that we are getting results for the money that is being spent. so I think it is a very straightforward question. We want to know when were the Premier's office, the Attorney-General and the minister for police's office contacted when the police had raided the DHS, and when did those three offices become aware that the DHS was briefing lawyers to block the files being handed over?

Ms PIKE — Just by way of introduction, the whole output group relates to the broad functions of the public health branch, of which HIV and sexually transmitted diseases are a small component. The whole work of that particular area is around the provision of in-home care and support for people living with HIV and AIDS and preventive work within the community by way of community education. The area that you are speaking about relates to a very, very small group of people — we are talking about within the teams — who are monitored from time to time by the Department of Human Services because they are engaged in risky behaviours.

Mr WELLS — I understand all that, but when was the Premier's office contacted?

The CHAIR — I do not think that is — —

Ms PIKE — Dr Brook is happy to give a bit more information.

The CHAIR — Sure, but you need to relate it to the estimates and the — —

Mr WELLS — I think it is the value for money regarding the HIV. There was $2 million that has been allocated.

Ms PIKE — No.

Mr WELLS — We just want to make sure in regard to that, that the money is being well and truly spent.

Ms PIKE — The $2 million that is additional funding — remember the $2.7 million last year all rolled out to community support and prevention programs.

Mr WELLS — Maybe Dr Brook could answer the question.

Ms PIKE — The $2 million that you are referring to in the budget papers this time does not relate to the area of monitoring of the handful of risky HIV cases; it relates to broader prevention and support programs. Nevertheless, I am sure Dr Brook can — —

The CHAIR — Dr Brook, if you wish to talk about the $2 million program — —

Dr BROOK — Thank you, there is no cost applied to the $2 million, nor to any of the other figures, which the minister has described. It is perhaps worth reinforcing a couple of points. The first is that we deal with courts and with warrants all the time across this large department. It happens in all sorts of areas — in child protection; occasionally in public health; in a range of areas. We have an internal legal unit, which provides advice on these matters. This was advice taken from that unit, and the cost of it was within the budget and indeed within the resources of that unit. Effectively the cost was miniscule.

There was no attempt to stop the police from keeping, or no attempt made to return, the files, even though they did not relate to the person whom the police were interested in. What was sought to be returned was case notes from partner notification officers, case notes which, from time to time, mention the names of third parties who are not people who are engaged in any kind of illicit activity but who have given information in confidence. Without that confidence they will not come forward, and we expect that there would be a decline in the presentation of such people. It was that which was to be — —

Mr WELLS — Can we assume that your department actually did not contact the Premier's office? Can we assume by the way you have danced around the question, the same as the minister, that you have not contacted the Premier's office in this regard?

Dr BROOK — I cannot make any categorical statement of that sort. This is internal business of the department. I cannot see any particular reason — —

Mr WELLS — It is a pretty straightforward question. Did you or did you not contact the Premier's office?

Dr BROOK — I did not.

The CHAIR — Deputy Chair, we are happy to talk about the protocols, happy to talk about the programs and happy to talk about the estimates in the budget.

Ms MUNT — Minister, could I refer you to budget paper 3, page 87, and in particular the heading 'Health advancement' that details a range of health promotion programs, in particular the program 'Workplaces and pubs and clubs complying with smoke-free environment laws'. As a re-educated smoker myself I am just wondering what progress is being made on tobacco reform in Victoria.

Ms PIKE — Thank you very much. In fact, it was just on Sunday that we released the advertisements that will be appearing in the print, radio and television media letting the community know that as of 1 July they will not be able to light up in a pub or a club. This really is one in a long road of initiatives that have been designed to decrease smoking prevalence here in Victoria. The latest figures — in fact they are not the latest figures — , the latest recorded figures are that 16.6 per cent of Victorian adults smoke. That is down from 20.7 just in 1999, so that is over a four-year period. Of course it has come down much further than that if you look further back. But what is most pleasing to me is that we now have the lowest take-up of young people, 12 to 15 years of age, smoking in the time that we have been recording this information.

We have rolled out bans on smoking in restaurants, bans on smoking in gaming venues, in workplaces — in enclosed workplaces — at under-age music dance events, in covered areas such as train stations, bus shelters et cetera. We have prohibited the display and sale of tobacco products at under-age events. We have strengthened the laws regarding sales to minors. We have prohibited buzz marketing, which is, you know, where people get dressed up in the livery of the particular packet that they are trying to promote; and non-branded tobacco advertising. And, as I said, from 1 July we will be banning smoking in pubs and clubs.

As part of the Australian Better Health Initiative, we have allocated $2.5 million over four years also to the cancer council to enhance the Quitline service and a further $1.87 million to support the development of a social marketing campaign. This is really important work because more than 4000 Victorians still die every year from tobacco-related illnesses. It still causes a lot of additional expenditure within our health system and is responsible for a lot of chronic illness, as well as death.

We have been very pleased at the way the Victorian public has responded to the changes in legislation around tobacco. Latest surveys show that around 80 per cent of Victorians are pleased with these initiatives and are supportive of the government rolling out these initiatives in our community.

I think that there has sometimes been some concern in the community that business might be affected et cetera. Every single international study has debunked that. In fact more recent research from the cancer council showed that in fact people would be more likely to attend a pub or a club if there were no smoking. So a proportion of people will come back into that form of entertainment who have not been coming before because they have been dissuaded by second-hand tobacco smoke. These are very, very important public health initiatives, and we of course are continuing to roll them out. The public health branch, which has been of such interest to members today is working on a next raft of reforms in the tobacco area so that we can bring that percentage of smokers down even further.

Mr BARBER — My question is also about the HIV prevention funding. Just by way of intro — and if any of these facts are incorrect, please correct them in your answer — there was $2.7 million extra last year for HIV prevention intended to be spent by 30 June 2008. The department has funded 10 projects costing 1.4 million, mostly around young people. You knocked back all the funding proposals that you received for gay men with HIV. The two major agencies in Victoria that put together those programs asked for feedback; they say they got no explanation as to why they were not funded. Last Tuesday 2 million more was announced for HIV, which is gratifying.

My question then is: what will that money be spent on, how quickly, and also why is there nothing in the forward estimates beyond 30 June 2008? Obviously it is not because we think we will have the problem solved by then, but from the point of view of organisations looking at funding, obviously they will not get funding after that time under these applications.

Ms PIKE — Thank you very much. The public health area already has $14.7 million in its base funding for this area, and that of course is ongoing. We also provide $10 million to Bayside Health for HIV/AIDS. The $2.7 million over two years, as you rightly described, will be rolled out, and this funding will support a range of work, including a project in clinics that have a high case load of people living with HIV/AIDS; a comprehensive multilevel gay community HIV/STI health promotion campaign; a safe-sex campaign aimed at young people; a

whole-of-school sexuality education project; a pilot project for the delivery of needle and syringes out of hours; and a Chlamydia testing program. That is funding that we have internally reallocated, so they are on top of the additional funding.

Then you have correctly identified $1.4 million of funding that has been rolled out to those groups that you identified, and you are right — they are mainly in the youth area, because we think that that is where primary education ought to be identified. We have $2 million of additional funding that is identified in this budget. We have recently established an additional task force within the department. We already, of course, have sexually transmitted illnesses and other groups and we have a gay and lesbian health overall group within the department, but we have set up an additional group within our department that will advise on the expenditure of that additional $2 million.

They particularly will advise on what is the most appropriate program targeted particularly at gay men. The Victorian Aids Council and People Living With HIV/AIDS are on the task force, and we will of course appreciate information from them. In fact it is not correct to say that they do not have feedback; they are on the task force, they are in constant contact with us and we will be working with them for the rollout of that, which of course is the major campaign. That will target the group who have been identified through all of the research. You will be aware of the national research that has been undertaken which identifies that it is men who have sex with men who are the group at highest risk of being infected, and therefore the targeting of that particular project has to be for them.

Mr BARBER — And post 2008? Just why don't you — —

Ms PIKE — We have found additional funding and we will continue to come to each budget process with additional resources. We think that, given the changing nature and the rise in HIV infection, we need to actually be very careful about how we target this money. We want to make sure that our strategies are working well. That is why not only have we engaged this task force, we have also engaged a national and an international expert to give us further advice on best practice.

The other thing is that I have had extensive communication and conversation with Tony Abbott, who is at one with me on the need to make sure that we have good and strong national guidelines around best practice in the area of preventing the spread of HIV/AIDS. So there is a lot happening, and we are shaping up our future responses as well as continuing to provide the services that are embedded in the budget.

Mr PAKULA — Minister, acute health services are reported in budget paper 3 on pages 71 to 74. In regard to cancer reform, I am interested in what have been the key achievements and how you see it progressing over the next financial year?

Ms PIKE — In fact we did identify in the 2002 election — when we came to government then — that cancer service development would be a very high priority of the government, and we are continuing to roll out those kinds of reforms.

We have now established integrated cancer services — three metropolitan and five regional around the state. Those integrated cancer services are really designed to make sure that, wherever you live, you have access to every aspect of your care — from, in a sense, your initial diagnosis, your initial contact with the primary health system, right through your journey through the acute health system if that is required, through your radiation, maybe chemotherapy, maybe long-term experience, integrated with social, family and community supports and then back to the primary system as a way of maintaining the kind of care that you require. So the integrated cancer services are designed to serve particular population groupings, making sure that all the cancer services are aligned to serve those population groupings effectively.

The other part of the strategy has been the establishment of local collaborating tumour groups. Basically what we have done is we have pulled together the people who have specialties in all the different tumours — from breast cancer and lung cancer to other kinds of tumours — and those are also multidisciplinary groups. So not only can we ensure continuity of care but we can also ensure standardised care.

If you happen to have a brain tumour or breast cancer, you can be assured that the quality of the service that you receive will be the same, wherever you live, because it has been informed by best practice around the particular care in that particular discipline. Those multidisciplinary clinical groups are also together.

We have also developed a quality framework in clinical excellence in cancer care. As I said, $9.1 million will be allocated to the ICS, as we call them — the integrated cancer services — in 2007–08. That will support their governance, their accountability and the further rollout of that multidisciplinary framework.

On top of that, you know that Victoria leads many parts of the world in our research efforts in cancer. We are establishing the Victorian cancer agency, which is an independent body to coordinate and promote the rapid translation of cancer research into improved clinical care, because what the researchers tell us and what the clinicians tell us is that actually getting things from the bench to the bedside — the translational aspects of work in this area — still require a lot of resource and coordination. We want to facilitate that for Victoria. We also want to facilitate the commercialisation of our research efforts, so that when people do work that has international applicability it can be rolled out effectively.

We also have provided extensive capital funding in cancer care, so that now if you live in Traralgon, Geelong, Bendigo, Ballarat or the suburbs in Moorabbin, you can have access to radiotherapy treatment, to high-quality cancer care, because we believe that it is best to move services, where we can, close to where people live. Certainly this budget builds on our ongoing work.

I also want to take the opportunity to commend the cancer task force that Professor Richard Smallwood, who was the previous commonwealth chief health officer, led. They have really helped us in the research effort, the clinical effort and also, of course, in our initiatives to roll out data management and IT solutions.

I will conclude with the fact that our work in giving people access to diagnostic services and treatment services right around the state will certainly continue.

Dr SYKES — My question relates to country health services — which probably comes as an absolute surprise to you. There are two parts, if I may. One relates to bush nursing hospitals and the second relates to the Victorian patient transport assistance scheme. In relation to bush nursing hospitals, page 84 of budget paper 3 indicates that the support for bush nursing hospitals goes $1.7 million, $1.7 million, $1.8 million, $1.8 million over the four-year period. Is that additional money or is that a continuation of that level of funding that has been in existence through the last budget period?

Ms PIKE — Regarding bush nursing hospitals, bush nursing hospitals are private or community hospitals that are not under the jurisdiction of the state government. They are licensed by the commonwealth and they provide services within their local communities. Nevertheless, even though we do not have jurisdiction over those hospitals, we know that they are very important, particularly in small local communities. So over the last period of government we have provided funding in a program for bush nursing hospitals. Bush nursing hospitals could apply for that funding and they could get upgrades to their facilities, those sorts of things, and that was very well received.

The money that you are referring to is new money. We are continuing with this program. In this budget we announced $7.1 million of extra funding for bush nursing hospitals and small rural health services, so that they can continue with the kind of minor upgrades and things like that that are quite difficult for very small facilities. We know bush nursing hospitals are really important, and that is why we have decided that we will continue to fund them even though actually we do not have any jurisdictional responsibility for them.

Dr SYKES — If I could clarify, I agree with you that you may not have a jurisdictional responsibility, but bush nursing hospitals, as you said, were set up by communities to meet a need.

Ms PIKE — That is right.

Dr SYKES — And in fact unless they get funded, the community that has shown initiative is being penalised for helping itself in delivering health services. Can I just clarify, the 7.1 million over four years — I have an email from a person involved in bush nursing hospitals that talks about 7 million over four years, which was in the previous budget, so are we talking — —

Ms PIKE — This is additional.

Dr SYKES — So there is now $14 million coming in over the — —

Ms PIKE — This is new. The 7.1 has been expended — the capital. This is not recurrent money. These are private hospitals where people use their private health insurance.

Dr SYKES — So the total allocation to bush nursing hospitals in the next four years will be around about $7 million?

Ms PIKE — That is capital.

Dr SYKES — Capital. Is that the total money going in — —

Ms PIKE — Yes. We do not provide recurrent funding. They are funded by the commonwealth or private health insurance.

Dr SYKES — Fine. I will just read to you a comment made to me by the person involved with the bush nursing hospitals, who is keen that you remember bush nursing hospitals in this budget, and says:

> … up until now DHS had a grants program running over four years for —

bush nursing hospitals. The total pool was about $7 million over four years — —

Ms PIKE — That is right.

Dr SYKES — That coincides with what you are saying. The email goes on:

> … about what is budgeted for in bike paths in Melbourne per annum, as I understand.

Mr BARBER — Is it that small?

Dr SYKES — That is bush nursing hospitals. I guess I express on behalf of the communities, particularly in Euroa and Nagambie, our disappointment at the level of funding. Can we move to — —

Ms PIKE — Can I just make a comment there? The Bracks government has actually funded these hospitals with capital grants. It is a new thing. Many bush nursing hospitals in the past either closed down or were amalgamated with public sector hospitals because they were not given any support. So I am very proud that our government has chosen to provide a capital grants program to a part of the health sector that we do not actually have jurisdiction over. I am pleased to and want to support them, but I think it is a bit disingenuous to try to make a disparaging comment about the government that has actually funded them. I think the disparaging comment should really go to the government that did not fund them.

Dr SYKES — I am passing on to you, Minister, a comment made to me by a person intimately involved in bush nursing hospitals.

If we could move from that to the Victorian patient transport assistance scheme, my understanding of this scheme, which helps patients who have to travel some distance to receive health treatment, is that the per kilometre rate of assistance is 14 cents per kilometre, and that was set a number of years ago, certainly a long time before the massive hike in fuel prices. I have had the need to raise concerns on behalf of constituents on several occasions about the inadequacy of that in relation to the costs they incur in travelling to health services. Has anything been done in the budget you have handed down to address that inadequacy of cost reimbursement?

Ms PIKE — There is an additional $1 million in the budget this year for the transport assistance scheme. We reimburse about $5.8 million a year for Vic/Tas travel and accommodation claims. There are 28 000 claimants. Just to let you know, the expenditure has increased by 50 per cent since 2001–02. There is a huge demand for this reimbursement by a huge and growing number of people. We are certainly adding extra funding to that, and we are proposing to increase the rate this year.

The original scheme in fact was commonwealth scheme. The commonwealth funded this transport, and of course, as it has done in dental care, it pulled out. So the state government has picked up the responsibility, and we have a significant allocation to it. We are increasing that allocation and we are looking at the rate as well. So we have a strong — —

Dr SYKES — Are you able to indicate what the new rate will be?

Ms PIKE — No. We are doing that work at the moment.

Mr SCOTT — My question refers to budget paper 3 at page 285 and the reference to bowel cancer screening. Minister, what is the government doing to manage demand for colonoscopy services as a result of the National Bowel Cancer Screening Program?

Ms PIKE — Thank you very much. The National Bowel Cancer Screening Program is an initiative of the commonwealth. Phase 1 of the program runs until June 2008 and involves the screening of a particular cohort of people turning 55 and 65 between May 2006 and June 2008. The part of the program that the commonwealth is funding is the sending of kits and information to eligible participants, and the Australian government will make a payment of $6.60 to health services upon notification of eligible procedures to the register in a prescribed form. No other funding is being provided.

The commonwealth has made a decision that it will roll out bowel cancer screening to people right across the Australian community eventually. We would have thought that this would have been a very good opportunity for there to be a partnership between the commonwealth and the states about the rollout of that program. Instead, they have rolled out the program, and now we have to provide the additional resources to absorb these people who will get a message in the mail saying, 'The sample that you sent has come back positive'.

The reality is that there will be a very high number of false positives, but nevertheless these people will need to come into the state-funded system for a colonoscopy. So $3 million has been allocated in this budget to meet the demands of that program for the additional people who will be coming into our system, but obviously it is quite a concern that you have the commonwealth making the decision to roll out this program and giving us a half-baked solution to it — no adjustment within the Australian health care agreement, no additional funding to actually test these people once they have sent their sample off in the mail to the agency that will actually test the samples. But we have provided additional funding, and we will work with the Cancer Council as well, and the general practitioners' division, to actually help them to support their individual clients who will, obviously, be quite confused when they receive these letters and are not quite sure what to do as well.

The CHAIR — Minister, perhaps there will be some further support in the federal budget tonight.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the computer-aided dispatch system for Rural Ambulance Victoria. Over the last three years there has been funding provided totalling $14.6 million. Last year you stated that the system would not be delivered by the end of 2006.

Can you please tell the committee when the system will be operational and how those funds of 14.6 million have been acquitted, and in relation to the line item in the budget 'Rural Ambulance response times', which was part of an election commitment, can you indicate how that relates to the computer-aided dispatch system and whether the fact that it has not been fully funded in the budget versus the promise will impact upon the delivery of that system?

Ms PIKE — I will answer the issue about the computer-aided dispatch system first, and I will seek a bit more clarification, I think, on the second part of your question. Last year I indicated that the rollout of the computer-aided dispatch system was contingent on the upgrading of the overall architecture of the telephone emergency service and that Rural Ambulance Victoria had in fact just signed a contract with Telstra. That provided the architecture for them to build upon — and that was the upgrading of the mobile radio communications. That was the $11.8 million.

RAV has actually commenced a pilot program in the Bendigo operations centre in November 2006 to test the functionality of the interim CAD (computed-aided dispatch) system. It is our intention to progressively roll out the CAD system over this year and as I have said we have contracted with Telstra to provide RAV with what is called mission-critical voice and data communications through the state mobile radio network. The transition — we have to move from the old to the new system — is being piloted for 12 weeks at a time, at which time then Telstra will make ready the remainder of the system across the new network. So the full program we expect to be completed by March 2008.

Mr RICH-PHILLIPS — The other part of the question related to the funding in this budget — page 262, if you want the reference, BP 3 'Rural ambulance response times'. Does that funding there relate to provision of the CAD system?

Ms PIKE — No. The funding relates to the upgrading of services which are to assist in response times. If you remember in my introduction I talked about the new ambulance services in Torquay, Ocean Grove, Lorne,

Bright, Romsey, Mooroopna — no, these are the ones that are being developed — Ballan, Paynesville and Irymple; and this year there are a range of additional services that are being funded. Some of the funding goes to making services 24 hour, which gives greater coverage, and some of the funding goes to additional capital or new services. That is what is in the budget this year — growth in paramedics, basically. The more paramedics, the more vehicles, the more stations you have the more you can meet response times.

The CHAIR — There is also a footnote there in (d), Mr Rich-Phillips.

Ms GRALEY — Minister, I know from my experience of serving on a health board how important radiotherapy services are to improve quality health care for patients. I just wonder if you could explain to the committee how the government's spending on radiotherapy has benefited Victorian cancer patients particularly those in regional Victoria and how this will be maintained in 2007-08.

Ms PIKE — Thank you. There is a big agenda and particularly in radiotherapy. So we have certainly, as I have said, been improving and expanding cancer services, radiotherapy services. We have funded replacement machines at the Austin, the Alfred and the Peter Mac. We have doubled the size of Moorabbin's radiotherapy to four bunkers and provided an additional, a third, machine as well for this service. In regional Victoria if you go to Geelong, you will see the Andrew Love cancer centre under way, expanding the service to four bunkers, and we provided $11 million to funding in Gippsland, in Traralgon, and $2.4 million for a second linear accelerator in Bendigo.

There have also been expansions in Ballarat, Bendigo and Gippsland for single radiotherapy services. We will be providing additional funding in this budget for particularly the professional services, to meet those needs for training and professional support and redevelopment, and also some funding for staff, so relocation for radiation therapists, because the workforce is obviously a big issue.

We are also providing funding here in this budget for expanded Bendigo radiotherapy services, a replacement of the second linac at the Austin. On top of that I spoke about the huge hospital equipment grant that will be provided this year, and on a case-by-case basis services will be able to apply to the government for hospital equipment, and much of the cancer equipment is also funded through that means, so more will roll out in that program.

Mr DALLA-RIVA — Minister , I refer you to budget paper 3, page 262. If you have it there, you might see in particular the difference between Labor's financial costings for election promises and the funding approved in this year's budget and the forward estimates.

I make the first comment, that I think you have missed out on the gravy train there, because when you compare against all the other departments, clearly the financial statement costings for Labor in those areas — and I would ask you to have a look at those in your own time — as opposed to the funding approved appears pretty much on par, except when you go to heath, where Labor's financial costings were quite substantial, yet the funding approved was comparatively less.

Given that you made election pledges to treat extra emergency patients, to provide additional outpatient appointments and improve ambulance response times — and you see those four areas there under 'Health services' — there is an allocation, and I will give you one example where 'Meet growing demand — expand hospital and outpatient capacity' for example, in the first year, 07–08, funding approved was 58.5. But then you go to the next year, 111.5 and the funding approved was only 57; then in 09–10, 112, the funding approved in that year is only 58, and for 10–11 it is 112 million and only provided is in fact 60 million.

If you look at increased emergency capacity, you have the same issues where there is comparatively less amount of funding approved, and in terms of 'Ambulance response times' in both rural and local — Melbourne, that is — you will see that the funding is also less. My understanding is that there is a shortfall in the allocations of some $375 million to fund such health promises. I understand that a spokesperson for you, Minister, on 3 May in the *Herald Sun* claimed that these promises would be funded by 'growth funding' being added over the years. My first question , to be blunt, is: where is the growth funding in the budget papers that meets that shortfall?

The CHAIR — Minister, I also note that there is a footnote to this, namely (c), which I am sure you have seen — it is the first-year funding of a two-year program.

Ms PIKE — To be quite frank I am actually surprised that this question would be asked by people on this committee, because the way that health funding is being funded in this budget is the same that it has been funded not just under this government but under every previous government as well. I think there is a big misunderstanding of Labor's financial statement (LFS) 3 and the budget process by people who might suggest that the commitment has not been met, and I think you have been rather ill-advised, I would have to say — —

Mr DALLA-RIVA — But every other department, Minister — and that is why I referenced it in my preamble — every other department has the costings funding approved which matches like for like.

Ms PIKE — But there is something different about health that you do not quite understand.

Mr DALLA-RIVA — Like, you are unique?

Ms PIKE — You obviously do not understand it.

Mr DALLA-RIVA — I am trying to get some explanation. A personal attack is not answering the question.

The CHAIR — Fair enough. We have the question; let us have the answer, please.

Mr DALLA-RIVA — Let's get the answer. Don't tell me I don't understand it.

Ms PIKE — We commit to two years of compounding growth funding and, in fact, in some of the areas we go beyond what our commitment is. So the 2007 state budget has fully delivered on our 07–08 commitments, and the 2008 state budget will fully deliver on the 08–09 commitment. Why health funding is different from other areas of government expenditure is that we get more people coming in through the door every single year. We have growth funding and it is compounding funding.

This year we are providing funding for the 72 000 additional outpatient services. That then stays in the base, and the following year we get our funding for the 72 000 plus the additional 72 000; and the following year we get funding for the 72 000 in the base, the 72 000 we had the year before, and the additional 72 000 we have in the year to come from that.

Health funding is different. It has always been treated differently. It has always been treated this way in the budget process. We will fully fund all of the commitments in LFS 3 exactly in the same way as we fully funded all of the commitments in LFS 2. In LFS 3 as in LFS 2 we put a figure against HDM in the commitment. That is fully funded, and into the future we will be evaluating the demand growth and will probably do what we did last time, and put in even more because of the great increase in demand.

It is a misunderstanding of the way that the health budget is compiled. I am very happy for the members of the department who have been doing this work for years and years to further explain it to you, if that is what is required. But it is a very fundamental error, and I was quite surprised to see that someone would put out a press release with such a fundamental error in it, because it really just indicates a lack of understanding of how the health budget is put together.

The CHAIR — Do you want further clarification?

Ms PIKE — No, we don't need any further clarification.

The CHAIR — Thank you for that, Minister. I want to ask you about maternity services. I know I am taking Dr Sykes' thunder here, but some of my constituents have family in the bush. I want to know exactly what is happening and what is going to happen in the future in terms of supporting rural maternity services.

Ms PIKE — Thank you very much, Chair. Since we launched Future Directions for Victoria's Maternity Services in 2004, which was a major strategic framework for the delivery of maternity services, we have achieved a lot in really expanding the choices that are available to women.

As health minister I particularly want to make sure that we offer women a low intervention service if that is their choice. We need to reconfigure our services to do that so that women can have a known and named midwife who

can follow them throughout their pregnancy, their birthing experience and beyond the birth. The whole framework was geared around the provision of a range of choices for women.

The other dimension of maternity services is managing risk, and even though 60 per cent of births are risk free, the truth is we do need to have backup that is available should there be some kind of emergency. We are making sure when we deal with the provision of services that we are able to meet those twin objectives: on the one hand, choice — low intervention if that is what women require, and that is what I would want to educate and encourage women to have; and on the other hand, the services that are in place should an emergency arise.

There has been a huge — and unanticipated, I would have to say — increase in demand for maternity services. I know Peter Costello would like to own it; but I do not know whether that is the case or not. In fact, particularly in Melbourne's western suburbs we have responded by funding additional maternity case loads to those affected services. We have provided comprehensive pregnancy care and emergency training programs.

We have rolled out the Victorian maternity record, which is a single record that follows women everywhere through, and in 2005 we funded what is called PERS (perinatal emergency referral service) which is there as a 24-hour phone service to provide clinicians with advice around complex pregnancies or the support that they might possibly need.

We have provided extra funding to 25 rural maternity services to increase the continuity of midwifery care. As I said, we have made a number of changes to the way that those services follow through guidelines and provide care to women who are there, particularly much greater collaboration between GPs, obstetricians and midwives. This budget will see further rollout of that funding to maternity services so that we can make sure that women continue to have the kind of choice that they need. On top of that there is the additional funding for the GP obstetrician training and the training for specialists that is part of the workforce package as well.

The CHAIR — Thank you, Minister.

Mr WELLS — Thank you. Minister, I refer you to budget paper 3 page 72 regarding specialist outpatient clinics. I notice that you have commented a number of times about the 72 000 additional appointments as highlighted on page 6 of the budget overview, and I want you to compare the 72 000 additional appointments with your election promise, which reads 'Policy for the 2006 Victorian election — when it matters' and to:

> Speed up access to an initial consultation with a specialist by funding an additional 200 000 outpatient appointments.

I also refer you to the figures provided in 2005-06, weighted or unweighted, with new targets for 07-08 that add 8000 unweighted or 13 000 weighted for additional specialist outpatient appointments. I wonder if you can reconcile the two figures for me — the election promise and the 72 000 additional appointments that you are focusing on.

Ms PIKE — I think I explained that in the previous answer. It is 200 000 additional appointments over four years, 72 000 in the first year — 72 plus 72 — these are compounding figures over four years, and they will be fully funded. We will be able to easily meet our election commitment, and in fact we will probably go further as the growth increases.

I have just been reminded that the 200 000, as I said, is over four years. As the four years progress, the super-clinics will continue to come on line and then ramp up to increase volume. Therefore over the period the full 200 000 will be easily met.

Mr WELLS — You tell me that it is fully funded in the last two years — —

Mr DALLA-RIVA — No, it is not fully funded — —

Ms PIKE — I will ask Lance Wallace to explain it a bit further.

Mr WELLS — It's just that we have an amount and then we have funding approved, so could you just — —

Mr WALLACE — The LFS 3 commitment that the government made explicitly did not include as much for outpatients in the first year; it included a larger amount in the second year. If you are looking at the increase in

the number of outpatients in the 2007–08 year and you are trying to indicate over four years whether that will meet the target, it will not because the LFS3 statement explicitly — if you look at the statement — shows a lower growth in outpatients in the first year and a higher growth in outpatients in the second year. So the budget is on track. The funding will be delivered provided that the LFS3 commitment for the following financial year is met, and it would be normal budget process for that to be considered in that year.

As the minister indicated, one of the reasons that the number was lower in the first year is that the number does not include additional outpatients who are being treated through the newly opened super-clinics. So the super-clinic outpatients are in addition to and on top of that particular commitment, and because they were coming on-stream — two new super-clinics were coming on-stream in February — there is already an extra capacity coming through those super-clinics.

Mr WELLS — Thanks.

Ms MUNT — Minister, could you please explain what the Victorian government is doing to make our blood supplies safer?

Ms PIKE — We are rolling out a number of initiatives, and I am very happy to talk about those. Our blood supply in Victoria is managed by the National Blood Authority (NBA), and we are signatories to agreements with the commonwealth and other states and territories to ensure the security of our blood supply.

That authority has the responsibility to provide adequate, safe, secure and affordable supplies of blood right around Australia — not just blood, but blood-related products and services — and to make sure it is managed in the most-effective way. The Red Cross has a deed of agreement to actually collect, as we know, and process and distribute blood and blood products. We have a very important system, and we are represented and we are fully compliant with all of our obligations under that system.

We have agreed to meet our share of the national costs and are also moving to 100 per cent pre-release bacterial testing of platelets. This has been an issue that has needed to be resolved, and we have certainly done that. Although it is not required under the code of good manufacturing practice, which is audited by the TGA (Therapeutic Goods Administration), 100 per cent pre-release of testing of platelets is regarded as best practice, and that is why we are doing that. We are also making sure that we are working with the Red Cross and the NBA to roll this out effectively by April 2008.

The other dimension that would be worth talking about is our submission to the national process around the fair trade agreement. People will recall that under the agreement with the United States there had been some evaluation of the competitive environment around the supply of blood products. Victoria was very concerned that if CSL was no longer the sole provider of blood products here in Australia, we could have no guarantee of the future quality of blood products and, in fact, the potential altruistic dimension of the blood collection service would be seriously undermined.

We are very pleased that the commonwealth has accepted Victoria's position and recently announced that it would not be subject to the fair trade provisions, as other areas are, which is good news for Victoria, because it protects jobs and a very important business, industry and research sector here in Victoria and also protects the character of our blood provision and area and also the altruistic dimension of that. Dr Brook may have further to add.

Dr BROOK — The only other thing that perhaps needs to be added is the question of leucodepletion of blood. Leucodepletion means removal of the white cells from the blood before the blood is transfused into a patient. That has been agreed nationally to be achieved over a period of years, a few years, three years to 100 per cent levels. This year we will be meeting 45 per cent of all transfusions by leucodepletion. Again, while there is often a difference of opinion about what is the right level, we are going to make sure that we move to 100 per cent leucodepletion of red cells, which will mean that in the future people will have less reactions to blood than is the case today and lesser risk of acquiring infection of any sort through the transmission of a biological product from one person to another, which must also always carry some risk.

The CHAIR — I am sure you would have been very interested in that one, Dr Sykes.

Dr SYKES — To continue with my theme of country health services, Minister, I am interested in particular in the issue of time to appropriate treatment. There are two parts to the question: one relates to rescue

ambulance services and the second relates to obstetrics. In relation to the rescue ambulance service the question is: what is holding back the provision of a rescue ambulance helicopter for south-west Victoria in order to put it on the same footing as the rescue ambulance helicopters which are available elsewhere in the state, particularly Gippsland and Bendigo?

The CHAIR — And your second question?

Dr SYKES — The second question relates to obstetrics.

Ms PIKE — Maybe I will take the first question.

Dr SYKES — I am happy with that.

Ms PIKE — Are you happy with that, Chair?

The CHAIR — That's fine.

Ms PIKE — The government has shown in many, many ways that we are happy to provide and have provided additional emergency services right across the state. We want to do that in the most efficient and effective way. We can only support proposals that are financially, technically and operationally viable over both the short and the long term. There is always a lot of debate about air services and road services, but we are advised from Rural Ambulance Victoria that they do not support a helicopter based in Warrnambool. It does not meet the service efficiency, technical or operational issues that are benchmarks by them for best performance.

The region is effectively serviced by the police helicopter, the air ambulance fixed-wing aircraft and road ambulance. It is not always the best solution to put someone into a helicopter. It is actually quite a traumatic move. It can be the best solution, but it is not always the best solution. I am advised by people who manage the ambulance system that this is not their preferred option.

We are waiting on a business case from WestVic, the body that is putting this proposal together. If it wants to put a proposal together and it thinks that it has further statistics that are going to be helpful in this regard, I would be most happy to receive this. But all of the advice I have is that the CFA, DSE and the police are well served by existing resources in this area and that MAS, which covers the air ambulance and the fixed-wing ambulance, are quite comfortable with Essendon, Bendigo and Morwell and that they are able to cover the response times; and that this is the best option for that community. But we are open; if they want to put a proposal to us, of course we will be very happy to have a look at it.

The CHAIR — And the timing provision of obstetric services?

Dr SYKES — I should declare a vested interest in this. As a veterinarian, I do quite a large number of caesareans on cattle.

The CHAIR — Try to keep it brief — —

Dr SYKES — There is a relevance to it, because a critical thing is the time to intervention. Whilst the minister is correct in saying that about 60 per cent of births are risk-free, what she means is they proceed without a muck-up rather than being risk-free. The risk is always there. The issue is whether it occurs or not.

Ms PIKE — That is right.

Dr SYKES — You can identify high-risk cases sometimes ahead of the event; other times it comes completely from left field.

The CHAIR — Please come to the question.

Dr SYKES — I am coming to the question. I am very aware that at times it is minutes that separate a live birth from either a stillbirth or a birth of a child with long-term hypoxic problems or other problems. The question from a rural point of view, and understanding the balancing act of expertise amongst your obstetrical services, is: what is a reasonable time in your opinion for people to travel to obstetric services or specialists to travel?

Ms PIKE — I am not a clinician; there is no way I would answer a question like that.

Mr PAKULA — Minister, on page 286 of budget paper 3 there is an item headed 'Family choice program', which from reading it appears to be about children and young people with complex medical needs being helped to return home from hospital. Can you tell me how the budget addresses that particular issue?

Ms PIKE — Thank you very much. The Royal Children's Hospital in particular but Monash to a lesser extent run programs for children who have very complex health issues. Those children are currently in the hospitals. When those children are ready to come home they require a very expensive package of support around them, which involves the provision of equipment, the provision of nursing, the provision of a whole range of ongoing support.

Nevertheless, obviously families are very keen to get those children home, because the disruption to family life and the challenges if you have got a baby or a child who has been in hospital for a long time are quite difficult. The demand for this program is increasing dramatically. The reason it is increasing dramatically is, quite frankly, because doctors are just so much better at keeping people alive, and medical technology is advancing, so these kinds of severe conditions now have a much greater life expectancy than they ever did in the past. There are a lot more options now for families and for children. As I said, the program has really grown, so we are providing funding in this budget to help alleviate the waiting pressures.

For the hospital obviously it is a complex issue. We have already provided some funding — they capture it in their global budgets — but we believe it is a very important area, and it is effective to get the children home rather than have them in a hospital environment. The program currently supports 124 children with these very complex care needs. We certainly want to provide, and are providing, the existing funding, which then goes straight to the hospital so they can eliminate the waiting list and get these kids home as quickly as possible.

Mr BARBER — Community health centres and capital spending, Minister: there are about 100 of them in Victoria, often looking after people on low incomes, with very little capital investment in them in the life of your government. In 2004 DHS conducted a survey of the facilities, showing expanding service sector and often in unsuitable premises.

In the case of North Richmond that was a bunch of portable buildings from the time of Gough stuck together on a piece of land owned by the City of Yarra, which is my interest. You have now funded North Richmond and MonashLink but that is from last year. I cannot find anything in the budget for this year — correct me if I am wrong — but my main problem is that this is drip-feed funding instead of a capital program, the same way we have for schools, roads, whatever.

Ms PIKE — Thank you. In fact, there has been quite a substantial increase in capital funding to community health centres under this government, because we really do see that they are a critical part of our health system. We have spent $62 million, in fact, to expand and strengthen community health centres.

Just to give you a perspective on what has happened historically, we have now completed capital works for Banyule; for Doutta Galla; for Niddrie; for Wyndham; for Sunbury; as you said, for Richmond; for MonashLink; for Peninsula; and now in this particular budget, for Stawell, Murtoa and the Kensington site in Doutta Galla. All have planning under way.

Recognising that there is a huge demand in this area — and MonashLink, by the way, is three sites — we have seen fit to invest. This year the capital funding for health will take our contribution in capital funding for health to $4.1 billion in the life of this government. Just to put that in perspective, you will have seen on my slides — and I have got the figure here, which I will give you — that in terms of capital funding, $4.1 billion and this year $554 million, which is a huge capital effort. Over the life of the previous government — and I will stand to be corrected — it was around about $800 million in total in the previous government's seven years, compared with $4.1 billion in this last seven years.

We have really seen an absolute transformation of the capital within our health system. I absolutely concur that there is more that needs to be done. I have a particular interest in and passion for community health centres, and, as I said, we have had a program of upgrading or completely rebuilding — with some of these we are talking about complete rebuilds. North Richmond community health centre, let me say, was a $20 million redevelopment of a very important service to a very vulnerable group of people, and I am very pleased that it has happened under our watch — and there will be more.

Mr BARBER — After the roof fell in.

The CHAIR — Thank you, Minister. I am equally passionate about community health services as well.

Mr SCOTT — I want to ask what the government has done to extend water fluoridisation, making a reference to budget paper 3, page 86.

Ms PIKE — I think everybody knows that the evidence is enormous when it comes to the benefits of fluoride in the water system. Research shows that people in fluoridated areas experience 36 per cent less tooth decay than people in non-fluoridated areas. We believe that this is a very important initiative, and we have been rolling out fluoridation over the last four years in the towns of Horsham, Moe, Morwell, Warragul, Sale, Traralgon and Robinvale. Wangaratta and Wodonga will have fluoridated water by 2007, and this budget commits another $1.5 million to keep expanding this program.

This has to be done in partnership with the water suppliers. Some have to make major adjustments and some have to make minor adjustments to their machinery — their capital — to actually be able to provide this in the water system. The other thing that we have been doing is providing information to the community about the fluoridation process.

Certainly we have very strong support from dentists, from doctors, from the AMA, from the dental association of Victoria; we believe it is a very important program. It builds on the huge rollout of additional funding that we provided in 2004–05 to expand the public dental services in Victoria. There are a lot of challenges in dental care. I am very hopeful that we might see some movement for the first time since 1996 by the commonwealth government in the budget tonight, but in the meantime we have been investing, and it has been bearing fruit.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the commitment that was made during the election for an extra million dollars for safety measures around nurses arising from the Victorian task force on violence in nursing. I have not been able to find it in the budget, not to say it is not there; I am just wondering: has that million dollars been allocated consistent with the commitment last November, and if so, where is it?

Ms PIKE — It is part of the big hospital demand management program, and the breakdown is for nurse and patient safety, $1 million over 4 years in LFS, and I will need to take some advice about where it sits within our breakdown of the global budget.

Mr WALLACE — It is part of the 152 HDM.

Ms PIKE — It is part of the 152. That is what I thought it was. It was part of HDM.

Mr RICH-PHILLIPS — So the $4 million is within that aggregate figure?

Ms PIKE — No, it is one million over four years, isn't it?

Mr RICH-PHILLIPS — How is it allocated across the four years? Is it available this year or is it — —

Ms PIKE — It is part of the 152 of hospital futures, which of course is not broken down in the budget papers. That 152 covers all the varying dimensions of demand that I have been talking about — like dialysis, chemo, inpatient services et cetera.

We, as you know, did have the task force, and there is a work plan that will be funded in those resources. That will include a whole-of-workforce approach to addressing violence and bullying in the workplace, strengthening occupational health and safety infrastructure, and there will be a public communication campaign as part of that as well.

We certainly were happy to accept the final report of the task force into violence against nurses. There were 29 separate recommendations in that task force, and we are providing funding to begin the rollout of our response to those recommendations.

The CHAIR — Thank you, Minister. You might be able to provide a bit more detail on notice.

Ms PIKE — I am happy to provide more detail.

Ms GRALEY — What is the progress for the establishment of the Victorian paediatric rehabilitation service?

Ms PIKE — There had not been a paediatric rehabilitation service specifically in Victoria, so we want to make sure that that is available in a dedicated way so that it can help children in a very multidisciplinary way recover from serious injuries, from surgery and other impairments.

In 2006–07 we committed $3.25 million, which included $2 million of growth, and that was to fund and expand the service at the Royal Children's Hospital and provide a dedicated facility. We also provided funding to Southern Health for the first time, and we will also be providing now funding to Eastern Health, Bendigo Health Care Group as part of a regional hub. We are going to build on that with an additional $1.6 million in this budget to further meet expanded need, and we think that that will be able to provide an additional 1000 bed days. That will double what we have been able to provide in terms of bed days in 05–06. It is a very important service and we are very pleased that we have been able to roll it out as a new initiative over the last few years and build on it.

The CHAIR — Thank you, Minister. We have time for one more quick question.

Mr DALLA-RIVA — It must be the end of the day — the answers are getting shorter as well.

Ms PIKE — I just want to give you another go.

Mr DALLA-RIVA — I refer the minister to the government response to the PAEC report no. 70 for the previous year, and to page 19, the response to recommendation 30. You probably do not have that with you?

Ms PIKE — I do have the response, I'm just trying to find it.

Mr DALLA-RIVA — The government's or the department's response was to reject it.

Ms PIKE — What page was it on?

Mr DALLA-RIVA — Page 19 and page 205 was recommendation 30. I have a copy of it. I refer to page 19 of your response and the concern expressed by the government about the use of simple bed numbers as an indicator of health system performance. I note the government's response, and the action taken to date refers to three areas, which I will read out:

> account for same-day-only treatment and recovery facilities separately from traditional bed number measures;
>
> account for neonatal cot usage;
>
> clarify the counting rules to set out clearly how each of these is counted in terms of a 'bed' available for same-day surgery.

My question is: Minister, can you provide an explanation of these measures and status of this agreement that was reached; and in terms of an additional or supplementary question, where are these measures provided or are they allocated in the budget papers and, if not, why not?

Ms PIKE — I just need further clarification on the last part of your question, sorry.

Mr DALLA-RIVA — I guess the first part is: can the minister provide an explanation of these measures and the status of the agreement that had been reached, and if there are any of these measures — —

Ms PIKE — Agreement with who, I'm sorry?

Mr DALLA-RIVA — The Victorian government is leading a working party of the Statistical Information Management Committee (SIMC) and agreement has been reached.

Ms PIKE — That is part of the Australian health care agreement. This is about standardised data collection around bed usage et cetera as part of the Australian health care agreement, because we want to make sure that we have nationally consistent measures so you can actually compare apples with apples, if you like, around the usage of beds and the definition of beds. For example, Hospital in the Home is a fully funded acute service but was not picked up by the Australian Institute of Health and Welfare as a provision of a bed service, systematically across Australia. There has been a real need to actually provide better definition of 'bed utilisation and characterisation' than has been available in the past.

Mr DALLA-RIVA — Just to get clarification, I understand the explanation, there is an agreement in place and those — —

Ms PIKE — It is being developed.

Mr WALLACE — I think we would be best to provide you a written response.

Ms PIKE — It is a working party.

Mr DALLA-RIVA — With the recommendation, you have rejected it and agreed to action it to date.

Ms PIKE — That is right.

Mr DALLA-RIVA — I guess what the committee is trying to find out is: where is that and how is that applied?

Ms PIKE — We will provide you with a written response.

Mr DALLA-RIVA — Thank you, Minister.

The CHAIR — I would also like the minister to take on notice what resources, funding and staffing does your portfolio department expect to apply to servicing this committee, based on experience over the past few years?

That concludes consideration of the budget estimates for the portfolio of health. I thank the minister, witnesses and departmental officers for their attendance today. It has been a very comprehensive session. Where questions were taken on notice, the committee will follow up with you in writing at a later date. The committee requests a written response to those matters be provided within 30 days, and they will form part of a future report of this committee to Parliament.

Committee adjourned.

Transcript of Evidence

4.12 Housing portfolio

The transcript for the hearing on this portfolio will be included in a future report of the Committee.

Transcript of Evidence

4.13 Mental Health portfolio

The transcript for the hearing on this portfolio will be included in a future report of the Committee.