V E R I F I E D V E R S I O N

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry Into The Impact On Victorian Government Service Delivery Of Changes To National Partnership Agreements

Melbourne — 17 November

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Ms Kym Peake, Secretary,

Mr Terry Symonds, Deputy Secretary, Portfolio Strategy and Reform, and

Ms Anne Congleton, Deputy Secretary, Mental Health, Wellbeing, Social Capital and Ageing, Department of Health and Human Services.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the impact on Victorian government service delivery of changes to national partnership agreements. All mobile telephones should now be turned to silent. I would like to welcome Ms Kym Peake, secretary of the Department of Health and Human Services; Mr Terry Symonds, deputy secretary, portfolio strategy and reform; and Ms Anne Congleton, deputy secretary, mental health, wellbeing, social capital and ageing.

All evidence is taken by this committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing, including on social media, are not afforded such privilege. The committee does not require witnesses to be sworn, but questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

All evidence given today is being recorded by Hansard. You will be provided with proof versions of the transcript for verification as soon as they are available. Verified transcripts, any PowerPoint presentations and hand-outs will be placed on the committee's website as soon as possible. Witness advisers may approach the table during the hearing to provide information to the witnesses if requested, by leave of myself. However, written communication to witnesses can only be provided via officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way.

I now give the witness the opportunity to make a very brief opening statement of no more than 10 minutes. This will be followed by questions from the committee.

Ms PEAKE — Like all health and human service systems across the country, we are facing pretty significant challenges in Victoria. Demand for public hospital services is increasing as a result of population growth, rising numbers of patients with chronic or complex conditions, new treatment technologies and increasing community expectations. We are experiencing in particular the increasing impact of chronic disease, such as cardiovascular disease, type 2 diabetes and cancers. Together those chronic diseases are now the largest causes of poor health and disability. We are also experiencing increased complexity of clients and concentrations of disadvantage, with increased demand for human services, including in the areas of child protection and family violence, homelessness, out-of-home care, disability and social housing.

The commonwealth is a really critical partner for us in meeting all of these challenges. A significant proportion of commonwealth funding for the services is being and has been delivered to Victoria via the commonwealth-state funding agreements introduced as part of the 2008 intergovernmental agreement on federal financial relations. You would be aware that there are two major types of agreements: the national partnership agreements and national agreements. National partnership agreements are really designed to support one-off capacity building and improve efficiency to meet the needs of under-serviced groups, while national agreements are designed to support the ongoing needs of the state in areas of shared interest. Both, we believe, types of agreement have an appropriate place in our financing arrangements, particularly if there is an effective collaboration between the states and the commonwealth.

NPAs are most effective when they are adequately funded and designed collaboratively to achieve reform. However, we often see NPAs that have been designed by the commonwealth with limited discussion with the states and consequently little local engagement. This limits the effectiveness of the resulting NPAs in outlining key objectives of the agreement that are reflective of this local need. NPAs are most effective when they are consistent with the terms of the intergovernmental agreement on federal financial relations, particularly when they focus on outcomes and provide the state with sufficient flexibility to allow for innovation and service delivery to be shaped to local client and service system characteristics. Well-designed national agreements have some of the same design elements in that they are stronger and more likely to succeed if they are developed in consultation with the states, agreed outputs are funded adequately and states are not constrained from allocating resources to where they are needed most.

NPAs have been most successful in achieving significant outcomes in health and human services in Victoria, and in general we are supportive of NPAs as a method of achieving reform in areas of shared interest. However, the appropriateness of NPAs as a funding vehicle in some cases does need to be questioned. For example, the NPA on home and community care has existed in one form or another since 1985. Because of this, it could be argued that such a long-term funding agreement would be much more appropriately supported via a national agreement rather than an NPA.

As a funding mechanism, when not aligned with the IGA on federal financial relations, NPAs pose risks to the state and the department that have the ability to impact on services, particularly if they are used by the commonwealth instead of national agreements to fund ongoing service delivery or if there is no provision in the agreement to support a transition to ongoing funding where required. Recent trends, including shorter term agreements, unanticipated withdrawals in commonwealth funding and limited consultation with states in their development, have eroded the effectiveness of some of these agreements.

Consequently this has had some negative implications for the delivery of important services. In particular, in recent years there has been a preference by the commonwealth to only offer states short-term agreements and for these agreements to be negotiated and finalised under very short time lines, without proper consultation. Such short-term agreements pose significant challenges to service delivery, particularly for those required to staff up and deliver the services, as they are not provided with adequate funding certainty to allow them to forward plan or support the development of their workforce. In areas such as dental health and homelessness, short-term NPAs are not an appropriate mechanism for funding what are long-term challenges for both levels of government.

A pertinent example of this is the NPA on adult public dental services. This agreement was originally announced for three years, before being reduced to a one-year agreement. In addition, there have been delays in finalising the shorter agreement, with states still waiting for the final offer from the commonwealth, despite it being scheduled to commence on 1 July this year. Changes to the duration and funding level of the agreement and failure to finalise the NPA are posing challenges for the management of Victoria's public dental services, causing longer waiting times and resulting in fewer clients treated.

The NPA on homelessness is another example of an NPA that has in recent years been negotiated as a one-year agreement, although then been subsequently renewed for a further two years. This trend has created uncertainty for the homelessness sector, generating staffing and operational issues that have impacted on the delivery of services to clients. Really more sustainable funding would help to more effectively address dental and homelessness issues, particularly by allowing, as I have said, greater forward planning, innovation and staged strategic reform.

The second challenge that we have faced is the withdrawal of funding. In recent years the commonwealth has acted unilaterally to withdraw funding from certain areas, effectively transferring responsibility to the states. For example, in the 2014–15 commonwealth budget the commonwealth unexpectedly and without prior consultation ceased the NPA on preventative health and the NPA on certain concessions for pensioner concession card and senior card holders. The commonwealth also announced that it would no longer honour the funding commitments made in the national health reform agreement, which Victoria estimates will result in a shortfall of over $17.7 billion in commonwealth funding over the next decade.

Other NPAs, such as the project agreement for Indigenous teenage sexual health and young parent support and the NPA on improving public hospital services have also not been renewed. These withdrawals significantly limit our ability to fund and deliver critical health and human services and achieve improved outcomes for Victorians. In response, the state government has been required to make decisions about maintaining the full value of programs, and has done so, maintaining the value of the Victorian concessions program and boosting health funding by 6.7 per cent in the most recent budget. Although in some cases the Victorian government has also made the decision to cover withdrawal in commonwealth funds, while we have done that, we cannot always absorb additional costs from continued withdrawal of funds by the commonwealth for key areas of service delivery.

Finally, there is a risk that is caused by prescriptive measures that constrain our ability to design services that are suitable to our service system and our client groups. We are seeing the commonwealth insert more prescriptive requirements into NPAs. With the NPA on homelessness, for example, Victoria has had to work very hard to facilitate innovation in the homelessness sector and address systemic challenges, such as family violence and entrenched disadvantage, but the evidence base for how best to respond is constantly evolving, and therefore it is important that NPAs do not lock us into a specific model of service delivery that might become outdated. Because of this, it is important that NPAs retain the flexibility to allow for innovation and service delivery responses that reflect changing need and evolving evidence of best practice.

All of that said, with recent trends in NPAs having some concerns for us, there are a number of opportunities for Victoria to continue to engage with the commonwealth to improve the way health and human services are

funded and delivered. In particular, the current work to look at the Medicare benefits schedule, the primary health care advisory group to progress primary health care reform and the reform of the federation processes are really important processes that we are engaged in. The reform of the federation process includes consideration of options to reform roles and responsibilities of commonwealth and states and territories in areas of health, as well as in housing and homelessness. Through this process we are also seeking a recommitment of the IGAFFR, which would help to rebalance the current trend towards NPAs that do not align with the terms and principles of this overarching agreement.

Specifically, and finally, we are looking to work through those processes with the commonwealth to agree a new sustainable approach to funding in critical health and human services initiatives formerly or currently funded by NPAs; to pursue reforms to governance and funding mechanisms that will foster a more community development approach to tackling social determinants of health; to improve the primary acute care interface, particularly for people with chronic disease; to transition our responsibilities for aged care and for some disability services in a responsible way, to ensure the strengths of Victoria's home and community care system are preserved; to jointly address homelessness and place funding for homelessness on a more sustainable, longer term footing; explore options to improve access to affordable housing; and more effectively share information across the spectrum of services to better inform policy development and the delivery of earlier intervention and prevention approaches. I am happy to take any questions.

The CHAIR — Thank you. I will lead off. I am just wondering, from your perspective, or from a DHHS perspective, do you think national partnership agreements work best if the federal government provides, for argument's sake, capital as opposed to funding for operational expenditure and having a division in that way, in the sense that does it better enable you to plan, I suppose, or go into an agreement with your eyes open, as opposed to saying, 'Well, the feds are coming into this space. There's going to be some operational expenditure for these targeted outcomes, these goals, objectives, but the funding is going to expire within three years time, and then we as a state have to then make a call as to either terminating that agreement and not continuing it or having to step into that breach, understanding that we might not necessarily have the financial capacity to do so'? Do you have any views from your perspective, from a DHHS perspective, as to what works best?

Ms PEAKE — Certainly. Chair, particularly in health it is really important that the starting point is that growth in demand for health services is outstripping population growth, and the practical reality is that the revenue base of the state is not well suited to meeting those growing demands. If we had that sort of division between only having capital support from the commonwealth, we would face really significant barriers to being able to meet community expectations around maintaining service levels to keep pace with that level of growth. In its most basic form, I think that we need that funding support from the commonwealth to maintain our public hospital level of service delivery and maintain our efforts in reducing waiting list times for emergency services and elective surgery.

The CHAIR — I was thinking more in terms of not taking away from what the federal government already commits in terms of that funding for operational expenditure. I was just thinking if the feds, for example, were to say, 'Well, look, the Wyndham corridor is growing at a great rate of knots. There's a growing population, there's a need for greater primary health care in that corridor. We, the federal government, will give you $1 billion to build that hospital', in addition to the normal run-of-the-mill expenditure you would normally achieve anyhow or receive from the feds. The state would pick up the difference. As a model in terms of a partnership, having a situation where you have at least got some visibility in terms of what your costs are likely to be, would that — —

Ms PEAKE — Yes. I mean, I think one of the other benefits of not having too black and white a distinction between what is funded is that often big system changes require there to be up-front investment in capacity building, workforce development, new systems which would be recurrently funded. Quite apart from the funding capacity question, to be able to do reform, which is a bit different to the normal operations, in health — again if I use that as the example, but it is exactly the same in the homelessness space — it is also really helpful for us to have both levels of government have some skin in the game, because so much of the way in which we get better health outcomes for people is making sure that we are having effective interventions in the right settings. As long as there is an incentive for primary health to not be carrying its load, we will continue to see people's problems reaching a point where they need to be hospitalised, or demand coming into the emergency department that might be better supported in another setting. One of the things you would lose, if there was only

investment in parts of the health system and in capital related to the hospital system, is that sharing of risk and sharing of incentives to make sure that the whole health system operates effectively.

The CHAIR — I will just pursue this a little bit more, if I may. Going into the future then, in light of the proposed funding cuts from the federal government, how do you see that unfolding? If the feds did start saying, 'Look, we are leading the field in some of these areas of endeavour and we're winding back those NPAs', do you anticipate then that you might, for example, have a negotiation between the state and the federal government where, for example, in relation to homelessness there is still a need and the state does not have the capacity to fill that need, so rather than having the feds on the hook via an NPA there might be some other form of funding available for that discrete project or for a particular plan? Is that sort of where you think it might go?

Ms PEAKE — Certainly we have not given up on the negotiation on funding continuing, but certainly we are very keen to keep working with the commonwealth about what is best to invest in, what are the interventions that work and where there has been investment in innovation and reform, and it has proven to work, how does that translate then into national agreements and ongoing recurrent funding to meet demand. So to your question, the relationship between reform investments and ongoing operational support is, we think, a really important part that the current architecture of federal financial relations should support and does not always in practice support effectively.

Mr MORRIS — So many issues, so little time.

The CHAIR — Where do we start?

Mr MORRIS — There are several rabbits to follow down that burrow, but I will try to restrict myself. Firstly, congratulations on your appointment.

The CHAIR — Hear, hear!

Ms PEAKE — Thank you.

Mr MORRIS — I am just interested in pursuing this whole question of the federal contribution to the space. You gave two examples of NPAs that are no longer active — preventative health and improving hospital services — and you also talked about HACC in terms of it perhaps not being appropriate for an NPA, all of which is really a bit outside of what we are looking at. I am not trying to put words in your mouth, so if I am not accurately representing you please say so, but the way I heard it the first time was that preventative health and improving public hospital services are things that should have been continued but the federal government elected to have those programs terminated. So effectively that is a policy decision on behalf of the commonwealth. I guess it is their right to make those sorts of decisions, as it is our right as a state to determine whether programs will continue or not, and quite often we get screams from local government.

In government I would say to local government, 'Well, guys, you've been taking our money, you've been badging it as your service and now you're squealing because we're not prepared to pay for it anymore'. I think there is a bit of an element of that, with great respect to all concerned. We have been providing a service, which has effectively been badged as a state service, and as Mr Martine said this morning, 'Yes, the money comes into DTF and then it's appropriated', and so to that extent it is appropriated as well.

I am just wondering how we get a more productive approach in this space, because I agree with you entirely about the HACC stuff. It was well and truly running along before I was first elected to the local council in 1987. That is a very long time ago, and it should not be on a four-year basis. But with some of the other stuff I think we really need, with respect, a little more rigour around our debate too. If the commonwealth, of whatever colour, elects not to continue a program or to run a program, then it is about the framework. That is a very cumbersome way of trying to lead up to a question, and it is going to be a very broad question: the irritations aside, the issues with health funding in a more general sense aside, what do we do to fix it?

Ms PEAKE — I might answer the question by just taking a couple of those examples. If we look at preventative health, then the importance of taking a population health perspective if we are going to not only get better health outcomes in the community and have people be able to be more productive in our community but also prevent some of them the more expensive Treasury costs — and I think that the commonwealth has recognised this in recent times, that population level preventative health is really important — then it becomes a

conversation about how are those programs best delivered, how are they best funded, who is best placed to actually support those programs. I think part of the conversation that we are having through reform of the federation is exactly to some of those questions. What is the link between primary health and preventative health? If we take that as an example, it is a good example of where there is a good conversation to be had about roles and responsibilities, and we might land at a different place than we have in the past.

Without opening up all of the health funding question, if we look at just how we are going to meet the needs of our community for acute health care, then there is automatically an interdependence between the commonwealth and the states. I think we have been having some really constructive discussions with the commonwealth about the acute primary care interface and the funding support. There will be debates about the level of indexation, but there is a shared responsibility for meeting the costs of those services.

Then we come to the question about, 'What is the relationship between a funding mechanism which is looking at doing things in different ways, more efficiently, more effectively, and how inevitably there needs to be some funding support if you are going to really change the way that health services work?' through to 'How do we make sure that there is that ongoing cost sharing for what we know is going to be continued unavoidable growth in the demand for those services?'. I would argue, and I think our position would be, that NPs are a valuable mechanism for that first piece of work about saying, 'What are some different ways of managing our elective surgery waiting lists, or what are the ways that we can have our emergency departments focused on the people who really need that emergency care, and have potentially mental health or aged-care services interfacing with emergency departments in a different sort of way?'. Those spaces where there is a national interest in these models of care being developed more effectively I think really do lend themselves to a funding stream that enables learnings to be shared, but that to be done in a way that is still sufficiently flexible to be customised to local service configurations and service needs.

Dr CARLING-JENKINS — I have just got a more specific question on NPAs, around their strengths and their weaknesses, and particularly around reward payments, which I believe has been quite fraught for your department in particular. There are a couple of paragraphs, for example, in the whole-of-government response around the improving public hospital services and the way the reward payments were there and then removed, which seems problematic in itself. I just wonder if you could discuss a little bit about the NPAs having reward payments attached to them — some do, some do not — and whether you have found that useful or beneficial. For example, do they actually assist in driving improvement or were they a distraction, and were they tied to realistic and achievable goals?

Ms PEAKE — I think there is a broader discussion that is happening in public administration about how we move to more of a focus on outcomes and how we incentivise all service providers to be really pushing hard towards achieving outcomes. So I think the concept of a reward payment is a good one, though it needs to be, as you have alluded to, combined with really well defined measures and developed measures of outcomes. Part of the success of NPs is that there is that collaboration between the commonwealth and the states to define what are the right measures to focus those reward payments on. All of the agreements where there are reward payments also have facilitation payments, so that some of the up-front costs are able to be met. I think the infrastructure or the architecture that was designed in 2008, that had a component of the funding tied to driving hard at outcomes, is a logical and effective mechanism. Obviously it loses its impact when that money is then withdrawn unilaterally before the end of the agreement, and again — —

Dr CARLING-JENKINS — Without negotiation, I believe.

Ms PEAKE — That is right. Again, as I mentioned in my opening statement, one of the priorities in the negotiations in reform of the federation is really to recommit to the principles and architecture of the intergovernmental agreement on federal financial relations.

Ms WARD — How much of the funding in a NPA is allocated for data collection, analysis evaluation performance reporting, and is there any administrative overhead included in the funding for this?

Ms PEAKE — Generally the answer is no. We have certainly had one NP, which was the homelessness NP, where the state put in more than a matched amount of funding to take account of both the administration and the evaluation needs of delivering that agreement, and that was built into our implementation plan and recognised as part of our effort. But in general terms they are not.

Ms WARD — Do you think that some of the NPAs are too prescriptive and that you get too bogged down?

Ms PEAKE — Certainly we have had mixed experience in this regard. The homelessness example, I think you have already heard from other presenters this morning, moved from being a broad agreement that was based on outcomes to being quite prescriptive about the cohort, so 25 per cent of the funding to be directed towards victims of family violence, for example. As it turned out, that aligned with our priorities. But as circumstances change that level of prescription certainly does pose risks of misalignment.

In other agreements — the health agreement — we have been required to provide a biannual report on progress. It has taken it from being really an agreement which is about one level of government providing funding support to another, to more of a purchaser-provider-type arrangement, which again is inconsistent with the principles of the federal financial relations agreement.

Ms WARD — And how adaptive are NPAs to change? You have gone along a certain course and then you realise, 'Actually if we veer just slightly this way or alter this, we could have a better outcome'. Is there that adaptive ability?

Ms PEAKE — Again, it varies. So I have certainly been part of processes where there has been some flexibility for renegotiation. In all agreements there is always a review that is built in and agreed — not always then actually given effect.

Ms WARD — Are reviews done along the way though generally, or is it always at the end?

Ms PEAKE — No. There is usually a review about a midpoint of agreement, but as I said, I have been part of negotiations of agreements where once you have started it is clear that the performance measures are not practical or it is going to take a longer time, and that is agreed, or there is a change in policy by one level — the commonwealth makes a decision which makes a particular performance measure meaningless in an agreement — and there has been scope for renegotiation.

Mr SYMONDS — Chair, if I could add that the structure of many of these agreements is that the state is required to prepare an implementation plan at the beginning of the agreement. Then circumstances change during the agreement, and with approval of the commonwealth we might make modifications to the implementation plan. An example might be the national partnership agreement on Indigenous early childhood development, which had a plan for the establishment of additional Koori maternity services. We said at the beginning of the plan that we thought we could do four within this time frame and these locations, and obviously as we engage with Aboriginal community-controlled organisations and their circumstances and capability changes, we take advice from the community about where that work is best located. We make changes to the implementation plan, and the commonwealth in both cases was amenable to those changes.

Ms WARD — Is there much scope to have those conversations at a local level before you enter into the NPA?

Mr SYMONDS — I think that varies by agreement. A number of them have quite tight time frames around agreement and you put the best case that you can around an implementation plan at the beginning. Obviously there are also expectations to manage with local providers and so on. Once you have got the money and have signed an agreement it is easier, I suppose, to go and engage people with an open book and have a conversation about that.

Mr MORRIS — Can I ask a related question on the homelessness agreement. There was a fairly comprehensive National Audit Office review of the program in 2013. Did the changes in terms of the reporting requirements and the structure come as a result of that?

Ms PEAKE — I would have to take that question on notice. I am aware that that ANAO report recommended more prescription in the agreement, but I would have to track back if that was the specific driver for whether that led to any changes on that agreement and come back to you.

Mr MORRIS — Could I ask for that work to be done? That would be helpful.

Ms PENNICUIK — Thank you for coming today. I am very interested in the preventive health area and the national preventive health partnership agreement, and I have been reading what is here in the

whole-of-government response and also the answers in response to questions from the committee. If you look at the total amount received since 2009, it is about $70 million if you add in the figure from 2009–10, which is in the response, and really the majority of that is since 2011–12. They were facilitation payments, as I understand it, and no reward payments?

Ms PEAKE — There was provision in the preventive health agreement for both.

Mr SYMONDS — There was a variation to the agreement as well, which brought forward some of what were originally reward payments.

Ms PENNICUIK — What were the reward payments going to be for in terms of achievements under this, given the commentary that is there in the government response and in the response to the question, which is that it takes a long time to measure achievements in this area. Also with some of the other discontinued NPs, in terms of public hospitals, acute beds et cetera, the state budget has accommodated those, but to what extent has this preventive health stuff been accommodated in the state budget?

Mr SYMONDS — The actual targets I would have to take on notice.

Ms CONGLETON — We would have to take that one on notice and come back to you.

Ms PEAKE — Sorry, and the broader question?

Ms PENNICUIK — The broader question is: if you look at the amount of money here to continue the program if the state was going to take it on, which it has with other discontinued NPAs, has it been absorbed into the budget? Is it continuing as it was envisioned to continue?

Ms PEAKE — What we have retained is two components of the program. The healthy together achievement program and the healthy together eating advisory service have both been extended through state funds at a total cost of about $1.8 million. That was really based on the feedback from local communities about particular parts of the program in which they saw value, which is not to say they did not see value in other components. The second year of the live lighter social marketing campaign is also continuing, for both of which there is a high degree of local support and they are the subject more generally of continued discussion with the commonwealth about broader prevention investments.

Ms PENNICUIK — Talking about the amount, $70 million, over all those years, and your introductory remarks about chronic disease being among the three biggest causes, the investment even under the NPA seems quite low in terms of preventing those three areas.

Ms PEAKE — I hark back to my earlier comment that more recently the commonwealth has started a significant conversation with the community about the importance of preventive health. Hence, in the context of talking about the primary acute interface and around better responses to chronic disease, where prevention fits in is a very live conversation at the moment. What that translates to in terms of proportion of investment is obviously going to be the subject of those discussions.

Mr DIMOPOULOS — I asked a similar question of the secretary of education. In terms of the amount of stuff you could do in health, which is enormous — for example, I am looking at the National Perinatal Depression Initiative — of the 50 or 100 priorities that we have in Victoria what are the chances of us getting our preferred initiative up in an NPA as opposed to the commonwealth's preference? Obviously they have the dollars and they have probably the bigger say. Do you find that while we are not unsupportive of that initiative, as one example, are there others that we would have a greater interest in which we just do not pursue because there is no commonwealth interest in them? A lot of these discussions come out of ministerial councils and COAG and a whole range of things. I have been involved in some of those, and I think the commonwealth generally speaks louder. Can you give me a sense of the balance of power in terms of who drives policy in NPAs?

Ms PEAKE — There are really two answers to the question. The first is that we engage very strongly with the commonwealth outside of the context of specific negotiations on initiatives. Since being in this role in an acting capacity I have attended two commonwealth-state forums where these sorts of discussions that are not about money but priorities have been the subject of quite long discussions. The intent is to seed the thinking and influence the thinking outside of a negotiation. That said, it is fair to say that NPs arise, whether it is through a

COAG process or through a ministerial council process, that are focused on a particular commonwealth priority. Your point is also right though that they are always pointing to needs in the community, so I do not feel that any of the NPs that we have had in place or have in place are a poor investment. As I say, we really do work hard to influence the commonwealth in both what is the priority and having agreements that give sufficient flexibility, so that it is not a particular model of service that is being imposed on the state but there is funding support for the interventions that are going to work for us. I do not know if you want to add to that.

Mr SYMONDS — I might add something if I could. Many of the NPAs predate the current national health funding model. I would say that we have moved from a model in which the commonwealth may have felt like they needed to be more prescriptive with certain agreements in order to get their priorities up to a model in which they are on the hook with the state for the costs of in-scope activity under that agreement — for example, elective surgery is in-scope activity under the national health reform agreement for joint funding, emergency department activity, even the subacute beds which are the subject of one of the agreements here has moved from being specifically prescribed under a national partnership agreement to now being in-scope activity under a national health reform agreement.

Notwithstanding current discussions around reform of federation and the future funding model, at least the one that we are in right now provides the joint funding of those services. The Koori maternity services that I referred to before that were seeded and established under a national partnership agreement are now in-scope activity for joint funding between the commonwealth and the state. These are good examples of where perhaps national partnership agreements were used to drive certain policy agendas in terms of activity, but I would like to think we have moved to a slightly more mature environment in which the states are free to determine those priorities and the commonwealth has signed on for joint funding of all of those activities that I have just referred to without needing to prescribe them through separate agreements.

Mr DIMOPOULOS — Without putting words in your mouth, is it a sense of the NPAs are not more restrictive than the normal recurrent funding that you get in educational health? It is just really a taste test for the commonwealth in a sense to get involved in a more ongoing way?

Ms PEAKE — There are degrees. There is certainly more definition around a national partnership agreement than there is around a national agreement, but compared to what used to be in place before 2008 they are more flexible than they were and there is more alignment because of that flexibility for us to ensure that we are directing the money to initiatives that accord with our own priorities.

Mr DIMOPOULOS — If you looked at the base health funding outside the NPA structure — so aggregate health funding, commonwealth and state — what percentage is the NPA roughly, or what figure, because health funding is like $20 billion or something, I think, just from us, from memory?

Mr SYMONDS — It would be worth taking that question on notice, I think, to give you a specific answer.

Mr DIMOPOULOS — It is quite a general question, actually. I am kidding, of course!

Ms PEAKE — It is about 7 per cent.

Mr DIMOPOULOS — Is that right? That was good, thank you. Seven per cent is NPA?

Ms PEAKE — Twenty-seven per cent for both NPAs and NAs, sorry. I am getting advice from — —

Mr DIMOPOULOS — Okay, 27 per cent.

The CHAIR — Just teasing that out in a little bit more detail, I appreciate the fact that things have moved on a bit now and there is a bit more maturity, so the feds, as it were, are on the hook and they are providing a degree of flexibility in terms of the way in which the state spends those funds. Do you think, though, that there will likely be a change in the coming years where, for example, they might turn around and have like a payment or penalty contract in place, as it were, saying, 'Look, if you do these reforms, if you try and make your hospitals run more efficiently or if you reduce waste in terms of the administration of your hospitals, then you will be eligible for these payments', and that will be the nature of those sorts of partnership approaches going forward? I am just curious to see, given the statements that the feds are saying that they are starting to withdraw and they are going to start cutting funding, and let us assume for argument's sake that we as a state are not able to be persuasive in preventing that happening and that were to occur, how do you see that unfolding?

Mr SYMONDS — Again, one of the advantages of a more mature national model is that there is agreement around, for instance, an efficient price for hospital services, and that is the rate at which the commonwealth contributes to hospital activity, so there is less need for them to be prescriptive around 'You should be reducing administrative costs' or 'You should be driving down costs in this area or that area'. They apply the same model now to states and territories that we have applied for more than 20 years to public hospitals in Victoria, which is to take an efficient price and apply it across the board, and if you are more expensive than the efficient price, you bear that risk and cost. That is the approach they apply to states and territories. It is an example of them really adapting a Victorian model for the national context, which means they do not need to be as prescriptive, I think, around costs and so on. That model is, as I said, currently under negotiation because it expires now at the end of 2016–17 and there are discussions going on through a former federation process to develop a future funding model. But for the time being that is a more mature model that does not require that kind of approach from the commonwealth.

Ms PEAKE — There is no doubt that there are still examples, and we mentioned the homelessness agreement where there is more prescription. I think part of what will lead to better funding agreements is us getting collectively better at our data collection and our outcomes reporting, because that then provides the transparency and accountability in a more effective way than simply money being provided for particular activities.

The CHAIR — I read recently the Grattan Institute had produced a report talking about the variances between different hospitals with different procedures. There did not seem to be any rhyme or reason as to why a hip replacement in one particular hospital was significantly greater than a hip replacement in another hospital. I think there is a hospital in India where the only thing they do is hip replacements, so as a consequence they are quite efficient and they have been able to push down the cost per replacement quite significantly. I suppose this is probably more of a question or a statement just in terms of whether that is something that the state could look at as a way of getting robust data collection in place to work out what is best practice and therefore being able to be quite rigorous with a response to the feds, saying, 'We want some additional funding, but looking at our data we think that we'll do this number of procedures at this unit price. Therefore that's what we will require'. Is that something that is being considered or thought about as part of these discussions?

Ms PEAKE — I might take it in two parts. Certainly the recent Travis review of hospitals in Victoria has absolutely pointed to what are the ways in which we measure that variability and the systemic approaches to reducing that variability. That comes with outcomes measurement, but it also comes with spreading innovation as well. As to how that then translates into how we negotiate with the commonwealth, it is really more about the efficient price than it is saying, 'We're going to do X number of activities' and locking ourselves into a more input-output approach, which does not take account of the fact that things will continue to adapt. Efficiencies will adapt over time, models of care will adapt over time and demands will therefore not be quite as precise as, 'We're going to have 5 of this and 10 of that'.

Mr MORRIS — As I am sure you would be aware, we — 'we' meaning the committee — sent each department a questionnaire and in response we got a whole-of-government submission, which certainly helps in tying things together, but it means we do not have the opportunity to analyse in detail some specific department outcomes. One thing in particular we all appreciate is that no matter what the subject, some parts of the Victorian public sector will do the job really well and some not so well, and it varies enormously from department to department and subject to subject. Everyone has got their good spots and their bad spots. I am particularly interested to know in terms of the NPs that the department has been involved in if you could give us a couple of examples — one that has worked really well, and perhaps give us a bit of background on that, and one that has worked not so well, and perhaps comment on that.

Ms PEAKE — A couple of examples of where we have seen some pretty good successes — the essential vaccines NP was a way of grouping up our purchasing of vaccines using national processes, which really drove down the cost. There was funding to bring our purchasing processes into a commonwealth scheme. Just to give you a sense of that, it became part of the national immunisation program. It resulted in approximately $19.8 million in savings nationally. I do not actually have the Victorian figure, but I can get that for you. But it was a program that really did lead to significant cost savings for the state. That was a really effective one.

The HACC we have already talked about. While it should move into a recurrent funding stream, it did really successfully shift care into the community, and was an effective model of care. It provided both impetus and

support for that process. I would also say that the national health reform agreement, parking the last decision of the commonwealth, as an agreement, was a really good approach of sharing risk for growth, and having, as I mentioned earlier, that skin in the game about how we think about conversations about the whole health system, not just individual parts of the health system. They are three that I think have shown the value of these sorts of national partnership arrangements in shifting models of care and shifting the dial on the type of conversation the commonwealth and state are having with one another.

In terms of agreements that probably have not been as successful, I think the experience of the homelessness agreement is probably one where it was a bit more fragmented. It was not only the level of prescription which we have already talked about, but I think the discussions we are now having through the national reform process about how do we think more holistically about affordable housing and homelessness is a better kind of conversation to be having. What I would take from that comes back to Terry's comment about how we have the maturity of conversation about, 'What are we trying to measure, what results are we trying to shift and what is the right service reform to achieve that and the right mix of funding mechanisms to achieve that?'.

Mr MORRIS — We heard this morning that — I think it was education — DET was saying that in their view the preferred model was to sit down with the commonwealth, saying, 'What do we want to fix basically first?', and then, 'What agreements do we need to achieve that outcome?'. Would you agree with that approach?

Ms PEAKE — I think that is exactly what I am saying, yes.

Dr CARLING-JENKINS — Thank you again for this opportunity. I would like to ask specifically around the national perinatal depression initiative. That has been funded since 2009, I believe — that is what the paperwork says — but it has now been discontinued. I understand that the state has propped that up for a further six months but after that it is my impression that it will be transferred to the state wholly. Just to put a service delivery face on it, I have had a couple of services in my office — Tweddle, for example, and QEC, that have both played a significant role in delivering on this initiative in providing psychologists — and they are both considering letting go most of their staff in that area. That is having a devastating effect on their workforce and their organisation, but more importantly it appears to me that it will have a devastating effect on women and their children and their families by letting go this initiative. What capacity does the department have to make up this shortfall? What plans do you have around perinatal depression?

Ms PEAKE — I might make a couple of comments and then, Anne, throw to you. Certainly just to reinforce two of the points that you made, as a program the perinatal initiative did lead to a significant increase in screening. In 2015, 88 per cent of maternity services indicated they screened routinely compared to 2011 when only 35 per cent said they did. The sort of start-stop nature of the funding in the last period of time has affected services' ability to plan and, as I have indicated earlier, some of the workforce development and training of workforces. This has been really picked up for us in the consultations on a new 10-year mental health plan, and that is a process that is in train. Without pre-empting what comes out of that process, it certainly is an area that has been the subject of strong feedback from stakeholders about its value and importance.

Ms CONGLETON — I just wanted to add that there were two main chunks to that agreement and those activities. There is one part around the support to the early parenting centres. You mentioned Tweddle, the Queen Elizabeth Centre and the O'Connell Family Centre. There is funding there. There is actually funding also in 2016–17, and that was for additional capacity to support mums and families who may have been identified through that screening process. Some of the funding is due to cease at the end of December, but funding for those services, which is around $300 000, is also funded in 2016–17 by the state. As the secretary mentioned, the whole issue around mental health and wellbeing for mums, families, children and young people has been a very strong theme coming through with our consultations on the 10-year plan. That is something that is not too far away from the government identifying what those major priorities are. I think that that will give us a good navigation point for any future investment.

Ms PENNICUIK — If I can back to the issue of the reward payments again, I noticed in the responses that in terms of the NEAT and NEST targets Victoria was not eligible for reward funding in the 2014–15 year as the performance targets were not met. My question really is: what were those performance targets and why were they not met? Was there not enough funding to actually meet the targets, like not enough resourcing to meet the targets that were imposed? The other question is going to follow on a bit from that and is following on from another issue which you were talking about, Mr Symonds, about hospitals funding being like a universal figure

or something and then someone else was raising the issue of hospitals having to do things within a certain resourcing requirement, but it seems to me some hospitals may have more difficulty doing that than other hospitals due to demographics, socio-economic issues et cetera.

Mr SYMONDS — I may come back and just ask you to clarify the second bit after I have answered the first bit, if that is okay. The NEAT and NEST targets included elective surgery — the percentage of patients treated within the clinically recommended time by urgency category; the average overdue wait time for elective surgery, which is the average time waited for those patients who had not been treated at that point in time, by urgency category; and a further indicator that was about a point in time and how many of those had been treated. That was just really for elective surgery. For NEAT, it was the proportion of the patients who had been admitted or left in an emergency department, either going upstairs to the hospital or going home within 4 hours. I guess it is a slightly complicated suite of indicators that we use to measure performance.

My comment would be that it is easy, I suppose, in the context of just an isolated national partnership agreement to think that that funding relates to that performance. But for individual hospitals the NPA contributions are a very small part of the funding they receive, and the demand pressures and overall budget considerations for them mean that we cannot ring fence one small amount of their money and say, 'That is tied to category 1, 2 and 3 elective surgery' and so on for emergency departments. They have to balance competing demands. So we sign up as a state to those targets in good faith and say we will give that our best shot and then we prioritise, as hospitals do, that the most urgent patients get treated and that everybody who needs care within a certain period of time gets it.

For Victoria, our record is stronger than any other jurisdiction — for instance, in terms of treating category 1 elective surgery patients within time. So patients with cancer or cardiac conditions have, with only a couple of exceptions in the last decade, been all treated within clinically recommended times. For category 2 and category 3, so urgency categories where there is a little bit more discretion around the timeliness of treatment, these were performance indicators in the NPA that our hospitals prioritised, maintaining treatment of all category 1 patients within time. They also treated emergency department patients and improved their performance on the NEAT but did not quite meet the targets. So I guess the direction of change is agreed. How far we will get is a bit hard to pick in advance, and in the context of overall budget constraints and demand pressures, we give it our best shot.

In terms of the targets, we did not meet the targets that were set for most of the years. In 2012 we got a small amount of reward funding. I think we would say we agree with our hospitals that the priority for that period should have been on ensuring that urgent elective surgery patients were treated within time and that they continue to improve their performance on emergency department treatments, which they did in both cases. Of course we would have liked to have got more reward funding, but those are the priorities we give our hospitals to do.

In terms of the second question about — —

Ms PENNICUIK — Just to follow up on your answer there, it goes to Ms Peake's comment about the reward funding. It has to be realistic, and you should not be penalised if you are actually doing a good job and you are not getting the reward funding because you are doing it in a slightly different way or prioritising something but still having a good outcome. It was a comment about how to actually fund hospitals based on — I forget the term you used, which is why I am struggling here — —

Mr SYMONDS — An efficient price.

Ms PENNICUIK — Yes, the efficient price. My question was about the efficient price. Is it a general thing across all hospitals? But my point was some hospitals have more challenges than other hospitals, perhaps, based on demographics, socio-economic factors and other factors. What I am saying is: are they going to be in the same sort of boat?

Mr SYMONDS — There is a number of modifiers, I suppose, that are made to the efficient price. Patients who stay longer in hospital because they are unwell do attract more money; it is just that there are agreed efficient rates for doing that. Aboriginal patients attract an additional loading and rural hospitals get an additional loading, so there are a number of considerations around the price. Apart from that, every procedure and condition that patients enter with has a different relative weight on that price.

There is, I would say, 21 years of experience of modifying those formulas to ensure that hospitals are not unfairly disadvantaged by the model, and that is certainly our experience. I think the national model reflects that, having now rolled that model out to hospitals around the country. The kind of discussions that we have with other jurisdictions or with the national bodies are exactly about the questions you are talking about. What should the loading be for Aboriginal patients? What should it be for children? What should it be for medicine versus surgery? These are the kinds of discussions that we have.

Ms PENNICUIK — People with complex health needs.

Mr SYMONDS — Exactly. That is right. Lots of work going on to develop models that are better at capturing the complexity of patients to ensure that hospitals are not disadvantaged.

Ms PENNICUIK — Or patients are not, by them, discharged or whatever, because we have certainly had experience of that.

Mr SYMONDS — Exactly, yes.

The CHAIR — Mr Dimopoulos?

Mr DIMOPOULOS — I am good.

Mr MORRIS — I would not go that far!

The CHAIR — I might ask a question just about the homelessness NP. You may have already answered this question in an answer to Ms Ward, but in relation to the homelessness NP, as part of that are you looking at the factors that drive homelessness? Is that part of the issue? Because it has been in place for some time, are you in a position to track what is working and what is not or what some of those correlations are?

Ms PEAKE — That is correct, and really coming back to the previous question about how you start, what the change is that you are trying to achieve and what the best funding arrangements or set of funding agreements are to do that. The work on homelessness is also obviously really importantly connected to our thinking around the family violence royal commission. It is related to our thinking around affordable housing, both as a state but also our engagement with the commonwealth on the sorts of policy settings that influence that. It is also really related to our thinking about what are the other sorts of supports that are important, whether that is about mental health, whether it is around drug and alcohol or other sorts of social support. I think there have been lots of good learnings from the innovative programs that are being funded out of the homelessness NPs that inform our thinking both within the jurisdiction but negotiations with the commonwealth about, through the reform of the federation work — where to from here.

The CHAIR — So you think it would be an iterative process in the sense that the learnings you got from the homelessness NP are able to then inform other policy pieces of work to hopefully drive it through.

Ms PEAKE — Correct; that is right.

The CHAIR — So would your hope be that in the future the feds just fund this as part of their normal other funding to the state, in terms of base funding? I am not sure if base funding is still used these days, but like general block funding from the federal government?

Ms PEAKE — Yes. Two things. One — yes, we would like to negotiate an ongoing long-term funding stream, a national agreement that provides a source of funding for homelessness initiatives, but we would also like to see that complimentary investments in all those other services that I talked about and how those are designed, whether they are state investments or commonwealth investments, are working to address the drivers of homelessness in an effective way. So there is a specific programmatic response and then a broader approach.

Mr MORRIS — I have two questions. The first one relates to page 20 of the whole-of-government response, which refers to the loss of potential reward payments of $37.4 million from the preventative health program. We are just interested to know whether that reward would be for actions that might be undertaken in the last two years of the extended two years of the program or whether it relates to things that have already been done and that is simply just money gone — in other words rewards that we were expecting for action to be undertaken but we are now not to receive.

Ms PEAKE — It is the former, is my understanding. For activities we have already taken there is then an evaluation that would have enabled us to attract those reward payments, but the reward payments are no longer available.

Mr MORRIS — Yes, but the action has already been undertaken, so we have done our dough cold, in other words.

Ms PEAKE — We have had the facilitation funding, but we will not attract the reward payment, the incentive payment, in the end.

Mr MORRIS — The other one really relates to the conclusion or the expiry of these agreements in terms of the process that is undertaken to either continue or to convert, or whatever. I guess I am really just interested in how it all works, and I am particularly interested in how much or how little input the states have to that process.

Ms PEAKE — It is really variable. In negotiating the agreements they generally have provisions in them that spell out the review process that should occur and how the review should be applied to make decisions on the rolling in of recurrent funding to an ongoing national agreement. That is a feature of most, depending on the nature of the NP — if it is for capital project, it is obviously not relevant — but for most of the NPs we have been talking about today.

In practice the experience of the past few years has been unilateral decisions about ceasing either part or a whole of an agreement without those review processes having taken place. Of course the agreements are not legally binding, and you made the earlier comment about policy decisions that are taken by one or other level of government. The reform of the federation has really therefore replaced the process that might otherwise have been expected for review of individual agreements, particularly in health, housing and homelessness.

Obviously the NDIS has been a separate process that has replaced some parts of what otherwise might have come through in NPs, had there not been an NDIS on the horizon. We are working — and I do not think you have yet met with Mr Eccles — but certainly through that department and DTF taking leadership roles but with our strong support on those discussions with the commonwealth about what from here.

Mr SYMONDS — It might be worth making a specific reference to the national health reform agreement. Clause A82 of the national health reform agreement did require that the national partnership agreement on improving public hospital services should be reviewed and that jurisdictions should have a chance to participate in that review to work out what the relative shares of ongoing funding should be. That review did not occur, so we now are in regular discussions with the national funding authorities about what the baseline is, what the growth is and what share the commonwealth and the state should have for costs like the additional subacute beds that were funded through that. But I raise that because it is an example of an agreed review process that was scheduled and written in up-front but never occurred.

Ms PENNICUIK — If I could just follow up quickly on the national preventative health partnership agreement, in the document responses, page 14, it does talk about some data that was collected in 2015 and that the next collection of population-level data is planned for 2016–17. My question is: is that going to still occur? Do you know where I am?

Ms CONGLETON — So page 14 — is that the interim evaluation?

Ms PENNICUIK — Yes.

Ms CONGLETON — There was an interim evaluation that occurred that provided some insight into impact. In terms of any further, because of the downsizing of activity I am not certain that that is going to occur to that same level that would have been first envisaged.

Ms PENNICUIK — And is that what is meant by the analysis of the population-level data and assessment of long-term impact is at risk, which is the final sentence in that section?

Ms CONGLETON — Sorry, I have just — —

Ms PENNICUIK — Same page, just the last sentence in that section says that the analysis of the population data is at risk. So I am really just — —

Ms CONGLETON — I think that refers to not being able to have that sort of global information. There is of course population health surveys that are undertaken on a regular basis, but in relation to this scope that is substantially curtailed.

Ms PENNICUIK — Yes, which is a pity since you started something and you are not evaluating it. My next question relates to page 16 of the government submission and is in regard to the agreement for Indigenous teenage sexual and reproductive health and young parents support. It seems that since I read through this that there is no continuation of that program.

Ms CONGLETON — That is correct. It has ceased. There are two parts to it. One was around the Wulumperi program that has concluded. There has been some additional funding that has been allocated to the Koori maternity services element of it in this financial year of around $1.1 million. Then that would be linking, in terms of broader funding for health services, into what element that would be picked up into the future.

Ms PENNICUIK — So that is at risk too. Is that what you are saying?

Ms CONGLETON — The first part of the Wulumperi program did conclude and, as I said, it would be to the extent to which, in looking at the delivery of Koori maternity services in broader health funding, as to how that could be translated.

Ms PENNICUIK — But in terms of teenage sexual health, that is not — —

Ms CONGLETON — There are additional services though. There is funding that goes to the Victorian Aboriginal Health Service. There is funding to the Melbourne Sexual Health Centre, which of course provides supports to Aboriginal children and young people as well as non-Aboriginal children and young people. So there have been a lot of learnings that have come from that that are informing practice more broadly.

The CHAIR — Okay, I think we are done. I would like to thank the witnesses for their attendance. Thank you, Ms Peake; congratulations on your appointment. Thank you, Mr Symonds. Thank you, Ms Congleton. The committee will follow up on any questions taken on notice in writing and a written response should be provided within 21 days of that request.

Witnesses withdrew.