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

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2004–05 budget estimates

Melbourne–19 May 2004

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Witnesses

Ms B. Pike, Minister for Health;

Ms P. Faulkner, secretary;

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

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

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

The CHAIR — Welcome. All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript early next week.

I call on the minister to give a brief presentation on the more complex financial and performance information that relates to the budget estimates for the health portfolio. Minister, over to you for a 10-minute presentation. I have asked that you distribute hard copies of the overheads, which allows us to jot down notes. Thank you for doing that. We would appreciate it if you could stick to that 10-minute presentation.

Overheads shown.

Ms PIKE — Thank you very much, Chair, and good afternoon to members of the Public Accounts and Estimates Committee. I want to talk briefly about some of the context that the health portfolio finds itself in and then take the committee through some of the priorities and highlights of the budget.

Let us think about what the broader context is. Members of the committee will be aware that health systems worldwide are facing continuing demand pressures. This has to do with, of course, population growth, the ageing population, the rising expectations of consumers, and lastly, the availability of new technologies. The smarter we get, the more technological options for dealing with health are advanced, the more people want to utilise that technology. That is a very important demand pressure.

We also know that the incidence of people with chronic illness needing hospital care is rising. Now more than ever our hospitals are dealing with people in the latter years of their lives who are living for many years with a chronic illness such as diabetes. In fact 12 chronic conditions account for almost half of all the years lost to illness or premature death. So it is a narrowing group of people. These pressures accumulate, of course, year after year. They are not unique to Victoria.

We also have some particular pressures here in Victoria. The commonwealth continues to give us less hospital funding than it has in previous years. In this year's budget there was nothing for public dental care or mental health services. We also know that we are facing a lot of work force challenges, and the number of places for nurse training has not kept pace with demand and neither have the places for doctors. We also, of course, continue to have many frail aged people within our public hospitals when they really need a longer term care option. Our hospital emergency departments are also continuing to feel the impact of the declining bulk-billing and after-hours services of general practitioners.

The next slide is a chart that really illustrates the point about how the commonwealth funding has changed. You will see that back in 1999 we were much closer to the fifty-fifty funding arrangement that has as its basis the Medicare agreement. As time has gone on that gap has widened, and now for every $1 we put in to run hospitals the commonwealth puts in 68 cents. The real impact of the lesser amount of indexation in this latest AHCA agreement will be in fact $350 million less to Victoria than it would been had the current agreement continued with the level of indexation in the previous agreement.

More recently, the commonwealth has announced additional reductions to the WC 1 (workers compensation 1) indexation rate, which has an additional around $71 million penalty to the state. Of course on top of that we carry all the capital load in terms of our hospitals.

I spoke about the decline in bulk-billing and after-hours GP services, and of course we are picking up more responsibility for primary care. Many people who should be treated by a general practitioner are now finding their way into our emergency departments, where we have seen a growth of about 30 per cent since September 2000.

In terms of how we are dealing with these demands in the broader context as well as with the unique issues that face us here in Victoria, we have in this budget a combination of new state resources and strategies such as the hospital demand management strategy, which has been under way for some time now. Those strategies, and particularly the hospital demand management strategy, have already made a significant impact on our performance. The vertical green line on that graph illustrates the intervention of the hospital demand management strategy. We have seen that that has had a direct impact on the level of hospital bypass, and even though at the same time the volume of hospital admissions is increasing, we are managing that demand quite well. Similarly the first three years of the hospital demand management strategy have improved the outcomes for emergency department patients, and

more patients are being treated within emergency departments within ideal times. So, yes, we have had a huge increase in demand, but, yes, we are managing that demand very well, and those standards are being maintained.

Previous budgets gave additional resourcing to strengthen the hospital demand management strategy. Last year we had additional investment to treat a further 35 000 patients, to employ extra nurses and health staff, and of course to continue our very successful Hospital Admission Risk program. We also made a significant investment in health information technology.

This budget furthers those investments, and there are three main components: first of all, to complete the funding of our promises made in the Labor financial statement (LFS), which was part of our 2002 election platform; secondly, to continue to reform our services and to strengthen them through hospital sustainability and growth, to have some special initiatives around children's health, and to have a very major initiative in dental health; and finally, to continue our ongoing investment program.

In summary, we will now have a health services system of over $7 billion — an increase of 8.9 per cent since last year — which is a very major investment. In our asset program this year we have $335 million of additional capital funding, and if you add to that what is flowing through from the Royal Women's Hospital, that is $585 million.

This slide covers funding for hospital sustainability and growth — $1.6 million over four years — to help the hospitals cope with rising costs and to continue our hospital demand management strategy; there is a range of initiatives shown there.

In the children's health package you will see that $128.2 million over four years will really home in and target some particular hot spots in children's health, the major initiative being the outcome of the paediatric services casemix price review, which will see an additional $10 million go into the base of children's health funding every year.

The next slide relates to additional resourcing for dental health, and that is a major program that will help us to deal with some of those very long waiting lists that have grown since the commonwealth pulled out of dental health in the mid-1990s. The next slide shows additional funding for ambulance services, which well help us to deal with growing demand and also compensate the ambulance service for the loss of its public benevolent institution status.

We also continue to invest in counter-terrorism measures, and the Department of Human Services has its role to play in those initiatives.

The next slide relates to the recruitment of general practitioners into community health services. Next is our major asset investment program to invest in upgrades of many facilities to continue to make sure that our infrastructure is in good shape and also to build some new capacity. This slide has a list of some of those initiatives. The Alfred Centre is a major new purpose-built elective surgery centre to treat an additional 4000 short-stay elective patients. You can see there a very attractive photograph of the new Casey Hospital, which will be opening on time this year. You will also note that the cancer treatment centres in the Latrobe Valley and in Geelong are a couple of highlights of our capital investment program.

More initiatives are shown in the next slide, including a number of aged care initiatives, which are often co-located with the acute system, and so they are included in our overall department list. Finally you will see there is funding for additional paediatric intensive-care beds, for community health, for dental health and for our drug and alcohol program. That is a thumbnail sketch of the challenges we face and the ways in which the government is working hard by investing both in recurrent funding and resources and in capital to improve our infrastructure and to help us to treat the Victorian public more appropriately in the health area.

The CHAIR — Thank you very much, Minister, and thank you for your efforts in getting through that second half so quickly.

The first question goes to hospital viability, particularly in the metropolitan area. I note that at page 276 in budget paper 3 there is reference to the hospital sustainability and demand management strategy. Could you outline a little more expansively what the government has done to strengthen the financial position of hospitals in this particular budget?

Ms PIKE — Thank you. Of course, one of the biggest components of the budget this year was dedicated to the work that we are doing to strengthen and to ensure the long-term financial sustainability of our hospital system.

When I talked about the challenges, clearly rising health sector costs combined with the greater utilisation, the higher community expectations, the new treatment costs of technologies and of course the rising costs of pharmaceuticals and medical supplies have put a major pressure on our hospitals. so we began last year to work on our financial sustainability strategy to improve the financial performance of our metropolitan health services. That began in 2002–03. It was strengthened in 2003–04 by developing financial recovery strategies for services, particularly Eastern Melbourne, Southern, Western and the Royal Women's Hospital and the Children's Hospital.

We then did a major piece of work on strengthening governance within hospitals, making sure that we had the kind of structures in place that would lead to greater accountability and strengthening of financial work within the financial area. We introduced the central purchasing process through Health Purchasing Victoria, and we implemented our strategy to stipulate the limitations on the use of agency nurses. We have been maximising the commonwealth revenue that is available to us, and we have been improving the efficiency of health services through greater use of medical technology. Lastly, we have been working with the Department of Treasury and Finance on a price review, which has been a very comprehensive piece of work, to identify some of the areas in our system where price needed to be adjusted.

We have provided additional funding in this budget to strengthen the viability of hospitals, and we have added to that the additional and ongoing funding for the hospital demand management strategy. So this is the largest injection of additional funding into our public hospital system in the history of this state. Coupled with those other initiatives, because putting money in alone is not enough, but coupled with those management initiatives and change-in-practice initiatives we believe that we will be able to significantly strengthen the position of our hospitals, particularly our major and metropolitan hospitals, in the years going forward.

Mr FORWOOD — I would like to talk about one of those metropolitan hospitals, and that is the Angliss Hospital, and in particular issue of asbestos that was reported in the paper today. I refer in particular to Dr Lazzari's letter of 29 April to Tracey Batten and also to the Premier. Dr Lazzari says at the bottom of page 5 of that letter that he had been given information by Ian Brown, the engineer, of the asbestos remnants in the building, and he received a plan of the building. He goes on to say:

> The information Mr Brown gave me clearly showed there was a significant risk of asbestos exposure to a number of people in Chandler House.

I understand some audits have been done, and I wondered firstly, if you would make public the asbestos reports in relation to this matter held by Eastern Health; if you could advise the committee what steps you have taken to ensure that there is no risk to community, staff or patients at Chandler House; whether you can confirm the amount of more than $1 million dollars is to be spent on fixing this problem; and finally there is an issue of the treatment of Dr Lazzari. Apparently he has again been threatened with dismissal for speaking out about these matters. I think this is an issue of some concern; asbestos is obviously. I would be horrified if the government's approach to someone raising these issues would be to threaten them with being fired.

The CHAIR — Alleged.

Ms PIKE — Certainly the first part of the question relates to the area of responsibility of this committee. I am not entirely sure how the latter part of the question is relevant, but I am happy to talk about the issue of asbestos. It is well known that both in the private sector and in the public sector there are buildings with asbestos present right across our community. The main issue with asbestos is whether it is contained: whether it is secure, whether it complies with occupational health and safety standards and that it is not disturbed in any way. I have certainly been made aware through the media of the letter that Dr Lazzari has written, and I have asked the department for assurances from Eastern Health that it has in fact complied with all of the relevant safety requirements regarding the treatment of asbestos. The department has assured me that that is the case. I certainly take the matter of the presence of asbestos and its potential damage to the community very seriously, and the issues that Dr Lazzari raises are serious ones. I am assured that Eastern Health has followed through all of the processes that are required. Should additional funding be required to deal with asbestos-related issues, and we receive reports and information about that, then of course we would take the matter very seriously and we would do what needs to be done. I do not know whether Mr Solomon wants to add any further comments to that.

Mr SOLOMON — I spoke with the CEO of Eastern Health yesterday evening about the matter, and she assured me that the asbestos was stable and that they had in fact before Dr Lizzari's letter taken pre-emptive action to commission the audit.

Mr FORWOOD — Will you make the audit available?

Mr SOLOMON — I have not looked at that at this stage.

Ms PIKE — I will take notice on that and find out where Eastern Health are up to on that matter.

Mr FORWOOD — I would like some assurance, so if the report could be made available.

Ms ROMANES — How will rural and regional health services benefit from the government's hospital sustainability and demand management strategy?

Ms PIKE — As I explained in the answer to the first question, the additional $1.6 million is resourcing for our statewide hospital programs to ensure their long-term financial sustainability and to help them to meet the demand they face. We particularly know that there are rural and regional agencies that face some unique circumstances, and some of them are in areas that are growing, very quickly, particularly those that are on the rural-metropolitan interface; that those agencies are very diverse, they have size and configuration that is changing very rapidly and so we work with each of those individually, and they will share in the additional resourcing that is available. There are some other factors. I talked about the interface agencies, and there are additional costs that agencies face when they are in less populated areas, such as delivering to a large-scale geographical area, patient transport costs, the need to retain multiple campuses and the need to have a broader scope of services. Many of them also have particular capital problems that add to the complexity and difficulty and sometimes the cost of service delivery.

It is these kinds of matters that are really to be picked up on an individual basis with each of the health services. Dr Brook and his team will be working individually with each agency looking at their unique situation so that they can continue to meet the demands of their community.

Mr CLARK — My question relates to the numbers of hospital beds that are available in the state. So far as I am aware neither the budget papers nor the quarterly *Hospital Services Report*, nor anything else that I am aware of that is published by the state government, discloses the number of beds available in the state. The Australian Institute of Health and Welfare data shows there have been about 591 beds closed between 2000–01 and 2001–02. So far as I am aware that is the latest available data. Can you undertake to provide to the committee a breakdown by hospital of the number of hospital beds available as at 30 June 2003 and the numbers anticipated to be available as at 30 June 2004?

Ms PIKE — The first thing I would like to do is comment on the institute of health and welfare data and make some broad comments about that, because I am familiar with the report and I am also familiar with the media comments made by the Leader of the Opposition regarding that report. What needs to be on the public record is that in fact the institute of health and welfare has changed the nature of its reporting of hospital beds and has in fact not included some significant categories of beds in that data. Our department has been working with the Australian Institute of Health and Welfare to ensure that in fact the data is comparable to the previous countings of beds so that subacute, for example, which is not included in its current report and which was previously included, and some other categories, will in fact be included. I do not know if anyone of my colleagues may have some further information on the other categories that were not included in this data.

Mr SOLOMON — For example, at Monash Medical Centre in 2000–01 figures were included for mental health beds and the year after they were excluded, so the figures showed a 194 decrease, which is simply a counting change.

Ms PIKE — It is important that the data we are working from is consistent. We have increased the number of beds that are available, and that data is available. But it is important to also go beyond that and to say that we need to make sure that we are actually counting what is relevant in health service delivery, and contemporary health service delivery is providing health services in a range and variety of settings with different utilisation of beds. The average bed day for most procedures has declined significantly due to advances in

technology. We are having many same-day services and many more outpatient services, again because that is more appropriate for patients and because those procedures can be done in that way.

While I am certainly very comfortable that this government has in fact increased the number of beds that are available to the public, I think it is important that we actually talk about services that are being delivered, and on that measurement and criteria there is no question that we are in fact treating many more patients — over 35 000 additional patients every single year and in some years it has been even higher than that. We have been able to manage that demand because of a number of the other strategies that we have been engaged in.

Mr CLARK — Does it then follow that you are happy to provide that information on bed numbers to the committee?

Ms PIKE — We are happy to work with the institute of health and welfare and make sure we have the correct information.

Mr CLARK — The department can supply us with your own numbers; you do not need to do it through the institute.

Ms PIKE — We will see what information we have that is provided on a hospital-by-hospital basis and make sure that the relevant information that gives an indication of the service that is being provided to the community is made available.

Mr FORWOOD — I will take that as a no. Why did you not put it in the budget papers? How many beds are there?

Mr MERLINO — I refer to page 81 of budget paper 2. The budget papers show that Victoria will receive $300 million less in specific-purpose payments than would have occurred if these payments were distributed by the commonwealth on an equal or per capita basis. Further to your comments and presentation, how adequate are the commonwealth government's current funding arrangements for Victorian public hospitals?

Ms PIKE — In my presentation I talked about the level of funding that is being provided by the commonwealth to the states. Victoria is not unique here. That has changed significantly over the last few years, and the graph I made available in my presentation gave a good indication of that. It is important that we are very clear about where that change has taken place.

In the previous Australian health care agreement (AHCA) the level of indexation over the life of the agreement was in the order of 24 per cent. If that level of indexation were to have continued, Victoria would have been over $300 million better off in its health budget. What the commonwealth chose to do was actually reduce the level of indexation to closer, in Victoria's case, to around 16 per cent. It is unclear why it made that decision because what is clear is that the demand in our hospitals has been rising. In the public arena we have had statements by the commonwealth that it is providing, I think, $13 billion of additional funding to all the states in the current AHCA agreement. It sounds like a lot of money, and the public may well understand it as a lot of money, but the reality is that it is less money — nearly $1 billion less, in fact — than had the previous rate of indexation been continued as it was in fact continued in the forward estimates. The question is what happened to that $1 billion, which was in fact in the forward estimates in the commonwealth's finances? We know that that $1 billion was in fact taken out of the commonwealth's forward estimates and applied to the first of the so-called fairer Medicare packages. It was a direct swap, I guess, of the money that was there for hospitals into that particular area.

Further to that we know that the commonwealth has since made yet another adjustment to its indexation rate. I referred to the WC1 indexation rate. The first adjustment it made when it cut us from 24 to 16 per cent was it reduced the utilisation factor for some unknown reason. Now it has made a further slice into the consumer price index (CPI) factor and that will see another additional penalty to Victoria.

So we are in a very difficult position with the commonwealth funding. The other two policy settings that are in their area of responsibility are the level of reimbursement that is given to general practitioners, which directly affects their capacity to bulk-bill; and secondly the number of aged care beds, which again has a direct impact on the number of services that we are providing in public hospitals to people who have been assessed as eligible for aged care.

In that context the share of Victoria's contribution to the public hospitals has increased dramatically to the point where around 59 per cent of funding now will be coming from the state after this current budget. It was 55, but it is now moving up to around 59. We are certainly having to fill the breach so that we can continue to provide appropriate services for the community.

The CHAIR — Thank you.

Mr RICH-PHILLIPS — I would like to ask you about bonus payments for departmental staff. The most recent budget outcomes reported at the PAEC noted that for 2002-03 more than $2 million was paid in bonuses to DHS staff, including almost $1 million to the executive officer and for the same year over $53 000 was paid in bonus payments to three executives of Eastern Health. Following the payment of that $53 000 in bonus payments two of the hospitals in Eastern Health — that is, Maroondah and Box Hill hospitals — sent out fundraising letters seeking donations to fundraising campaigns for hospital equipment. Maroondah Hospital was seeking $28 000 from the public, and Box Hill was seeking $80 000.

Firstly, with respect to the issue of bonuses can you tell the committee how much will be paid to DHS staff in bonuses for the current 2003-04 year? How much will be authorised for the period of this budget? Will you allow hospital executives, having paid themselves bonuses, to continue to send out letters seeking funds from the public to pay for hospital equipment?

Ms PIKE — There are two parts to that question, and I will just pick you up on your final statement. Did you say that hospital CEOs were paying themselves bonuses — was that what you actually said? Obviously executives are not in a position of paying themselves bonuses. If bonuses are paid, they are paid by their employer, which is the board of management. I clarify that point.

The first part of your question related to the payment of bonuses to the Department of Human Services executive, and of course all remuneration is covered by the Government Sector Executive Remuneration Panel (GSERP). The terms and conditions of people's employment are within the overall public sector guidelines. Patricia Faulkner is the head of our department. I think she will talk about that, then I will answer the second part of your question.

Ms FAULKNER — The first part was about bonuses paid to executives within the Department of Human Services.

Mr RICH-PHILLIPS — For this year, yes.

Ms FAULKNER — For this year?

Mr RICH-PHILLIPS — For the 2003-04 year, what the figure will be.

Ms FAULKNER — It is normally 8 per cent of the executive budget. We have not been informed as yet. It is usually a government-wide guideline. Usually you have to get your bonuses to average at 8 per cent. They have an entitlement to a 20 per cent bonus, and you would expect that not everyone would receive that, so we usually average it out at 8 per cent. That is usually a guideline that is handed down by the Department of Premier and Cabinet.

Mr RICH-PHILLIPS — When will that be confirmed?

Ms FAULKNER — We do not usually pay bonuses until the completion of the financial year. We would normally get advice around August-September about what the guideline will be, and we stick within that guideline. Another point I should mention is that the executive remuneration package has now had a reduction in the bonus payable, so we would assume therefore that the average level of bonus would be reduced as well.

Ms PIKE — The second part of the question related to Eastern Health, but more generally I think the question was about bonuses across our hospital system. Under the GSERP guidelines CEOs are able to receive up to 20 per cent of their remuneration package as performance-related incentive bonuses. It is up to the boards of each individual health service to determine CEO remuneration and what the terms for bonus payments are within the GSERP guidelines, which I am very happy to make available to you.

I must say that up until now each health service has a range of criteria and applies those criteria in a way that they believe has been appropriate to enhance the performance of their individual health services. Under the governance

and accountability bill, the new governance arrangements which are currently before the Legislative Assembly, there will be some changes to the whole area of remuneration. Clause 11 of that bill inserts a new section to provide that in the case of a public hospital the remuneration, the terms and conditions, the bonus payments and the criteria et cetera must be approved by the secretary of the Department of Human Services.

Members of the governance panel did identify this as an issue that we needed to have far greater consistency and clarity on, therefore it was one of their recommendations in their report around enhancing accountability to the community. So if this bill passes the house, we certainly believe that it will ensure that performance bonuses are only available in the appropriate circumstances and in accordance with government policy. We are currently undergoing some work to review CEO remuneration and the application of performance bonuses.

Mr RICH-PHILLIPS — To clarify, will that require the secretary to sign off on individual bonuses for each individual, or is it on an agency-by-agency basis?

Ms FAULKNER — At this point in time there is a recommendation, and the way in which that will be implemented is still under discussion. It could be in the same way as I described earlier, which is an averaging, or it could go to approval of individual bonuses, but that would be a very onerous task administratively, so we are still looking at whether there is a way of doing it that keeps the consistency and control without having the individual bonuses approved.

Mr RICH-PHILLIPS — Thank you.

Mr DONNELLAN — Minister, I refer you to your slide presentation. Can you outline what the department is doing to ensure Victoria is prepared in the event of bioterrorism or pandemic outbreak?

Ms PIKE — Certainly. The government is providing almost $11.5 million to the Department of Human Services over the next four years to enhance our capacity to deal with a potential bioterrorism incident. Our focus is particularly on the chemical, biological and radiation threats, so we have been working very hard to enhance our level of preparedness. We have been focusing on plans to manage demand on the health sector. That involves reviewing our stockpiles of pharmaceuticals and also developing and implementing enhanced disease surveillance systems.

We, of course, work nationally on these issues. There is a communicable disease network that has a whole range of guidelines within which we work, and in fact our public health staff are very closely engaged in that area. For example, there is a national smallpox strategy, there are guidelines for anthrax and there is also national work on influenza pandemic planning, so you will know that with the SARS epidemic and now with the Asian flu area, we have everybody working closely, and that plan will include protocols for surveillance, use of vaccines, anti–viral drugs, as well as the use of hospital and community medical facilities.

The other area that we have been working in is the emergency services coordination, and a chemical, biological and radiation planning and response unit so that we can ensure that we have people educated and trained within the whole system. When you go to our hospitals you will now see, in the ambulance bays and in the emergency departments, full showering facilities. A lot of those initiatives that really did not need to be there in the past are now there, and of course the whole area of training to back them up. It might be helpful if we talked a bit about Medical Displan Victoria, because we have the key role. Dr Brook may be able to give us some information on that.

Dr BROOK — The department administers the Medical Displan Victoria program, which is separate from some of the things the minister has talked about, but is an integrating force for all of the elements of first line response for terrorism and pandemic outbreaks as well.

Displan draws on the resources of the state's healthcare workers to ensure that in the event of a disaster — and a disaster can be quite small or quite large — there is the capacity for an immediate response in conjunction with ambulance and other emergency services including our own public health emergency service, to attend and ascertain what should happen to individuals or groups of people who are injured or harmed in some way by some incident.

The particular role that each group takes will depend, for example, on the matter at hand; so clearly if it is a radiological or biological incident the first responder will be the public health emergency team, but they in turn will rely on Displan and ambulance services to deal with the people who may be affected.

The Displan group effectively triages people and ensures they are distributed according to where resources are available so that they can receive appropriate treatment and care so you are not having a large number of people arriving simply at one hospital rather than being distributed.

There will be issues at hospitals as well, which will be coordinated by Displan through the hospital, because in any large–scale disaster event around 60 per cent of people take themselves for treatment — actually being the walking wounded — so the Displan system is highly integrated and coordinated and it links in with other emergency services and with our hospital emergency departments and intensive care units and has the facilities, drugs and skills necessary to deal with almost anything. They have containment suits, self–contained breathing apparatus and a range of drugs and therapies which they can administer on site or in conjunction with ambulance services and in transport.

Ms GREEN — Minister, I refer you to budget paper 3 on page 87 in the health and social development output group which includes funding for obesity prevention. Can you inform the committee of the department's response to public health concerns over obesity?

Ms PIKE — We, of course, know that rising levels of obesity have the potential and already are causing significant poor health outcomes for many people in our community, and when we know that very young children now can show signs of type 2 diabetes, which has always been associated with older adults, then this is just but one indicator of what has been described by some people as an epidemic of obesity and something that all governments need to be taking very seriously.

We have also recognised, however, that just tackling obesity as a health issue does not lead us to understanding the inter-relationship of the responsibilities of varying other parts of the community in this area. The causes of obesity are very complex. They have to do with changes in recreational activity, changes in diet, changes in the use of transport, people relying on cars, all of those things — we are probably all familiar with them — and therefore we do need a whole-of-government initiative to begin to address this issue.

The Department of Human Services has $10 million available for funding for the obesity and diabetes prevention area, and we have joined that with funding for a physical activity promotion initiative — $10 million from the Department for Victorian Communities. The Minister for Sport and Recreation and I have endorsed a joint strategy that is being developed for a physical activity program, and of course its connection to the prevention of early diabetes and tackling obesity.

The strategy will involve a range of communication activities, particularly targeting children and family. We are also establishing healthy behaviours from the early age, again through a range of different educational activities, and we are also already supporting, within the department, a number of community-based pilot programs which allow people within the community to get together and find solutions that will be meaningful for their own community.

In Colac, for example, we have had a very successful range of activities with the health providers and people within the local primary school, encouraging children to monitor their weight, to engage in more physical activity and to eat in a much healthier way. We have established a minister's forum with the Minister for Health, the Minister for Sport and Recreation, the Minister for Aged Care and the Minister for Education Services. Together we will be overseeing the implementation of this strategy.

Also, of course, I am part of the Australian Health Ministers' Conference, and we have also committed ourselves to working together with other states and territories to reinforce a national program. The Australian government, I understand, is currently working on a strategy. There were no resources in the most recent budget, but it has indicated that it is working on a strategy for a national perspective.

This area is very worrying to people within the community. It is a very complex matter. Quite simply it involves people having to rethink some of their behaviour, and anyone with young children will know that trying to keep them away from junk food is a mammoth task; so we are also working with the media, with the food industry, with

the fitness sector, and also even with some chefs to ensure that this initiative is broadly based and something that captures the imagination of everyone in the community.

Mr FORWOOD — Minister, I refer you to the Department of Human Services tender dated 15 May for a panel for provision of discipline and whistleblower investigation services. The tender description is:

> The Department of Human Services is seeking suitably qualified and experienced persons to investigate alleged misconduct; breaches of discipline or whistleblower issues by departmental employees; and other specified general complaints.

I further refer you to Dr Lazzari's letter, where he says:

> There exists in the state's health authority a rampant culture of bullying, harassment, intimidation, gagging, obstruction, lies and deception.

He in particular mentions instances of bullying at 555 Collins Street by Andrejs Zamurs and Ben Hart, two members of your staff. You might need to take this on notice. My first question is: could you provide for the committee how much has been spent on the investigation/discipline function in the years 2002-03 and this year; and how many cases have been investigated in each of those years? Secondly, will you ensure that an investigation is undertaken into the allegations made by Dr Lazzari of his treatment?

Ms PIKE — I will ask the secretary of the department to elaborate on some of the more specific details of your question, but I will indicate that the appointment of a panel that can be available to be engaged in the investigation of issues within the Department of Human Services is, of course, a practice that has been in place for many, many years — well before the time of this government — so this is not new at all. It is very important within a department the size of the Department of Human Services that you do have the capacity for independent investigation to occur from time to time. This is absolutely something that is around public confidence and I do not think the public would be satisfied if they felt that in cases of serious allegation the department was always investigating itself. I think it is quite appropriate to have independent people who are there. I will give you an example of the kind of investigation that takes place. Most of it, might I say, is not in health. Most of it is in child protection, community services, and disability services — in those areas.

I will give you an example where we required the services of an independent investigator. That was when I was Minister for Community Services. You may recall that there were some allegations made about some staff at the Malmsbury youth training centre and activities on the site of that centre. Of course the absolutely appropriate course of action was to draw on someone on the panel to conduct for us an independent investigation and that is exactly the nature of the work of these people who are on a panel. When we need someone to do an independent investigation we do not put a huge ad in the newspaper every single time. We have a panel and it is a common process in tenders.

On the broader question of the existence of this panel and these people, they have been around for a long time before this government was in power. It is a process that has been well accepted by previous governments and it is a process that I think is absolutely fundamental to public confidence in public administration and I am very comfortable with it. But it is an area that is in the responsibility of Patricia Faulkner, our head.

Ms FAULKNER — I think the specific question was about the expenditure and the numbers of investigations.

Mr FORWOOD — Yes, that is right.

Ms FAULKNER — I do not have it broken down the way you wanted it, but I have got that in the last three years: 191 investigations and the total costs, $780 000, if that is helpful. If you wanted it broken out differently, I can get that, but that is the sort of thing. The panel was first established in 1998, so this will be the third panel that is being established. The only difference this time is that we are combining whistleblower investigations because that is new legislation. We have found the need to have external and independent people to look at the allegations made as protected disclosures under the whistleblower legislation. So we are now having the one panel that can do both discipline inquiries as well as whistleblower inquiries. So it is a broader ask and the panel is being briefed very soon about the requirements.

Mr FORWOOD — Minister, did you want to answer the last part of my question?

Ms PIKE — I am not sure that this committee is the forum to make decisions about the investigation of individual complaints. Chair, maybe you could give us some guidance on that?

The CHAIR — That is entirely your call.

Mr FORWOOD — Sure. I mean, if you do not want to answer it, do not answer it, but I mean — —

Ms PIKE — I do not believe this committee is the appropriate forum to make those decisions.

Mr FORWOOD — So you will not investigate it?

Ms PIKE — I did not say that.

The CHAIR — She did not say that.

Mr FORWOOD — She did say that.

The CHAIR — Minister, I refer to budget paper 3, page 90, where there are increased resources for drug treatment and rehabilitation. I ask you to outline a little more fully what you and the department will be doing to prevent alcohol misuse in the community as a result of that funding initiative.

Ms PIKE — Thank you, Chair. In June 2002 we launched stage 1 of the Victorian alcohol strategy. We have had a number of activities that came out of that stage 1, including a range of multimedia campaigns. We targeted risk populations, including the under-18s and tertiary students. The reason that we have done that is because, whilst we have done a lot of work in reducing the harm from drugs and working to prevent drug abuse and other initiatives around drug abuse in our community, we felt it was important to have a focus on the whole area of the abuse of the alcohol. Research has certainly shown that young people — particularly young people, I might say — are drinking to excess in some cases and drinking in a harmful way.

Mr FORWOOD — 'Young' means?

Ms PIKE — I am talking about younger teenagers rather than older teenagers. I think the age of some of these teenagers is quite a concern for people within the community because it is the frequency and the volume of binge drinking that is a major concern.

The next phase of our strategy , and the additional resourcing is here to support that, is around four key areas — this will be our Victorian alcohol action plan stage 2 — first of all, minimising alcohol-related harm to young people, tackling alcohol-related incidents in and around licensed premises and events, working to provide good information and education around the harmful consumption levels of alcohol and, of course, responding to public drunkenness.

We have also taken a very important lead role in the review of the alcohol advertising arena. That is, at our instigation, being undertaken by the National Committee for the Review of Alcohol Advertising, which is a subcommittee of the Intergovernmental Committee on Drugs, of which I am a member. We know that some companies have been behaving in an inappropriate way — one company, for example, sponsoring schoolies week and schoolies-type activities, directly marketing and providing free giveaways et cetera to young people, very inappropriate advertising, using young actors, the connection of alcohol consumption with social success et cetera. All of these areas have placed a lot of pressure on young people. That is an area we have a particular concern about. That is an area that we have particular concern about.

We have a partnership between the Department of Human Services and key stakeholders, particularly in the crime prevention area, looking at how we can reduce alcohol-related violence within the community. We have commissioned major research on foetal alcohol syndrome in Victoria, and we have also begun some work on a set of clinical guidelines to inform practitioners on the application of brief interventions as a treatment for alcohol. We are really trying to skill up general practitioners and help them to identify some of the symptoms of alcohol abuse, particularly in young people, so that they have some good strategies to assist in that and of course so that they have the appropriate referral information et cetera. Stage 1 of that alcohol strategy has been very successful, and we are certainly going to be using additional resourcing to move into stage 2, to work with the community to try to deal with this very serious issue.

The CHAIR — Thank you.

Mr CLARK — I turn to the issue of small rural services, which as you know is a new output group you created this year taking elements from acute health, aged care, home and community care and primary health outputs.

I refer you to the footnote on page 83 of budget paper 3, *Service Delivery*, which says that:

> Substitution of acute, aged and home care, and primary health services is encouraged in order to meet local needs. Therefore the quantity of services delivered per output may vary from target, while maintaining effort across all outputs.

I refer further to a radio interview you gave on ABC radio on 25 September last year in which you were reported as acknowledging that surgical and obstetric services might not be available or viable in small country hospitals. In consequence of that I am concerned that this is not going to be used as a mechanism to close acute hospital beds by stealth across country Victoria, and my question is: can you guarantee there will be no acute bed closures in country Victoria through this restructuring?

Ms PIKE — This is a restructuring of the funding mechanism, and obviously a key objective in this new funding mechanism and accountability approach is to facilitate a sustainable and flexible mix of services within communities that are responsive to local needs. By bringing all this resourcing together, in a sense, we think it will strengthen the capacity of small rural services to have that flexibility to respond to the changes within the communities they serve. It will cover around 67 small rural services. Dr Brook can expand on the funding mechanism, and then I might go to the answer of the latter part of your question, if that is appropriate.

Dr BROOK — The new initiative is directed towards very small health services, by no means all of them hospitals. There are approximately 14 group E hospitals. These are extremely small health-care settings, all of them in towns of less than 5000. In addition to that, there is another group — group D hospitals. There are health care centres that were previously called multipurpose services.

Mr FORWOOD — Do you have a list of the Ds and Es for us?

Dr BROOK — It is actually all available in a publication, and you are most welcome to have as many copies of that as you like. It is also available on the Web. I can certainly make this publication readily available to you. It also includes multipurpose service agencies that have previously been called health-stream agencies, which was an initiative of the former government in much the same direction as this, to increase flexibility of state funding in the absence of commonwealth funding. There are also some bush nursing centres. This basically sets a global budget for these agencies which is dependent upon their historic allocation, but it frees them from having to apply specific outputs simply to obtain income for those specific outputs, so that they are able to freely convert between inpatient and outpatient services and between hospital and community services, dependent entirely upon the consideration of the local board of management in consultation with their communities.

The way in which we can be sure that services in aggregate are provided is through a conversion factor or a weighted value unit, which we call the rural services unit, which gives a weighting to the efficient cost of any particular kind of output delivered. So if you were to deliver one inpatient service of a particular inpatient type that might cost, say, $2000, that $2000 might cover 10 outpatient attendances or 10 home-care attendances, so we can be sure that the output monitoring that is provided does ensure that we have a very clear indication of efficient use of resources. But it is quite fair to say that it is entirely up to the local community, through their own board of management, as to the type of services they wish to deliver. And it is also fair to say that people in different communities have historically moved in different directions in this regard.

The question of whether you could guarantee that every acute bed in every small rural hospital would forever be open does not reflect the reality of the past 20 — let alone 5 — years, which is that in fact people in some communities have to some extent moved from providing acute inpatient services to providing a range of different services, particularly home-based care services and allied health services, which are not dealt with in a casemix inpatient funding system. It is their call. No-one is placing pressure on anybody to change.

I should also reflect that there is a community choice element here. In very small communities it is not at all uncommon for the community to choose to have the secondary-level services provided in a subregional hospital of a somewhat different scale. One does not receive hip or knee replacements in group D or E hospitals.

Mr FORWOOD — Just looking at the measure, what is that 145 000 the number of?

Dr BROOK — You are looking at page 83?

Mr FORWOOD — Yes.

Dr BROOK — Under primary health?

Mr FORWOOD — I am looking at the one above it, too.

Dr BROOK — Yes. That 145 000 is the number which would have applied last year under primary health service units, and it is equated to 111 650 in rural health service units. For each stream of output we have a relative value unit, just as WIES — weighted inlier equivalent separations — is a relative value unit for the cost of inpatient care. We have always attempted to have a simple measure by which all kinds of services provided in a stream can be related the one to the other. So in this instance we are looking at what would have been a primary health service delivery unit number of 145 000, but that now becomes a rural health service unit number of 111 650.

The CHAIR — But what does it measure?

Ms PIKE — What it measures is hours of nursing time, hours of podiatry.

The CHAIR — These are hours?

Mr FORWOOD — Hours?

Ms PIKE — No, they are encapsulated in units of service.

Dr BROOK — Correct.

Mr FORWOOD — Is there a definition of 'units' in the budget papers?

Dr BROOK — We have talked for a long time in the casemix funding environment — in fact since 1992 — about weighted inlier equivalent separations. It is an entirely theoretical concept that relates one treatment to another. This is no different in concept. It is a relative value unit — or weighted value unit — that says, 'Let's take a unit of production. What does this kind of service cost compared with that kind?'.

Mr FORWOOD — In terms of units?

Dr BROOK — Correct. So this is the aggregate of those things, and generally it is set at around $20 or thereabouts per unit.

Mr FORWOOD — Okay. That is what I was after — $20.

Ms PIKE — No.

Dr BROOK — You have to be careful about looking at the exact numbers here.

Ms PIKE — We do not have the exact figure, but around about.

Dr BROOK — The rural health service unit is, as you can see, higher than that.

Mr FORWOOD — Sorry, I interrupted you.

Ms PIKE — Not at all. Rural communities have been asking us for this change. They want greater flexibility with the use of their funding. The fundamental question is what have we been doing with the funding for rural health services over the time that we have been in government and what will we do as a result of this budget? Every single rural health service in the whole of this state has increased its funding year after year after year since this government has been in office. In the case of Heywood, 50 per cent — not including this budget, but in previous budgets; in the case of Lyndoch in Warrnambool, 40 per cent. Let us get to some little ones: in the case of Terang and Mortlake, a 23 per cent increase in funding. There is not one rural service that has been closed, and there is not one rural service that has received a reduction in funding.

However, what rural services have said to us is that they do want greater flexibility. If their population, for example, is ageing the capacity to be able to move between acute and aged care is a really important one that they want to have for their own community and their own service viability, so that is why we have moved to this greater flexibility. It is not at all, as your question implied, about cutting services. All our services have grown, they have all expanded. It is about being responsive.

We do not have the same hospitals that we had in the 1950s, and if by your comment you are assuming that every single bed in every single hospital will be used for every single purpose that is utterly the same for the next 20 years, then I think we are in a very sad state of affairs. We are about having a modern hospital system that provides adequate resourcing for the changing needs of the community. Things will change, and I do not shy away from that at all. That is about being responsive and being contemporary. I am glad we do not have hospitals that look like they did in the 50s; I am glad things have changed, and I hope they change more.

Mr CLARK — In other words, you are not guaranteeing there will not be any reductions? In fact you are saying that will be an inevitable part of the process?

Ms PIKE — It depends on how you measure service. I think that a very narrow and old fashioned interpretation is quite unhelpful.

Mr FORWOOD — On a technical issue, I wonder if you would mind if the committee put on notice the question of how this unit system works and in particular how you would report against it if you do start switching it from one output group to another.

Ms PIKE — Certainly.

Mr FORWOOD — Because that is the effect of note (a).

Ms PIKE — I can advise you that the rural and aged care area of the department is working on a major document that does exactly that and that articulates the mechanism and methodology and that will be available late 2004. It is a divisional output.

Mr FORWOOD — Excellent.

The CHAIR — That is helpful, because if you are working on a major document, it is no wonder that we did not understand it completely.

Mr FORWOOD — Because I would not want to be going through this next year, trying to compare. You know what I mean, do you not?

Dr BROOK — Yes.

Ms ROMANES — On pages 279 and 280 of budget paper 3 the state budget papers detail quite an extensive new asset investment program in health in 2004–05. Can you, Minister, provide the committee with information on the department’s track record in delivering such capital investments on time and within budget?

Ms PIKE — This is an area that I would have to say the department is performing very well in. We currently have an investment program of endorsed projects for health facilities of around $1.49 billion. Our department is working on around 30 projects at this time, expending that money and making enormous improvements to the infrastructure of our health and aged care systems. They range from really big projects like the Austin Health redevelopment through to upgrades in small nursing homes, in small rural communities; and of course they also include our ongoing commitment to addressing infrastructure issues within our hospitals.

The program of projects under way in 2003–04 includes projects funded in the budget cycle as well as those funded previously and still under construction. I know that you have through your chair requested information on all projects with a TEI of $10 million and over. We are happy to say that all projects are being delivered on time and on budget, and in fact the asset investment budget for the health facility project in 2003–04 is almost $280 million and will be fully expended, so that will be just the amount that is expended within this year.

I think it is a very good record. The major projects do remain on target, and where there have been minor expenditure variations along the way they do not impact at all on the overall project expenditure. There are some

areas in fact of under expenditure, and I think that shows the department's capacity for working within a very complex environment.

One area that I do want to highlight is the health information strategy. We are rolling out that project, and that will have a very significant impact on the efficiency of work within our hospitals. It is a big program with a lot of projects and we are very pleased with our performance in this regard.

Mr RICH-PHILLIPS — Minister, I wish to ask you about the reported deficit at Southern Health. I refer to the annual report for Southern Health for year the ending 2003, and the consolidated result for the 2001–02 year. The operating deficit was shown as $9.1 million. For 2002–03 the operating deficit was $12.5 million, so a deterioration of $3 million.

In November last year, the Auditor-General published his public sector agencies report for November 2003 and did a section on public hospitals operating under financial difficulties. As part of that report the Auditor-General published a table showing the operating result for the various health networks. For Southern Health in figure 3.3(e) the Auditor-General showed an operating deficit for Southern Health for the 2002–03 year of just over $26 million, which was substantially different from what is reported in the annual report.

The Auditor-General has made a note that the figure he has quoted of $26 million excludes $13.5 million which was forgiven for a finance lease from South Eastern Medical Complex Ltd. So there is a distinct difference in the accounting treatment shown in the annual report and the accounting treatment applied by the Auditor-General. The net effect is whereas the annual report shows a deterioration of $3 million, the Auditor-General shows a deterioration of $17 million.

Firstly, I seek your comment on the Auditor-General's accounting treatment showing the $26 million deficit, and secondly, what process was involved in not showing that $13.5 million in terms of guidance provided by Department of Treasury and Finance to your department; was it advice sought from DTF as to how that should be accounted for?

Ms PIKE — I will ask Shane Solomon to give a more detailed answer, but that $13 million figure you see there refers to the final payment for Monash Medical Centre. It has been since the hospital has been built. I will ask Shane to explain that further.

Mr SOLOMON — I think we said last year, and also included in our comments of last year, that we have some difficulty with the way the Auditor-General is presenting the operating result, particularly in the sense that revenue related to capital is excluded but depreciation on the cost of capital is included. We would have difficulty commenting on what we regard as not an accurate reflection of the operating result. I suppose I should also say that the annual report of Southern Health is an audited statement.

Ms PIKE — And signed off by the Auditor-General.

Mr SOLOMON — And the Auditor-General's is a reworking of an annual report, if you like. You yourself are reworking the annual report. I think sitting around the table we should be reluctant to move away from what are the audits signed by the board — published results.

Mr RICH-PHILLIPS — Did DHS take advice from DTF on the reporting of what the Auditor-General has described as a forgiveness of that finance classification?

Mr SOLOMON — I am not sure why we would take advice from Treasury on that.

Mr RICH-PHILLIPS — Given the disparity between DHS's view and apparently the Auditor-General's view.

Mr SOLOMON — As I said, in relation to the Auditor-General we have expressed our view to the Auditor-General and in writing to last year's report in response. While the exclusion of abnormals we would have no difficulty with, the different treatment of capital on the revenue and expenses side is not what we would regard as a comparison. You are asking us to, I suppose, get an opinion from DTF on something that we have already disagreed with.

Mr DONNELLAN — The state budget papers, specifically budget paper 3 at page 90, indicate that the department provides a comprehensive response to drug prevention control treatment and rehabilitation in Victoria. What specifically is being done to address illicit drug misuse and harm associated with the rave and party scene?

Ms PIKE — Of course we collect a lot of data within the Department of Human Services about the use of illicit drugs within our community. Recent data suggests that there has been quite a dramatic increase in the use of ecstasy and other party drugs. People will be aware there was a recent focus on GBH, which is code-named grievous bodily harm but stands for something much more chemically correct. But GBH is a major problem within the party scene. The reason GBH is a major problem is because it is very cheap. A relatively small amount is required for a drug-induced state, but the difference between a smaller amount and a larger amount can be the difference between a drug-induced state and being in some difficult and significant trouble and requiring emergency support.

The other concern that we have is polydrug use within the party scene. Our emergency services and emergency departments are seeing people who are using a wide range of drugs, and these, of course, have the propensity to cause serious health problems and precipitate drug overdose.

We have begun a number of initiatives. Of course we continue to fund Rave Safe, which is a peer education program targeting illicit drug users who attend rave parties, and they are provided with a whole range of drug prevention information and education resources. We have also introduced the guidelines to provide free or low-cost drinking water in licensed premises as a public health initiative, and we are also working with industry to develop a multifaceted code of practice associated with party drug use.

People will be aware of course that in 2002 the Drugs and Crime Prevention Committee conducted an inquiry into the use of amphetamines and party drugs, again in response to the concern about the rise of party drugs within our community. The committee, I understand, is finalising its findings, but we are certainly not flatfooted on this issue and we are working hard on a range of strategies to try to address this growing problem — and it is a growing problem.

As I said, particularly GBH is one of those drugs which does not actually kick in; you do not necessarily feel the effects, for up to 2 hours. So what a lot of young people do is take some, they do not feel any effects, so they take some more, and just an increase in that dose can be deadly. It is a very difficult issue. Obviously surveillance and initiatives to address crime are all part of this too, but from a public health perspective, which is fundamentally my responsibility, we are trying to educate people, give people good information and work with the community on this issue.

Mr FORWOOD — I want to return to the issue of asbestos at Chandler House at William Angliss Hospital. I think Mr Solomon indicated that he had spoken to the CEO last night, and that the CEO had suggested that there was not a problem there. I do not want to put words in your mouth, but that is my — —

Let the record show that Mr Solomon is nodding his head! *Hansard* does not record nods of heads.

The CHAIR — And mouths smiling!

Mr SOLOMON — What I said was that I was advised that it was stable. We use asbestos throughout the Western world but, as the minister said, the problem is if it is unstable, and that is what you get audits to look.

Mr FORWOOD — It came to light because of the flood, which meant that it was unstable and they went through the drying-out process, so we can talk about it being stable or not stable. I guess you would be aware that last Thursday a number of signs and notices were erected throughout the hospital. I do not know what the actual words were, but they were attached to manhole covers in the ceiling and elsewhere advising of the presence of asbestos. Do you regard that as a satisfactory response to the issue?

Mr SOLOMON — I am not sure what your source is, so I am not aware of that person —

Mr FORWOOD — It is a very reliable source. We could go out together and look at them.

Mr SOLOMON — We could do that, but what I rely on is the technical experts. Without having seen the report from the technical experts myself — I have asked for a copy of it — it may well be that at as an extra

precaution they recommended that that occur. Without having read the report, I am speculating, and I would far prefer to read what the technical experts have to say.

Mr FORWOOD — We look forward to receiving a copy of the report as well.

Ms GREEN — Would you advise the committee on what the government is doing to increase access to mental health services? I refer you to the mental health outputs on page 75 of budget paper 3.

Ms PIKE — Thank you very much. I think everyone is very aware that the mental health area is a very challenging area for our community and that there is increased public awareness of mental health issues within our community, and that is a good thing. It means that people are talking more freely about mental health issues and that people are coming forward for treatment for mental health. We are constantly working to make sure that the kinds of responses that we have to mental health issues are ones that really genuinely meet people's needs, and that our responses are not potentially taking us back to some of the practice that characterised the mental health system in the past — that is, placing people within large institutions, depriving them of their liberty and giving them very little opportunity and chance to lead normal lives.

It is true that one in five Australians may have a mental health episode at some stage in their lives. That can vary from mild depression through to a more serious mental health episode, but many people — of course, most people — go on to recover from that episode and to lead happy and satisfying lives. Our responsibility is continually to improve what we are doing but also continually to offer leadership within the community so that we do not have knee-jerk reactions which could send us back to that kind of poor practice.

We made a commitment in 2002 to increase our funding over a four-year period by $105 million. This year the mental health strategy will receive another $15 million, which is there to address critical demand pressure and to provide support workers for people who are living with mental illness within the broader community. We recognise and acknowledge that there is a lot more work to be done in mental health. We have committed ourselves to opening up new beds, and we are doing that. There will be 25 additional mental health beds coming on stream at the new Casey hospital. There is an expansion in subacute programs in mental health — that is, programs that provide the interface between hospital and community services. We have already opened one of those facilities in Shepparton, and we will be opening another one in Box Hill and another one within the metropolitan area.

As far as the community-based mental health services are concerned, we have gone in this state from providing services to around 2000 people in the community in the mid-1990s to now providing services for nearly 10 000 people within the community. Victoria is the only state in Australia — and this is a program that was begun under the previous government — that has a comprehensive community-based mental health support service system. Whilst it is a system that is always under pressure and demand, it nevertheless provides support for thousands of people in our community. The funding this year after this budget will be around $53 million. It is the proportion of the mental health budget that is to be provided to community-based services that is increasing in response to the changing service needs.

The only area that is of disappointment is that there was no funding for mental health in the recent federal budget. We expend nearly $700 million a year on mental health, and only $14 million of that is provided by the commonwealth government, so there is need for a national approach as well as of course the work that we are undertaking here in our state.

Mr CLARK — I refer to the issue of the Clinicians Health Channel, which as you know makes available to clinicians a wide range of information online through a web site. As you will also know, the future of that has been under a cloud with aspects of it due to end in August and other aspects in December this year. In a letter dated 14 January this year to a colleague the Honourable David Davis, a member for East Yarra, you said:

> The Department of Human Services is actively seeking future funding options, to allow the CHC to continue beyond August 2004.

and —

> Funding will be resolved as part of the May 2004 budget process.

Now we have the budget can you tell us what the situation is regarding the Clinicians Health Channel?

Ms PIKE — I certainly can. The Clinicians Health Channel was funded under the previous Australian health care agreement (AHCA) with funding from the commonwealth. It has been a very important initiative and provided access for doctors to an online service whereby they can have access to particular journals et cetera that they would not be able to afford themselves. Certainly it has been rated very highly as a very valuable service. Therefore we were extremely disappointed that the commonwealth determined to cease funding for the Clinicians Health Channel, thereby transferring that responsibility to the state.

We have been working within the department to look for ways that we can continue to provide that service to people who value it highly. The letter that you read out reflects that commitment. I am awaiting further advice from the department about how that will happen, but I have given a commitment that there will be a continuing of the service, and I will ask Mr Solomon to give further details.

Mr SOLOMON — The minister mentioned earlier that there is a very large amount available for sustainability and growth funding as part of the hospital demand management strategy, and it is within that global allocation that we are looking to fund the Clinicians Health Channel. We are very confident that it will fit into the envelope that we have.

Mr CLARK — It is commonwealth seed funding, so we should congratulate the commonwealth for doing that and hope that it continues.

Ms PIKE — As a further comment, I have actually written to the federal health minister and not only asked him to reconsider the federal government's decision to de–fund the very valuable service, but also to look at the possibility of a national program because, given that this is an information technology–based service, there is really no reason that it could not be, and Patricia Faulkner, the head of our department, has been leading the information and communication technology strategy for Australia — a partnership between the states and the commonwealth — and I know that this provision of information, whether it be to the public or clinicians, is one of the matters that is on their agenda as well.

While we do not want to see it fall by the wayside from Victoria's perspective, we certainly would be very pleased to hear of any support that people might be able to offer as we try to have something happen nationally.

Mr SOLOMON — We were exploring a number of other options as well, and that included whether we could do something with the other states who have similar programs operating. There is a level of duplication, but the prospect of getting an agreement between everybody obviously became fairly remote over time, so it comes back to us.

Mr CLARK — But you are already running a similar program in conjunction with New South Wales and Queensland, as I understand it?

Mr SOLOMON — No, we are not. They are separate.

Mr CLARK — That is what the healthcare association says.

Ms FAULKNER — This issue of being able to do something once for the whole of Australia is something that the group I am chairing is taking up, because on a whole range of information technology fronts it is useful to have the whole of Australia develop standards for ICT.

The previous health minister's conference agreed to look at the establishment of an entity which would be shared between the commonwealth and the states to try and drive reform in this area, so it has been a battle to date, but people are starting to see that it makes sense to try and do things like this that take a lot of resourcing, that are useful across state boundaries, once for the whole of Australia.

The CHAIR — Minister, my question goes to the earlier one on obesity. You began to outline a little about the physical activity program and joint strategy being developed across a number of departments and across a number of ministries. I found that very interesting.

I know that Bicycle Victoria has made a presentation to a number of members of Parliament, yourself included, and it has a very interesting health promotion and wellbeing information and IT display, prepared by somebody in my own electorate, and I was wondering whether you could fill us in a little more on the physical activity programs that might be possible, and just give the committee a little more detail, tied in with Bicycle Victoria's health and

wellbeing promotion? I understand they are also doing innovative work with people with disabilities and mobility issues who may think they are unable to cycle?

Ms PIKE — Certainly. The strength of this whole-of-government approach is that we will be able to draw in a whole range of groups from right across the community, and Bicycle Victoria is one of those groups with some very creative and innovative ideas about increasing the level of physical activity through riding bicycles, and of course bicycle riding is exploding.

Bicycle Victoria is one of the largest groups of its kind in the whole world. It says it is number one, and I am not at all surprised. It has the largest membership of a bicycle group. But it is not just concerned with supporting its own membership; it really is thinking creatively about how it can contribute to the health and wellbeing of the community and it has done a lot of research into the physical benefits of bike riding, and it has some proposals before government at the moment, which would be their to enhance people's participation in bike riding, and also some simple planning ideas about how you can facilitate and make it easier for kids to ride bikes to school and so on.

The other group I want to commend, and of course Mr Forwood is on the board, is VicHealth, which has a whole range of fabulous programs to address the issue of obesity in a positive way. The Walking School Bus program has been a fantastic success. I was recently, in a different context, meeting some allied health professionals in one of our country hospitals who said they had connected up some of their clients with diabetes problems with the Walking School Bus program, and they were using them as the volunteers to lead the kids, which I think is fantastic.

Mr FORWOOD — Yes, that is very true.

Ms PIKE — So that particular program and a whole range of others are important. The reason also that this needs to be a whole–of–community thing is that we do need to get architects and planners and a broader group of people involved in how we design our communities and suburbs to enhance physical activity and how we incorporate physical activity into our everyday lives so that we can turn around this major problem.

The CHAIR — Would you care to make any comment in relation to people with a disability and their physical activity levels through Bicycle Victoria or other groups?

Ms PIKE — Absolutely. This is an example of the way these organisations like Bicycle Victoria are thinking about a whole range of different groups. It is much harder for people with physical disabilities to exercise. Their work in this area is to be commended.

Mr RICH-PHILLIPS — Minister, I would also like to ask you about the obesity programs. You would have seen the press release that Diabetes Australia, the Heart Foundation and The Cancer Council released on Monday in which they say:

> Diabetes Australia - Victoria, the Heart Foundation (Victorian Division) and The Cancer Council today released data showing at least 1400 Victorians will die each year if the Victorian government and others do nothing to address the issue of obesity in the Victorian community immediately.

So they are stressing that it is a very important issue.

Picking up on the $10 million commitment that has been made over four years, firstly are you able to provide the committee with a breakdown of where that will be spent as far as the communication aspects of the program versus the interaction with community groups is concerned?

Also, as far as the performance measure for that program goes, the one measure that has been listed in the budget paper is one that Sir Humphrey Appleby would be very proud of. For both last year and this year it is shown as 'Community agencies in targeted locations participating in community obesity prevention strategies'.

I would argue that that does not actually measure a great deal, so perhaps you could explain to the committee exactly what you are attempting to measure with that and how it reflects the performance of your strategy, particularly in terms of the communication aspects.

Ms PIKE — Certainly, and measurement of course is an interesting word when we talk about obesity. Let me first comment on the work of the Heart Foundation and The Cancer Council and Diabetes Australia - Victoria. We have been working very closely with those organisations and I certainly commend them for again drawing this matter to the community's attention and making a plea for additional work in this very important area. We have been working very closely with them.

We provide support in the area of diabetes, cancer and heart disease generally, of course, through all of our health programs. For example, we have been long-term supporters of initiatives through Diabetes Australia for research into the impact of increased use of weight-bearing exercise to reduce insulin dependency. Those kinds of programs have been funded through home and community care initiatives. Exercise classes for older people, weight training et cetera are all a feature of our general programs through our primary health initiatives. I certainly welcome their contribution and will continue it — they will be actively involved and engage in every dimension of the obesity strategy.

In terms of the actual initiatives, it is not $10 million; it is over $20 million in fact, because we have the combination of the health money with the sport and recreation money and also some aged care money that is adding to that. So it really is coming together as a major program. The government is about to announce a whole range of initiatives under that program, which will be provided to the committee, which will have a breakdown of all those initiatives.

In terms of the output measures, I will ask Dr Brook to further comment. I think it is about being realistic at this point about what we are going to use as an evaluation mechanism but obviously that would need to be — I have to be careful, I cannot say expanded or grow or all those words, into the future.

Dr BROOK — The measurement of improvement in obesity and its relation to one campaign is, of course, extremely difficult and no-one should be under any illusion as to the difficulty associated with looking at a social trend or a set of issues that relate to a significant change in social behaviour, which is predominantly the lack of exercise in our community — the fact that we are all now sedentary people who push buttons rather than walk.

The CHAIR — Not all.

Dr BROOK — To some extent or other — some of us more than others. The ultimate measurement, of course, is reduction in aggregate weight of the community and the rate of exercise. But those two things are incredibly difficult. In the short term the sorts of measures that we will be using will be looking to how many people access the web site that is proposed to back up the media campaign and indeed a web site that will, of course, link to other web sites such as the one you have mentioned in relation to Bicycle Victoria. It is too early for me to give you any defined output targets for that because it is simply not developed to that point but there is no point in having a media campaign or a series of local initiatives unless that can be disseminated throughout the community and readily available. So it is proposed that sitting behind the obesity and diabetes-prevention program will be a new linked web site — —

Ms GREEN — Jogging behind.

Dr BROOK — Jogging behind, that will enable people to access all of the information that is available through those respective approaches and allow them to use that information to, hopefully, generalise that into their own setting. Clearly we can run model nutrition campaigns and we can run model exercise campaigns — and indeed VicHealth already does so — but the imperative for us is to find a technology which actually uses technology to fight itself. We are actually trying to use the people who press buttons to read that they should be standing and pressing buttons or running and pressing buttons.

So I think that for our first target measure we can look at impact assessment but I think impact assessment simply tells you how many people have seen a campaign and picked up a message or not. We are more interested in the number of people who take pages off a web site because then they have had some practical involvement. We will be looking at that as we do for other information channels as our first, I think, measurable. But it is too early for me to give you exact targets at this point.

Mr RICH-PHILLIPS — Can we expect to see those type of measures incorporated in future budget papers in place of the rather obscure measure that is currently in?

Dr BROOK — Yes, we would be happy to look at that.

Ms PIKE — It is a genuine attempt to do something meaningful.

The CHAIR — There is a supplementary and then I would offer a comment as well.

Mr FORWOOD — Just a quick comment about this: I take it that no-one is disputing the 1400 figure of the annual deaths caused through this issue. I would suggest that one of the best measures we could have is to either stabilise the 1400 as a too-high figure or over time reduce it. Should we not be saying that our aim, rather than people accessing web sites, is to actually reduce the number of deaths so a meaningful target is: no increase or at least the beginning of a decrease?

Dr BROOK — If I could add to that, if that is okay with the minister?

Ms PIKE — Yes, certainly.

Dr BROOK — The fundamental difficulty with a measure of that sort is the time frame in which you would make that assessment. In order to address the problems of obesity and type 2 diabetes, it is important that we as a community teach our children different behavioural patterns. To a certain extent those adults, including myself, who are overweight and at risk of this problem — —

Mr FORWOOD — You are a lost cause.

Dr BROOK — Not quite a lost cause, I trust, but there is less benefit to be achieved. There is always benefit to be achieved in changing lifestyle and improving fitness and behaviour, but it will be the future generations who benefit from the investment that we make now. That is why we put so much emphasis on young people, including through VicHealth, not just our expenditure. That is why the whole program is focused on improving the activity levels of people who will remain active for the rest of their lives. Of course we are looking at the whole community and, as the minister has said, including senior Victorians — aged Victorians as well — because of the obvious benefits that are achieved. So, yes, you are right: the time frame is very, very long. In the short term you need to look at measures which are essentially impact or rather enhanced impact measures. It is true of any kind of change that is a whole-of-society change; it is not unique to this. You could look at the long-term — —

Mr FORWOOD — We did with smoking.

Dr BROOK — We look at rates of smoking reduction.

Ms PIKE — Yes, we look at rates but we do not necessarily look at deaths, directly.

Dr BROOK — I think the other difficulty with the 1400 number — I do not choose to disagree with it but I have not actually seen the working that lies behind it — the difficulty with projections of death rates from, say for example, obesity, is that there are common risk factors associated with many diseases. So heart disease may be influenced by obesity but much more influenced by cigarette smoking. So those things do cause some issues.

The CHAIR — We are all very interested.

Ms PIKE — Yes, and can I also say that part of what we are interested in doing also is supporting research that does help to define those measures that are meaningful and appropriate. I agree that we do have to be able to evaluate the success of what we are doing. It is appropriate.

Ms FAULKNER — I just want to speak in defence of the existing measure. The strategy is to try to engage communities and community agencies in activities to try to encourage physical activity and better eating patterns, as the minister described in Colac. If we can actually get a percentage of the agencies in an area that has been targeted — we are targeting areas because usually obesity is a problem of less fortunate communities, so we can target areas where obesity is more prevalent. We are looking to try to get a large number of the agencies in that community engaged in the physical activities strategies, such as the walking school bus and so on. It is one of those that Chris described, that it is on the way to getting a better measure but it is a good interim measure.

Mr RICH-PHILLIPS — Have you identified all the areas that you will be targeting?

Dr BROOK — We will have to take that on notice. I am happy to provide you with the specific list of measures subject to ministerial approval, because we can provide you with the health component but there are others. We are looking also at what people are doing. Obviously we are not wishing to duplicate what VicHealth does or what anybody else does. Can we take that on notice and come back to you with that?

Mr RICH-PHILLIPS — Thank you.

The CHAIR — By way of supplementary comment, particularly in relation to the secretary's defence of the performance measure, Bicycle Victoria has a fabulous initiative in Shepparton that I am sure they would be only too happy to share with members of the department, not just the minister.

Ms ROMANES — I want to ask a question about departmental funding, which is not such a lively topic, but which is mentioned on page 12 of budget paper 2. There the new departmental funding model is outlined, and it highlights the fact that government has developed this model to better drive productivity growth and achieve improved policy outcomes and that it replaces the former productivity dividend. How will this new budget funding model impact on the health sector in 2004–05?

Ms PIKE — Thank you, Glenyys, for that question. The new funding model for departments is a fundamental reform to the arrangements which will assist us in fulfilling our policy outcomes and also drive productivity growth. You mentioned changes to the productivity area, but there is certainly no intention to move away from working towards greater levels of productivity.

The new model will make a difference to our hospitals and give them a lot greater certainty with respect to their funding. It removes the 1.5 per cent required productivity dividend which was in fact first introduced in the mid-1980s, so it has been around for a long time. We will still expect appropriate levels of productivity, but the new model adopts a more sophisticated approach to allowing hospitals to take account of their own individual circumstances and to realise productivity themselves. We have also improved the whole sustainability of funding through our increase under the financial sustainability model, which will provide in particular a higher level of growth in the non-wage area, which has been the area where there has been the greater number of issues. So we are going to give hospitals greater certainty in that non-wage cost area. We believe our department has been very supportive of the new funding model. We think it will actually help the health sector, and it will certainly help the hospitals. Lance Wallace might want to make a comment.

Mr WALLACE — The main issue is the removal of productivity, but the only other relevant factor is the way that indexation is applied. Under the previous budget model there used to be a delay in the way that indexation was applied, so indexation on operating costs was applied to prior years and not the current year's estimate of operating expenses. If you are an organisation that is not growing, it does not make a lot of difference whether the index is applied to current funding levels or not, but if you are an organisation that is growing rapidly with demand in health, it makes a lot of difference when you apply the indexation on the current levels of spending. So that is also very advantageous to the health system.

Ms ROMANES — Can you clarify at what point the indexation is actually applied?

Mr WALLACE — Yes. The indexation was applied on DTF's assessment of the current CPI rate as determined in the budget, and it was applied on the prior year's levels of supplies and consumables, whereas the previous model was applied on levels of four years ago. It is a technical matter, but the main impact is that it does provide significantly more funds for hospitals.

Mr FORWOOD — Minister, I turn to the issue of the $90 million non-clinical support services tender that was awarded to the Spotless Group for the Alfred hospital catering and cleaning contract. You would be aware that Bayside Health's lawyers, Phillips Fox, wrote a letter on 13 February to the contracts and compliance manager at the Alfred and raised a number of concerns about what was happening, and finished the letter signed by senior partner, Nigel Preston, by recommending that the tender process be abandoned. Subsequently, of course, it was not abandoned, and the tender was let to Spotless.

I would like to know what process was followed once Bayside's own lawyer had written a letter recommending that the tender be abandoned. Did someone take this to DTF, because part of the advice indicates that the tender was not in compliance with particular parts of the tender guidelines? I am interested in the process that was

followed once the flag had been run up the flagpole saying, 'Hey, we've got a problem'. What process was followed that left the contract going ahead in the way it did?

Ms PIKE — Just to provide a bit of background on this, in fact the tendering out of cleaning and catering, security, patient movement and ward support and all those other non-clinical services was undertaken in 1997, so the process of tendering out those services is not new and has been in place for a long period of time. The staff who provide those services to the community at Bayside Health are therefore not the employees of Bayside Health, they are the employees of the agency that is contracted to provide the clinical support services.

The Tempo Services contract, as you have correctly identified, was due to expire in December 2003, and Bayside tendered, as it should and as is appropriate. These are externally provided support services, and, of course, the whole original intention of tendering out services was to get good value for money within the appropriate criteria. That process was undertaken, and, as we know, the winning tenderer in that process was Spotless. Bayside Health signed a contract with Spotless on 23 February.

The reason this has come to light or has gained more public attention is because the Health Services Union of Australia has lodged a notice of industrial dispute in the Australian Industrial Relations Commission. It has been concerned that there have been changes to the utilisation of some staff and that that is its responsibility, and therefore this matter is now before the Australian Industrial Relations Commission, and since then the matter has moved to the Supreme Court. The matter is before the courts, so there is some difficulty in making expansive comments about the matter. These processes are undertaken by the board. It is its responsibility to make sure it complies with the appropriate tender processes, and we have certainly received advice from the board that it has followed the appropriate processes it is obliged to comply with.

As far as I am concerned, my responsibility is to be assured that that has happened, and to that end I have asked the department for further advice on the matter to assure myself that it has in fact followed the appropriate process. But it is important, and you have raised important issues about process. This matter has become muddied because of the involvement of the union, whose concerns are more about employment of staff, whereas the questions you have raised go to the heart of the process, which is, of course, the area that I have to assure myself of.

Mr FORWOOD — Thank you for that. I leave to one side the issue of the health services union's process, and I make the point that the contract was signed 10 days after the legal advice, which was very quick. I must say that I am concerned that there would be such haste after receiving a letter like the one that Phillips Fox wrote.

I must say that I am concerned that there would be such haste after receiving a letter like the one which Phillips Fox wrote. In particular, one I am interested in is whether or not DTF, which had responsibility for tender guidelines and compliance in these issues, was involved in that 10-day period and whether it was possible — —

Mr SOLOMON — I do not know why they would be.

Ms PIKE — They would not normally be involved in every single tender.

Mr FORWOOD — Every single tender, Minister, is $90 million, and not everyone gets a letter like this.

Mr SOLOMON — I suppose you need to step through the stages of the process because the way it is being presented is that it was signed — I think you said that it was signed within 10 days of the legal advice.

Mr FORWOOD — That is what the minister said.

Mr SOLOMON — Sure. What I am saying is we need to step back. The implication is the process started then, but the process started well before that. So if I can go through the process for you — that is what you are requesting — the tenders closed on 24 October last year. The recommendation for short-listing was made to the board on 11 December last year. The board determined that the short-listed tenderers, being Tempo and Spotless, should be asked to examine their bid prices — that is standard practice under DTF guidelines. Following the process a further recommendation was made to the board on 16 January — again, this was before the legal advice — proposing that Spotless be selected. On 4 February, after the decision had been made by the board and all matters had been considered, Tempo requested that Bayside reopen negotiations.

Mr FORWOOD — On what basis?

Mr SOLOMON — Exactly! On what basis? Bayside Health then said that it would be a breach of DTF guidelines to have gone through all that selection process and just say, 'We will reopen negotiations', so a decision was made a long time earlier than when the contract was signed. My understanding is that it was after 4 February in response to what Tempo had asked — you know, 'fair process, let's get some legal advice on it'. The advice is ultimately, like all legal advice, a contentious interpretation of a clause. So Bayside was basically saying, 'We have gone through this whole process of selection; it would in fact be a breach of this selection process if after all this we then reopened it'.

Mr FORWOOD — That is not what the legal advice suggests, though. It does not suggest reopening. The legal advice is that the tender process should be abandoned.

Mr SOLOMON — Then you would have to reopen the tender.

Mr FORWOOD — No.

Mr SOLOMON — Yes, you would, because Tempo's contract expired on 13 December 2003. So how else would you — —

Mr FORWOOD — Under the Department of Treasury and Finance guidelines you have the capacity under clause 1.23, from memory, to terminate the tender process and enter into private negotiations with either of the tenderers.

Mr SOLOMON — That is what happened, and then a selection was made. What Tempo was asking was to reopen negotiations with both parties, and the DTF guidelines essentially say you can only do that if negotiations with a third party have broken down, which they had not.

Mr FORWOOD — I do not want to go too much further on this, but I am interested in the DTF aspect of it.

Ms PIKE — I have said that I have sought further assurances from the department about this particular matter that is with Bayside, and when that comes to light I can provide more information.

Mr MERLINO — I refer to page 277 of budget paper 3 and the recruitment of general practitioners. Could you please provide some further information about this new initiative to put more GPs into community health services?

Ms PIKE — Certainly. In fact we do have some additional funding in this budget to try to address this issue of the decline of general practitioners within community health services.

Community health services provide very vital primary health services for many Victorian people, particularly disadvantaged Victorians. That is why we believe we have to do everything that we can to enhance the whole program of general practitioners within community health centres, so we are using this funding to create formal links with existing private general practice services, to establish new GP clinics in community health services, and to help community health services to go out and recruit GPs. The way that they can do that is often by offering administration-type support such as better billing services, more use of information technology, introducing and providing technology such as electronic prescribing — all of those kinds of areas — plus, of course, strengthening the arrangements between general practice and the other kinds of services that people can be referred to that are within the community health service like the ancillary services, the allied health services.

The decline in bulk-billing is causing significant difficulty for certain members of the community, and often community health centres have been the only place where people can continue to have bulk-billing services. We therefore believe it is very important that we do everything that we can to drive the availability of general practice services, bulk-billing services, freely available services, to our network of 100 community health services that are within the Victorian community.

Mr CLARK — My question relates to the problems that arose earlier this year with Intragam P. As you will be aware, Minister, a national shortage developed, and on 12 March Dr Brook issued a memo stating among other things that health services and/or patients also have the option of purchasing Sandoglobulin, the CSL replacement product from hospital and/or individual budgets. My question is: when did the National Blood Authority first warn the department of the impending shortage? When did you become aware of it yourself? Did

you support the proposal that health services and patients should purchase Sandoglobulin as a replacement from their own budgets, and what action did the department and you end up taking to overcome this problem in the current financial year and at what cost? What provisions have you made next year to ensure there is no further move to impose the cost of these treatments on individual patients?

Ms PIKE — Dr Brook is our representative on the National Blood Authority strategy. His role was absolutely critical in this area, so I will ask him to comment.

Dr BROOK — This is a complex issue, so I warn you that we will go through a longish explanation. We need to begin with the understanding of what Intragam P is and how it is derived. Intragam P is a propriety product, which is produced by CSL, made from human plasma which derives from voluntary blood donors. It is exclusively produced from Australian plasma from voluntary blood donors. It is an intravenous immunoglobulin which is a mixture of proteins and antibodies. It is generally used by people who do not have antibodies themselves, either because they were born without the ability to produce antibodies or because they are receiving treatments, for example, for cancer, that harm their capacity to produce them.

It is used for a range of fairly elastic uses, generally for people who have neurological problems of a chronic type that cause loss of nerve conduction, therefore loss of muscle power. There are other uses. There are many potential uses of this substance.

The plasma that is collected for the production of Intragam P is collected by the Australian Red Cross Blood Service, which is now a national entity. All governments now have a single contract with the Australian Red Cross Blood Service through the National Blood Authority. The first point to make is Victoria does not have a direct contract with the Australian Red Cross service to produce plasma. It is a national contract delivered through a national authority, and a single national agreement. That plasma can either be collected through specific plasma collection where you hook somebody up to something akin to a washing machine and suck up their plasma and put the red cells back into them — that is the technical description — or through the collection of whole blood where the Red Cross takes off the red cells, keeps the plasma and sends it off to CSL.

Every year we increase the amount of plasma we get from the Red Cross but there is a natural and practical limit to the ability of the Red Cross to produce plasma, and indeed there is a further natural and practical limit of the ability of the Red Cross to increase plasma production each year. We have been increasing plasma collection each year for many years, and indeed CSL has in turn been increasing the yield of its product called Intragam P, so that we have more Intragam P, or intravenous immunoglobulin, than ever.

National blood funding arrangements, until this issue arose in Victoria, only ever covered voluntary blood donations collected for direct transfusion purposes or for blood products derived from voluntary blood donations processed by CSL. There are very sound reasons for why we rely on what is called a self-sufficiency policy, including perception of quality and safety as well as reality of quality and safety and the imperative of maintaining a voluntary blood donor system. Over time, however, demand for or at least use of intravenous immunoglobulin in a number of Australian states has exceeded supply, so limitations have had to be put on the amount that can be used compared with what some people would desire but not necessarily what is ideal. This is one area where we have limited clinical guidelines, if I can put it that way, so it is hard to be absolutely certain about what this should be used for, how much should be supplied and when. The management of the available supply of Intragam P is conducted on our behalf by the Red Cross, so the Red Cross gives the plasma to CSL, CSL produces the refined product, the Red Cross then manages the supply on our behalf. In every previous year, despite the fact there have been variations in supply and potential shortfalls, it has been possible to manage within the existing supply.

To turn to the specifics of your question, it was in late 2003 that the newly formed National Blood Authority produced for the first time ever data that told us what was happening in terms of the actual supply and use of intravenous immunoglobulin. It is important to say that because none of us had ever had this data before. We were never part of that management chain, and indeed are still not part of the management chain in terms of practical use. We looked at the data and asked for further analysis to be conducted and further information to be brought back to us, which happened. Again, it looked as though we may in fact have a shortfall so we therefore, along with people in other states, asked the Red Cross to look to its utilisation, to restrict use to what are called category 1 patients — I will not go to that in detail here — with the expectation that we would arrive at the end of time with what had happened in every previous year, and what happened indeed in New South Wales for an exactly similar shortage.

In Victoria's case, for whatever reason, that result was unable to be achieved, and we hit a short period where there was in fact a shortfall of the product. As soon as we were notified about that by the ARCBS Victoria we issued a circular to hospitals advising them that there was a problem, and at the same time, but before that had happened, we were already in negotiation about what to do as an alternative. It is not as if something happened and we then responded. There had been a protracted period, or some weeks at least, of being concerned about this, entering into negotiation about an alternative, but without the ability to supply additional Intragam P — so that was not available to us.

As a result of those negotiations what has now happened is that the national blood funding arrangements allow for imported intravenous immunoglobulin. It is not called Intragam P. As it happens there is only one product on the market; it is marketed by CSL; but there could be other products on the market in the future. The product we have purchased now through the national blood funding arrangements — this was never previously possible — called Sandoglobulin, has been supplied in significant quantity to the Australian Red Cross Blood Service Victoria. We set aside just over $2 million for the purchase of that product. In fact that has not had to be used. So it shows there is fairly significant variation in the use of the product and that we hit a shortfall. We had begun negotiations to try to obtain new product and that was obtained, but the benefit was that it became part of the national blood funding arrangements.

That same arrangement will continue next year and every year in the event that there continues to be a shortfall of intravenous immunoglobulin as compared with prudent usage. In terms of prudent usage we have established an intravenous immunoglobulin user group with the full cooperation and participation of leading clinicians, who are generally haematologists, oncologists, neurologists and endocrinologists — they being people who are concerned about the various kinds of illness that lead to this. We have already seen that the usage of it is looking closer to the available supply. People do prefer Intragam P to Sandoglobulin, there is no doubt about that, but you cannot make more of something than you can make.

We are increasing again the amount of plasma that the Australian Red Cross Blood Service will collect next year, but it may well not meet demand for intravenous immunoglobulin. The contentious issue in some people's minds is why was it said that hospitals and/or individuals may purchase the product? You have to reel back slightly. I have said that for the first time ever, because of this shortfall, we obtained authority essentially from the commonwealth, which provides the majority of funding for the national blood agreement, to include imported product on the national blood funding arrangements. Prior to that it has been the case that hospitals have had from time to time a reason to purchase the Sandoglobulin, much more so in New South Wales than in Victoria, because that is the way you purchase something which is a biological substance used for clinical purposes, like a drug. We have to be a bit careful about definitions here, but that is the way it has happened. In the private sector the public hospital funding system does not apply, so ultimately if a person was in the private sector they would have to purchase it somehow individually, and funds do not cover it. So the purpose of the memo we sent was merely to inform people of the facts of the situation.

We moved, I believe, extremely quickly to make sure we had a guarantee of supply. We said so to the clinicians when we met with them even before this became a very public issue, and we fulfilled that within days. I am happy to answer any further questions, but I think that is as comprehensive explanation as I can reasonably give.

Mr CLARK — A very thorough explanation, and I thank you for that. I suppose the remaining issue is why there was not a decision made earlier on in the process that you would not be looking to have individual patients pay to meet the purchase of Sandoglobulin, given that these difficulties were seen to be arising.

Dr BROOK — That would never have happened in relation to the public hospital system. It would only have happened if a patient had been a private patient receiving treatment privately. The vast majority of people receiving this drug do not receive it privately, but there are some who do. That would be a decision the doctor and the patient would have to make. There is always a default position, which is if it is a lifesaving or urgently required treatment, it is provided through the public hospital system, so we would have anticipated that there would have been some shift. But, as I said, that would be the very small minority of patients concerned.

The only way in which it could have been funded, other than through the national blood funding arrangements was for hospitals to purchase it like they would purchase any other product. The issue that seems to have arisen then is the means of communication. There seems to be concern that we let hospitals know by circular. Well, that is a pretty normal thing, so I cannot comment further on that.

Ms GREEN — Minister, I refer you to page 278 of budget paper 3. Could you advise the committee how the funding for the child dental health initiative will be spent?

Ms PIKE — This year's budget contains the largest-ever range of initiatives in the public dental area since the commonwealth changed the arrangements in 1996 and withdrew its support for public dental care right around the country.

The government has provided significant additional funding for public dental health for adults by removing a number of people from the waiting list because of the provision of care, but we have also had a range of child dental health initiatives. The 2004-05 budget allocates an additional $6.1 million for a child dental health initiative. This includes $3.45 million, or 26.8 over four years, to increase access for preschool children to dental services, and also to reduce the time between checkups for primary schoolchildren attending the school dental service. This initiative is going to reach 77 000 preschoolers and 75 000 schoolchildren over the next four years. The real focus of this will be on oral health promotion, and we are also particularly targeting children from disadvantaged backgrounds.

The other initiative, which is a very important initiative, is that the government is making $1.9 million of funding available in 2004-05 to extend fluoridation of water in certain communities. Members of the committee will be aware that there are still some areas in Victoria where the water is not fluoridated. This is a very significant thing that the government can do to increase the dental health and enhance the dental health particularly of children in those communities. Research shows that children who live in communities where the water is not fluoridated have a much higher level of decay than children who have fluoridated water.

The other part of that mix will be the provision of $3 million over four years to reduce the shortage of dental professionals particularly in rural Victoria. We will do that by supporting professional development, working to retain and mentor new graduates and providing scholarships.

Of course we continue to seek the provision of additional dental places within our dental schools, that being a matter that is within the commonwealth's responsibility. We do need to train more dentists in Australia, but we also need to train other dental professionals — that is, dental therapists, hygienists et cetera. This is a very major initiative and one that will have a positive impact on the health and wellbeing of children. It is a preventative early-intervention strategy, and I think it is a very good one.

Mr CLARK — Minister, I refer you to a memorandum from Mr Andrej Zamers to the Premier, dated 3 November last year, which has come into the public arena. Amongst other things he said:

> There is a reported widespread view amongst other hospitals that the management task has become unachievable because demand and costs are now unreasonable. The price review being undertaken from DHS, DTF and DPC is the major factor keeping them on board.

You have touched on this price review in some of your remarks so far, and I think it has been referred to in the budget papers. Can you inform the committee what the current status is of this review and the expected time lines for it? Can you give the committee an outline in broad terms of what parameters you are looking to include in this new pricing model?

Ms PIKE — The price review has been completed. The outcome of the price review has been reflected in the $1.6 billion increase in funding to our public hospitals over the next four years. We worked closely with the Department of Treasury and Finance on two major initiatives that would address the financial viability of the hospitals. One was the governance review, which I have spoken about. It is about strengthening financial performance and accountability within our hospitals. Shane Solomon oversaw a price review, which basically analysed a whole range of procedures within our hospitals and looked at the varying components of funding — that is, funding for staff and funding for a whole range of areas — and really analysed very closely and in a great deal of detail what was the price that we needed to pay particularly for the non-wage areas such as pharmaceuticals, medical equipment and all of those areas. We work to make sure that our pricing levels adequately reflected the growth in cost in those areas. So that has been the pricing review. Shane might like to add a few more words to that.

Mr SOLOMON — The outcome has three elements to it. In terms of benefits to hospitals the first element is one of increasing base price. I guess it addresses an historical shortfall. That is a one-off but ongoing increase in price. The second element is a change to non-salary indexation, recognising particularly that medical

surgical supplies and pharmaceuticals grow at a higher rate than CPI, so it acknowledges that in the new indexation arrangement. The third benefit to hospitals is an end to the productivity dividend, which last year cost about $48 million.

Mr CLARK — Were there any broader structural changes?

Ms PIKE — The other component to the price review was an adjunct review. That was a review of the paediatric cost weights where we worked closely with a group of service providers in the paediatric area and analysed every single procedure and adjusted the weightings. That has resulted in a $10 million base-level increase, and of course ongoing higher rates of indexation for the provision of paediatric services right across the state. What was the other part of your question?

Mr CLARK — Were there any broader structural changes? For example are hospitals now going to be funded for the cost of replacement of some medical equipment under the leased model depreciation et cetera? I suppose the other question is: has the new model been released publicly as yet?

Ms PIKE — Regarding the first part of the question, no. The hospital equipment program is funded in two ways. There is an allowance within the base-level funding for hospital equipment replacement. There is also an additional capital amount made available on an annual basis for equipment of a one-off, more expensive type on an application basis. The other part — —

Mr CLARK — Has the model been made public and, if not, when will it be made public?

Mr SOLOMON — There have been presentations of the model to hospital CEOs and boards.

Mr CLARK — Will the model be made public?

Mr SOLOMON — In the policy funding guidelines — when you say, The model', it is an expenditure review committee (ERC) decision and review, so the policy funding guidelines will give effect to the model.

The CHAIR — When will they be issued?

Mr SOLOMON — On 30 June.

The CHAIR — Minister, I thank not only you personally but also your staff and departmental officials for your attendance here today. It has been extremely helpful. Before we officially close, there are two comments: One is that I want congratulate the department on the quality of its response to the estimates questionnaire. I am conscious that there is a considerable amount of work done around this time of the year both for the budget and for the Public Accounts and Estimates Committee, so we do appreciate that.

We flagged in our budget outcomes report that there were some matters requiring follow-up from DHS in relation to WorkCover. We raised with another minister earlier some outstanding follow-up questions, so we would appreciate those being returned as soon as possible.

Thank you again, and thank you also to Hansard. We appreciate their attendance. You will be provided with the *Hansard* transcript early next week. Thank you and good afternoon.

Committee adjourned.