

# PROOF VERSION ONLY

## STANDING COMMITTEE ON ECONOMY AND INFRASTRUCTURE

### LEGISLATION COMMITTEE

#### **Inquiry into the impact of the carbon tax on health services**

Melbourne — 19 February 2014

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Secretary: Mr K. Delaney

#### Witnesses

Ms F. Diver, deputy secretary, and

Ms L. Price, director, capital projects and service planning, Department of Health.

**Necessary corrections to be notified to  
secretary of committee**

**The CHAIR** — Good evening. I would like to welcome you both here and thank you very much indeed for coming out on what has turned out to be a very wet evening. I realise that it is an unorthodox time, but thank you very much indeed for being here with us this evening. I have some formalities to read through, and then we will begin proceedings.

I declare open the Legislative Council Economy and Infrastructure Legislation Committee public hearing. This hearing is in relation to the inquiry into the impact of the carbon tax on health services. I welcome Ms Frances Diver, deputy secretary, and Ms Leanne Price, director, capital projects and service planning, from the Department of Health. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Legislative Council standing orders, therefore you are protected against any action for what you say here today, but if you go outside and repeat the same things, those comments may not be protected by this privilege.

All evidence is being recorded, and you will be provided with proof versions of the transcript in the next couple of days. I ask you to begin by introducing yourselves. Once again I welcome you here today.

**Ms DIVER** — Thank you for the opportunity to present to the committee. My name is Frances Diver. I have broad responsibility for health service performance across the system. That includes funding, quality, capital and a broad range of issues in relation to hospitals. My colleague Leanne Price is here with me today.

**Ms PRICE** — I am the director of capital projects and service planning. The title says it all, but I am responsible for the capital program in health, including asset management and the property portfolio.

**The CHAIR** — Thank you. If you could begin your presentation, we would most welcome it.

**Ms DIVER** — Thank you very much. I have about 10 slides to give you an overview of where we are in terms of our action on dealing with the impact of the carbon tax. I will just take you through them.

#### **Overheads shown.**

**Ms DIVER** — Just to be clear at the outset, the health system in Victoria is broader than just public hospitals. My main responsibility relates to public hospitals and health services. The carbon tax impacts the private sector, but I am confining most of my comments to the public sector.

There are 86 entities across Victoria broadly spread across rural and metropolitan regions. Probably the most significant part of the spread of our services is that there is a range of size of services, from very large services to very small services. We undertake monitoring of environmental and energy performance across all of our services, and we have a system to monitor that for about 115 campuses. We have 86 entities, but some entities have a number of campuses. A good example of that would be Monash Health; it is a single entity, but it has a number of major hospitals, including Monash Medical Centre, Dandenong and Casey et cetera. We do have a system to monitor the energy performance in each of our campuses.

The Victorian public health services use 4.4 petajoules of energy. There are an awful lot of zeros after that — 15 zeros. That is a petajoule. Generally you would say we use a really large amount of energy. About a quarter of the Victorian government energy use is for public health services. Obviously there is a mix of energy, including electricity, gas, LPG, diesel and solar. The carbon intensity is variable in each of those kinds of energy that we use. There is a different mix of energy use at each of our agencies.

Another comment on energy use in the public health services is that one of the particularly important issues is security of supply. There is a pricing issue and there is a mix issue and there is carbon intensity, but prominent for us is the security of supply in terms of continuity of services.

What are we doing in terms of energy efficiency in the health sector? We are doing a number of things, particularly in our existing facilities. A range of initiatives have been undertaken to improve energy efficiency within our existing infrastructure. Those are undertaken mostly locally, but at times they are funded by government programs — the Rural Capital Support Fund, for example and infrastructure works. Health services will assess on its merits any business case that can improve energy efficiency, and there are a range of things that have been undertaken. We have solar panels in Echuca, I think it is, and the other panels are in Yarrowonga. That is energy efficiency in existing facilities. We then go to cogeneration. We understand that public hospitals

have the largest amount of cogenerated energy in Victoria. That assists us with continuity and security of supply as well as with efficiency and price.

Capital works is also a really important part of energy efficiency across hospitals. In our development of business cases and our budgeting for new capital works we have a standard allowance for sustainability initiatives that ensures that there is capacity to undertake sustainable design and construction. We also have 80 practices that are standards that are provided to construction companies and designers, and they are required to comply with them when they are approaching the design and development of new facilities.

Regarding environmental management planning, the last area there is about our capacity to monitor and measure health service energy performance. We use a range of indicators, and we are also in the process of acquiring a new software system so that we can have regular reports from the vendors or the retailers that provide the energy for our health services.

In terms of what has been achieved, this is a graph of our energy efficiency indicators. They are gigajoules. We have a couple of measures there. That is according to bed days, according to square metres — that is, the physical area in a health service — and separations. Bed days is a proxy measure of activity in hospitals. Separations is another measure of activity in hospitals. A separation is really just an admission. A patient might be in there for one day or five days, but that is considered one separation. From 2005–06 to 2012–13 you can see that our efficiency has improved on a square metre basis and on bed-day use.

I will now move on to VAGO. VAGO undertook an energy efficiency audit and made a range of recommendations in relation to energy efficiency across the health sector. The first two recommendations were specifically directed to the Department of Health. The last recommendation — we have grouped them — relates to the Greener Government Building program. The Department of Health accepted the recommendations from the VAGO report. In general the VAGO report, as an overall comment, pretty much said that there had been a lot achieved in health in terms of improving energy efficiency, but that more could possibly be done. It made some recommendations to ensure that we were able to optimise improvements in our energy efficiency.

One of the recommendations was around measurement of energy efficiency and reporting energy against a wider range of measures. That has been instituted. VAGO was critical of using just separations. We have added bed days and square metres to our measures. There was also some criticism, or a recommendation I should say, that we should have guidelines; and we have reporting guidelines which I am happy to table here. We have issued reporting guidelines to health services.

In relation to the development of a portfolio energy data management system, we are in the process of procuring a software solution that will enable us to have data on the energy performance in our individual agencies. That then provides us with the opportunity to benchmark an individual agency's performance with similar sized services.

The next recommendation is focused on getting a more strategic approach to our energy efficiency, and the department has produced some guidelines around that. We have produced guidelines that cover off our roles and responsibilities: so the separation of what is the role and the responsibility of the department, and what is the responsibility of individual agencies. We were also encouraged to, or it was recommended, that there be a more strategic approach to implementing the greener government buildings program, and we released guidelines on energy performance contracting, which we can also table.

There are also three recommendations that relate to the greener government buildings program, and we have acted on those recommendations with more extensive interaction with DTF, with industry and with health services. We have progressed under the greener government buildings program with two services — Austin and West Gippsland — with energy performance contracts in place; and the work has commenced on the design of the energy improvements. We have a further 10 health services for which a tender was released to support energy performance contracts being put in place in those services.

In terms of the cost of energy, you can see the graph shows the total energy usage across the top — that is the blue line. You can see the cost going from 2005–06 through to 2012–13, and you can see that there has been an incremental increase in the cost of energy across the health system. The colours on the graph relate to natural gas, LPG, steam and electricity; and what you can see from that graph is that there was a significant increase in cost in 2012–13.

We had undertaken a piece of work by SKM, Sinclair Knight — —

**The CHAIR** — Merz.

**Ms DIVER** — Thank you: I only know them as SKM; so SKM had undertaken some modelling for us. That modelling indicated that there was expected to be an approximately \$13 million impact on the cost of energy for health services. We were then in a position to collect the information from health services' invoices and determine what the cost actually has been. It turned out to be very close to what was forecast, so it is \$13.5 million. That is not a forecast number; it is actually off the bills. There is an example of Bendigo's bill, and you can see there that the carbon charge is actually itemised. We have had an audit of the invoices from health services to determine what the impact is. A small amount of that \$13 million — about 14 per cent — was forecast based on historical data, but the majority of it was based on actual invoices. I can table the impact on each of the individual services — that is, the results of the audit.

That was the cost. The other terms of reference relate to the benefits of repealing the carbon tax, so for us there is an assumption that the costs that are currently incurred as a result of the carbon tax would be removed. We expect a reduction in energy costs of around \$13 million assuming that those savings are directly passed through. Whilst we are not sure of the details of the direct action programs that have been proposed by the commonwealth government, obviously we will be very interested to see if there is an opportunity to access funding through those programs to support health services in improving their energy efficiency.

**The CHAIR** — Thank you very much indeed. Could we have a copy of those slides?

**Ms PRICE** — Yes, they have been provided.

**The CHAIR** — Thank you very much indeed. Could you give me some indication of what you would get in the hospital system for \$13 million? How many beds would you get?

**Ms DIVER** — Probably a good way to describe it would be an elective surgery case, which we usually say is about \$5000, so \$5000 would buy you one elective surgery patient. That means that \$13 million is — if I just do my maths very quickly: \$10 million divided by 5000 is 2000. If someone can do the maths for me — we will do the maths, but it is 13 million divided by 5000 per case.

**The CHAIR** — Thank you very much indeed. That just gives us a relative cost.

**Ms DIVER** — Yes, just to give you a sense.

**Ms PULFORD** — Thank you, and thank you for the breakdown. That probably saved us a whole lot of questions that we were ready to ask you. Thank you very much for the presentation. The national health partnership agreement between the commonwealth and Victorian government was negotiated with projected growth in expenditure in the health system. Is that more or less than \$13 million?

**Ms DIVER** — I think you are probably referring to the national health reform agreement, and you are referring to the indexation that is provided by the commonwealth to the state. Previously there was an SPP — specific purpose payment — that the commonwealth government provided as their contribution to the cost of delivering public hospital services. The national health reform agreement has now replaced those arrangements under the specific purpose payment, and we now have the Independent Hospital Pricing Authority that provides a determination of what the indexation arrangements are for hospitals. A final determination has not been made for 2014–15, and, from memory, the determination for this financial year was around 4 per cent. It gets a little bit complicated because we have gone from a block funding model through the specific purpose payment to an activity-based funding model, and that activity-based funding model will have an impact from 2014–15.

It is a very complex environment because we are moving from one funding system to another funding system. The key issue would generally be health price, so the ABS would declare the price increases in health. The most recent ABS indicator for health price increases is 4.1 per cent. That is what the ABS has declared. The commonwealth government contribution is less than that, and I will have to get back to you with the exact detail of what we were provided from the commonwealth. But the \$13 million increase is greater than the indexation that we received from the commonwealth government.

**Ms PULFORD** — Does the new commonwealth funding agreement — pardon my clunky terminology; the one that applied, say, for 2013 — account for other growth in costs to the health service, such as an ageing population and an increasing population?

**Ms DIVER** — The calculation of the specific purpose payment increase in funding relies on a few things. It relies on a population demographic number, it relies on a utilisation factor and it relies on a cost increase factor. Because the specific purpose payment covered both growth in services and the increase in price of services, one of the issues that we have confronting us is that under that arrangement and the new arrangement's price — so the increased cost of delivering the same level of services, just if you use that as an example — the price is based on historic costs so it uses a five-year rolling average of increased price. When there is a new cost into the system — for example, the carbon tax cost, that \$13 million — that is not accounted for in the indexation arrangements that are provided from the commonwealth.

**Ms PULFORD** — Chair, if you will just bear with me as I follow up this point.

**The CHAIR** — Yes, a final question because we are going to run out of time.

**Ms PULFORD** — Was the Victorian government seeking compensation or some additional contribution in the negotiations around that funding agreement to account for the anticipated carbon tax?

**Ms DIVER** — Correct. The minister wrote to the federal health minister at the time and also the federal climate change minister at the time. His correspondence to the federal minister for health was to seek compensation for this in terms of extra price in the indexation arrangements, and his correspondence to the federal climate change minister was in relation to allowing public health services to access some of the programs to support industry to reduce their carbon intensity, because health was excluded from those arrangements. I am happy to table those letters, if that helps. We just have not got copies.

**The CHAIR** — That would be very helpful, thank you.

**Mr DRUM** — It is quite amazing that you have been able to maintain the level of energy use in the health system over eight or so years, effectively with no discernible increase. How have you been able to do that?

**Ms PRICE** — Energy usage has gone up because I think it is fair to say that our activity has gone up. What we have tried to do is improve the efficiency of our services, so that is why the unit measures have actually fallen. The usage per floor area that was shown before and the usage per separations have decreased so we have been driving efficiency. The absolute usage has in fact increased marginally over time or kept relatively level.

**Ms DIVER** — It also partly relates to the improved efficiency that we have in delivering hospital services so that we are able to treat more patients by reducing the length of stay, increasing same-day care and the changes in model of care where we have driven significant improvements in the actual service delivery model, so it has allowed more patients to be treated within the same square metres, if that makes sense. That has also had an impact. There are a couple of things operating. There is the efficiency of the service delivery model and the use of the asset, and there is the efficiency of the energy performance of the asset, and the investments we made probably in the early years in some relatively low-hanging fruit or some of the relatively straightforward energy efficiency initiatives have shown to be effective.

**Mr DRUM** — In the slides you showed earlier we could see that LPG is a smaller but significant part of energy use in the system. Is there any way that we can reasonably and accurately cost the carbon tax on other types of energy other than electricity? With electricity it is quite simple. We just go to the bill, we tally the bills up and we come out with \$13.5 million. But in relation to LPG and some of those other forms of energy that are still critical — every hospital has a diesel back-up generator, for example — what is the cost of the carbon tax on diesel, what is the cost of the carbon tax on LPG and all the other subsidiary types of energy uses that are important?

**Ms DIVER** — Sure. I am not in a position to answer that right now.

**Ms PRICE** — We will take that question on notice. But I can say that to the extent that they are documented on bills, we definitely could identify it. It is the amount of work that would be required to get into that.

**Mr DRUM** — I am just looking for an estimation.

**Ms PRICE** — Electricity is much easier for us because a large amount of electricity is actually purchased through a single buying group so we are able to tap into that and get it from the retailers. Getting into the other sources of fuels means that we would have to go in and do a fair amount of work, so I do not have the relativity of that.

**Mr SCHEFFER** — Chair, can I seek clarification on Mr Drum's question? Are you saying that the carbon charge is only on the electricity charge?

**Ms DIVER** — What we have shown you is that it is identified on the electricity bill; it is not identified, that I am aware of, on the other invoices to health services.

**Mr SCHEFFER** — From what Mr Drum was saying, it only refers to electricity.

**Mr BARBER** — There is no carbon tax on diesel, Mr Drum.

**Mr DRUM** — But there is a cost associated with it, Mr Barber.

**Mr BARBER** — There is no carbon tax on diesel.

**The CHAIR** — Ms Price has offered to give us some clarification in writing on just this question. She will give us a breakdown of those figures on notice.

**Ms PRICE** — Yes.

**The CHAIR** — Mr Drum, are you happy about that information?

**Mr DRUM** — That is fine, absolutely.

**Mr BARBER** — It was an excellent presentation. You answered a lot of questions I was going to ask. I have a couple more arising out of your presentation though.

**Ms DIVER** — Sure.

**Mr BARBER** — That chart tells us that despite more or less static levels of energy consumption, no carbon tax and you working as a big health buying group for electricity and gas, your power bills went up 25 per cent in the five or so years; is that correct?

**Ms DIVER** — Assuming you have done the maths right, yes. That sounds right.

**Mr BARBER** — The Auditor-General said 25 per cent, and that looks like 25 per cent to me.

**Ms DIVER** — It sounds right to me.

**Mr BARBER** — Your bills have been going up a lot over those five years. The Auditor-General in the report that you referred to made the following conclusion:

The Department of Health's ... approach to statewide planning for energy efficiency is inadequate. It does not have a documented policy or plan and lacks a strategic focus and a coordinated approach. It also does not align with health services' local planning.

While there have been improvements in energy efficiency across the health system over the past seven years, the lack of an adequate planning approach has potentially limited the gains that could have been made.

He then goes on to note that in June 2012, when he started this audit and on the eve of the imminent financial holocaust of the carbon tax that we had all known about for years —

**The CHAIR** — We can do without the emotions, Mr Barber.

**Mr BARBER** — including since 2007 when the Howard government went to an election promising to —

**The CHAIR** — We can do without the emotions; just stick to the question, Mr Barber.

**Mr BARBER** — you had just then, according to the Auditor-General, developed an energy framework. When I looked at your chart and you did those measures of energy use per bed day and energy use per metre

squared, what it showed in the year since the Auditor-General made his report is that your energy efficiency had got worse, not better in that last year. Can you account for that?

**Ms DIVER** — I will just bring the slide up. I think what you are referring to here is that we have continued with the improvement in the energy efficiency and separations. The energy efficiency in the square metres has flattened and the energy efficiency in 2012–13, according to bed days, has risen slightly. There are two things at play. One is the use of bed days and one is the energy consumption. I cannot directly explain the fact that that has flattened or that bed days have increased, but the other two measures are still heading in the right direction.

I guess one of the issues in our assessment of the environment is that we made significant gains in energy efficiency in the early years, as we talked about with other initiatives. That has made a significant impact on our energy efficiency. Then we have the intention to make more investment through the energy performance contracts that we have in place with Austin Health and West Gippsland Healthcare Group at the moment.

**Mr RAMSAY** — I have a quick question, and thank you very much for your presentation. I was interested in the methodology. The only query I have is that we have only one written submission from the Colac Otway shire indicating that there is negligible cost of the carbon tax to the health services in its particular shire, and yet I look at your chart and I see that Colac Area Health has a carbon cost of \$60 019, in Lorne it is \$7444 and in Timboon it is \$6823, so it is 13 per cent, 10 per cent and 13 percent. Either Mr Small, as chief executive officer of the Colac Otway shire, is not aware of the significant cost of the carbon tax within his municipality or your figures are not accurately reflecting his submission.

**The CHAIR** — I think she is slightly at a disadvantage in not knowing what their submission is. Would you care to answer?

**Ms DIVER** — Sure. We can validate it. We have done an audit. We have collected the invoices of those individual services. They are part of the audit, we have collected the invoices and we have identified the carbon price on the invoices for those services.

**Mr RAMSAY** — I take it then that this written submission is in fact inaccurate?

**Ms DIVER** — I have not seen the submission, and I cannot comment on the shire.

**The CHAIR** — We have only just passed the submission. It is not a public document as yet, so the reality is — —

**Mr RAMSAY** — Yes, but we want to put factual information on the website.

**The CHAIR** — We can write to Mr Small. We can have a discussion about that later. This is neither the time nor the place to do that. Would you care to say anything else?

**Ms DIVER** — The only clarification that I can make is that some of the smaller health services buy energy directly off the retail market and it would be quite difficult for us to collect the invoices from them. I am saying that the \$13.5 million across the sector has been derived mostly from actual bills; 14 per cent of that \$13.5 million has been modelled as the impact based on the impact on the other services. I would need to check if Colac, Timboon and those services in that shire were from actual invoices or whether we had modelled the impact.

**Mr BARBER** — Can I just clarify that; it is very important. So some of the numbers on the spread sheet you have provided us with are actual and some are models; is that what I am hearing?

**Ms DIVER** — Correct — \$1.9 million of the \$13.5 million is modelled.

**Mr BARBER** — Chair, could we ask that another spread sheet be produced with a little ‘M’ next to the ones that are modelled?

**Ms DIVER** — Sure.

**Mr FINN** — So it could be more than \$13.5 million?

**Ms DIVER** — Yes, I guess that is true.

**The CHAIR** — Could I ask that for clarification you take that on notice? Is it a possibility that we could have that detail?

**Ms DIVER** — Sure.

**The CHAIR** — Thank you very much indeed.

**Mr MELHEM** — Just on that, when you get the bill from the electricity companies does it actually state, ‘The carbon tax is X’, or is it something that you worked out, the difference between kilojoule and — —

**Ms DIVER** — Here it is here. That is an example of an invoice from Bendigo Health Care Group, and circled there is ‘Carbon charge’.

**Mr MELHEM** — Yes, but is that from the electricity company or from the hospital?

**Ms DIVER** — That is the electricity company sending a bill to Bendigo Health.

**Mr MELHEM** — So that is exactly it, because I do not get that on my bill, so how do you get it and I do not get it?

**Ms DIVER** — My understanding is that for domestic and commercial there is a different arrangement. So domestically you do not see it on your bill, but for commercial hospitals, that is a live bill from the energy retailer to Bendigo Health. I think that is right.

**Mr MELHEM** — I am not doubting you, just clarifying.

**Ms DIVER** — That is all right. Just to clarify.

**Mr SCHEFFER** — I have a question in principle. You have described that some of your energy comes from fossil fuels and some of it could be from solar sources and some of it is CoGen?

**Ms DIVER** — Yes.

**Mr SCHEFFER** — And you are drawing a general argument that your efficiency is improving, notwithstanding the questions that Mr Barber asked. As you improve your efficiency and lower your reliance on power inputs, do you expect that carbon charge to decline?

**Ms DIVER** — Our expectation is that the carbon charge will no longer be in existence.

**Mr SCHEFFER** — Yes, I understand that, in the new world, but we are doing a rear vision in a lot of ways. We are looking at the carbon pricing system as it existed. This quantum that SKM put together of \$13 million is based on that; it is not based on a future direct action world.

**Ms DIVER** — Yes.

**Mr SCHEFFER** — In that world, where we have this quantum that you are paying, the whole purpose was to reduce the cost as you became more efficient. I am asking you to comment on that.

**Ms DIVER** — Sure. Our aim is to improve the energy efficiency so we have less energy required and therefore the carbon tax being paid will be less.

**Mr SCHEFFER** — So therefore partly it is in your hands to reduce your carbon charge?

**Ms DIVER** — The second part is that it is the mix of energy sources that we use and the type of energy sources in terms of their carbon intensity that would have an impact. So if you go from a high carbon energy intense source to a lower carbon energy intense source, then you will reduce your carbon usage and reduce how much you pay.

**Mr SCHEFFER** — So it is within the health system’s power to reduce its electricity and then the charge?



**Ms DIVER** — Yes. It is our aim to improve our energy efficiency and reduce our energy consumption.

**The CHAIR** — I can see that in the graph. Thank you very much indeed. In the information you have given us and the detail between what was actual and what was in a formula, do you have any statistics that are more recent than 13 June? Is there anything for the last half of last year? Do you just do it by fiscal year?

**Ms DIVER** — We do not routinely collect the invoices in terms of the identification of the carbon tax. We did that as a one-off exercise to determine what the impact was on the price or the cost base for health services. We do monitor health service energy use through our data systems, but I do not have more recent data than that.

**The CHAIR** — Thank you. It says here, 'Period 1 July 2012 to 30 June 2013', so it is obviously done by fiscal year.

**Ms DIVER** — Yes, that is correct.

**The CHAIR** — Thank you both very much indeed for a very comprehensive presentation and for the courtesy of giving us additional information. I thank you both very much indeed for coming tonight.

**Witnesses withdrew.**