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

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2014–15

Melbourne — 9 May 2014

Members

Mr N. Angus
Ms J. Garrett
Mr D. Morris
Mr D. R. J. O'Brien
Mr C. Ondarchie
Mr M. Pakula
Mr R. Scott

Chair: Mr D. Morris
Deputy Chair: Mr M. Pakula

Staff

Executive Officer: Ms V. Cheong

Witnesses

Mr D. Davis, Minister for Health,

Dr P. Philip, Secretary,

Mr L. Wallace, Deputy Secretary, Corporate Services Division,

Ms F. Diver, Deputy Secretary, Health Service Performance and Programs Division, and

Professor C. Brook, Chief Advisor on Innovation, Safety and Quality, Department of Health.

Necessary corrections to be notified to executive officer of committee

The CHAIR — I declare open hearing 2 of the estimates hearings for 2014. I welcome the Honourable David Davis, the Minister for Health, and from the Department of Health the Secretary, Dr Pradeep Philip; Deputy Secretary, Corporate Services Division, Lance Wallace; and Deputy Secretary, Health Service Performance and Programs Division, Frances Diver. I believe we also have the Chief Advisor on Innovation, Safety and Quality, Professor Chris Brook, PSM, and the Chief Executive Officer of Ambulance Victoria, Greg Sassella.

The estimates hearings this year are again being webcast and are available on the parliamentary website. In accordance with the guidelines for public hearings, I remind members of the public gallery that they cannot participate in any way in the committee's proceedings. Departmental officers may approach the table during the hearing to provide information to the minister or other witnesses if requested and by leave of myself. Written communication to witnesses can only be provided via the officers of the PAEC secretariat.

Members of the media are requested to observe the guidelines for filming and recording proceedings in the Legislative Council Committee Room. These include: cameras remaining focussed on the person speaking; not panning the public gallery, committee or witnesses; and ceasing recording as soon as the hearing is completed.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act 2003, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing are not protected by parliamentary privilege, including any comments made on social media from the hearing itself. The committee does not require witnesses to be sworn, but I remind you all that questions must be answered in full and with accuracy and truthfulness. Any persons 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 fact verification within two working days of this hearing. Unverified transcripts and PowerPoint presentations will be placed on the committee's website as soon as they become available, and the unverified transcripts will be replaced by verified transcripts within five days of their receipt.

Following a presentation by the minister, committee members will ask questions relating to the inquiry. Generally, the procedure to be followed will be that relating to questions in the Legislative Assembly. Sessional orders provide a time limit for answers to questions without notice of 4 minutes, while standing orders do not permit supplementary questions. It is my intention to exercise discretion in both matters; however, I do request that each question is answered as succinctly as is reasonable, recognising that many responses may include a degree of complexity.

I ask that all mobile telephones be turned off or to silent.

The minister now has an opportunity for a brief presentation of no more than 10 minutes on the budget estimates for the health portfolio.

Overheads shown.

Mr DAVIS — I will begin with the budget highlights presentation in the first instance, and I point to the significant increase in funding in the portfolio this year to $14.9 billion — a record and a significant increase since coming to government. It is important also to note the 10.3 billion for acute health, the 439 more for acute health than in the 13–14 budget and 190 million over four years for elective surgery in particular.

There are obviously many smaller programs that can be highlighted, and you would go for a long time to talk those through in significant detail — for example, 2.5 million per year over four years to improve outcomes for at-risk pregnant women and their babies and $1 million for the national diabetes syringe scheme. One part of the portfolio that people tend not to focus on is the cemeteries section of the portfolio, but there is a small grant program that will recognise the Anzac centenary for our cemeteries around the state. These are some of the smaller programs by way of example.

There is significant capacity uplift, though — about 4.5 per cent in the acute health services area. There is significant money to respond to patient growth, or demand growth, of $45 million over four years — $190 million — to boost elective surgery capacity. There is $1.8 million to improve bariatric care and access —

that is $8 million over four years — and this is an important group of patients. There is 60 million for health service winter demand capacity enhancement, and there is obviously a significant need for that.

There is 3.3 million for the capacity to enhance support for rural patients through VPTAS, which is a reimbursement scheme that makes sure that those who are from country Victoria are able to access particularly cancer services but also a wide variety of services. That is a significant uplift in the rebates that will be available. More money has been added to the program to deal with the increased numbers, but this actually adds an uplift in the rebates and makes health services more available for those from country Victoria.

Obviously there are several ways that this can be approached in terms of making proper health services available for those in country Victoria. If you take the example of cancer services, there is obviously a rolling out around the state of additional cancer service capacity in country Victoria. There is the Albury-Wodonga centre that is being built, Ballarat has recently opened, the radiotherapy capacity at Warrnambool, the additional capacity that is also being provided at Latrobe and Mildura — all of these are important additional cancer services around the state. But there will always be some patients who will need to travel for particular services and, recognising the needs of country Victorians, there will be additional service there.

If you look at ambulance services, there is a significant increase in funding since coming to government and again record funding this year. The government committed, on coming to government, 151 million to employ 340 more officers — 310 paramedics and 30 patient transport officers — and the reality is that there is significant growth right across the state, whether it is in metropolitan Victoria or in country Victoria. Indeed more than 465 additional paramedics are in place now delivering services. So there is additional growth here in this budget.

There is also, importantly, the HEMS contract, the helicopter contract, which has been announced and is recognised in the budget. This is $550 million providing new helicopters — a lease arrangement that will provide better helicopters, more modern helicopters and helicopters that can lift more, have a greater winching capacity, a greater distance capacity and indeed are faster. So on all counts these helicopters will pay a significant dividend. I believe country Victorians in particular, but indeed anyone who needs a helicopter to lift them, perhaps because of trauma, will see a significant benefit in terms of the helicopter contract that has been signed.

I pay tribute to the work done here by Ambulance Victoria and their professionalism and can indicate the contracting for this process was undertaken by Health Purchasing Victoria, which is obviously very experienced in these complex contractual arrangements and complex arrangements in terms of tender. Ambulance Victoria worked magnificently with Health Purchasing Victoria to get a good deal — a deal that will actually see better helicopters in place over the period.

There is also, I think, the important work of the Ambulance Transfer Taskforce, and the current statewide performance has improved significantly. Indeed we have released some additional data today — and I think I have made that available to you, Chair, just prior to the hearing — which shows the significant performance improvement in terms of the transfer times.

I want to pay tribute particularly to the work done by Andrew Stripp and his team. The figures just released today show a very significant improvement — these are an update on the figures that are available on the screen: 86.7 per cent of patients transferred to emergency departments within 40 minutes — and that is a 9.7 per cent improvement over the March quarter, across that period of the March quarter — and some hospitals are showing particular improvements in their transfer capacity. Frankston, if you look at it to March 2013, has gone from 58.9 per cent to 86.3 per cent, and Monash Medical Centre at Clayton had a 25 percentage point increase from 58.1 in quarter 3 last year to 83.1 per cent in this quarter just gone — just released today. This is all the work of Andrew Stripp and his task force, and I pay tribute to the clinicians who were part of that — the nurses, the emergency physicians and indeed the ambulance service, in particular Tony Walker, for the work that was done through that task force, which has put in place a much better system statewide for transferring patients across within the benchmark times.

There is obviously ongoing capacity building around the state in terms of new investment and new infrastructure in ambulance stations. There are also key pieces of infrastructure like the Ballarat helipad that is being built currently at Ballarat. That will make a big difference for people through that Ballarat region and the

capacity for ambulances to move patients to Ballarat or indeed to move patients who need, for urgent reasons, to come to Melbourne — to lift them from the helipad at Ballarat Health.

I pay tribute in this context to the work done by local members, particularly David Koch and his long fight going back to 2004, advocating — and, Chairman, a member of your committee, David O'Brien, has also been very active in that fight — to have the helipad built at Ballarat Health. I think that will make a big difference. Obviously we struck a deal with the council so that additional car parking capacity was put into the construction — so car parking not only for the health service but councillors become a partner there — with the helipad on the roof and the car parking underneath.

I go to the health workforce section. The government in its budget announcement last year committed $238 million over four years — a very significant uplift in funding for more doctors, more nurses, more allied health professionals and an integrated training approach. We released a document laying out the workforce strategies in our People in Health initiative, strengthening the health workforce in Victoria, ensuring the ongoing and integrated investment to develop a sustainable health workforce, a best practice clinical learning environment framework for all 86 of the health services and also a commitment to work with private services — and we need increasingly to bring private services into the training loop so that there is additional capacity to provide for interns and other training approaches. There has been a particular focus, for example, on radiation training and capacity, and we are working right across the whole spectrum. There are significant increases in the numbers of doctors and nurses and allied health professionals in our public hospital system — 961 more doctors; 1748 more nurses and 856 more allied health professionals than when we came to government — so there is significant uplift in those areas and we are very proud of the work we are doing there.

There is an ongoing challenge to make sure that the commonwealth plays its part here too, and going back to 2006 the increase in medical places as new medical schools were rolled out around Australia was to be matched in the agreement by increases in places in state health systems — our state health system has done well over 80 per cent in terms of uplift in medical intern places — but the commensurate lift in commonwealth-supported places in the private sector and in primary care settings has not occurred. I think there are only 17 that are funded by the commonwealth statewide in Victoria. I stand to be corrected on this number, but I think it is well over 800 in the public health setting. That gives you some idea of the challenge.

Victoria is tackling smoking rates and protecting the health of Victorians in that way. We have a number of key steps that have been taken there, particularly with respect to smoking there is a focus on children and families and sporting events. The recent bans that are in place now on smoking in certain public areas, particularly children's sporting events and children's settings, have been well received and are being successfully implemented, driving down the number of places where people can smoke and driving up the number of places where people can congregate, particularly as a family or with children.

There are also the steps we have taken in terms of a solaria ban with the skin protection framework and the shade grants, and some of these matters were matters of all-party support as they went through the Parliament. I welcome that all-party support.

The trial of rapid HIV testing has also been important, and Victoria has led the way there. I can say that I understand the commonwealth is looking at home-based testing currently, and I certainly welcome initiatives it might take in that area.

There is a push to lift the immunisation rate in Victoria to 95 per cent. I can point to the win that we have had with dental services, bringing down the dental waiting times very significantly from well over 20 months in many cases to 11 and 12 as a comparator. There is massive health capital spending — more than 4.5 billion under way with additional announcements in this budget. The comprehensive cancer centre, the Eye and Ear, Monash Children's and Northern are all important capacity projects that are going to deliver for Victoria and importantly in country Victoria as well.

The Box Hill Hospital project is nearing completion. Frankston Hospital is pushing forward very strongly. The comprehensive cancer centre is something people will see the enormous progress on every time they drive to the airport. There is a webcam if they want to watch a 15-minute refresh on the construction site and see the progress day and night. The Monash Children's is something we are particularly proud of. The tender has been

signed, the design process is proceeding fast and we will soon be making announcements about breaking soil and the outcome there.

Statewide I have mentioned a number of the key announcements with HEMS, with the helicopter contract. The Austin short-stay unit is another important one. There is equipment replacement. There are investments in country Victoria. Bendigo Hospital should read $630 million, not $620 million. There are investments in Kerang, Maroondah, Mildura, Healesville, Waurn Ponds, Barwon Health North, which was announced in this budget, and the Melton ambulatory care centre, which is a significant funding announcement.

Bendigo Hospital is moving at a very fast rate, and those who have been up there will I think be very pleasantly surprised at the progress on the Bendigo Hospital site. It is, I can indicate, ahead of time, and that is a good indication. It will create additional capacity, and massively so in terms of construction jobs; there will be more than 770 construction jobs.

I have talked about cancer investments and the VPTAS matters already. I am happy to talk at length later about the commonwealth engagement. There are a number of matters on which we are deeply engaged with the commonwealth at the moment to see what steps occur through the commonwealth budget process and parallel to the commonwealth budget process. The national health agreement is something we have had significant debates with national agencies about to ensure that we get proper indexation arrangements in place, and there are matters around health data and privacy that we are pursuing with the commonwealth closely.

The Health Priorities Framework is being implemented across the state. There is obviously the pressure of demand, the pressure of ageing and the pressure of population growth in Victoria which make the health portfolio always challenging, and this year I am sure will be no different.

The CHAIR — Thank you, minister. We have got until about 4.15 p.m. for questions. I will just flag that it is my intention to take a 5-minute break at about 2.45 p.m. just so everyone can stretch their legs. Moving to questions and picking up on your comments about capital spending, Minister, I ask you to outline to the committee examples of infrastructure in the health portfolio which will deliver not only facilities for people in the Victorian health system but also growth and jobs in terms of the wider economy?

Mr DAVIS — Chair, I thank you for that question. Clearly the massive infrastructure projects that are under way at the moment are historic in their scale and are playing a significant role in refreshing infrastructure but also building additional capacity. There is the comprehensive cancer centre, which I believe will be a unique facility, a new home for Peter Mac, at $1.1 billion, but it will also have integrated research as a key part of its activity. It will bring together many of the activities in that Parkville area and do so in a way that I believe will deliver very well for our community into the future.

Obviously cancer is an area where there are more services required. The population is growing and ageing, and as the population ages the number of cancers detected does grow. In terms of the number of cancers detected, we are obviously treating more patients than ever before and building this capacity not only at the comprehensive cancer centre but also statewide, whether it is Ballarat, Albury-Wodonga, Latrobe or Warrnambool. All of those areas will have increased capacity, including I might add Mildura.

There are announcements in the budget for Latrobe Regional Hospital, with its $73 million increase in capacity. This investment will make a significant difference at a local level, increasing the range of specialist services. Latrobe is an important hospital because it is the main regional hospital for Gippsland. The need for capacity is very clear. Again, that will create local jobs in the construction phase and ultimately local jobs in the delivery-of-service phase. Barwon Health North is an important announcement that the government has made. We will build a new facility — a $28.1 million announcement in the budget — to provide a range of community-based ambulatory care services catering for the growing demand in that region. The government did significant service planning with Barwon Health over the last several years and understands the need for those services. They will help take some of the pressure off Geelong Hospital. Obviously Geelong Hospital itself has a massive construction process under way and provides the central support through the Barwon south-west region.

There are also equipment grants — the medical equipment and statewide infrastructure grants — and small but important announcements like the Boort District Hospital, with its very ageing and frankly clapped-out infrastructure. There was very significant advocacy from the local member there. It will deliver more than

30 beds, but 25 aged-care beds, so there is an integrated approach there that will provide for country Victoria, and there are other programs of the type around the state, whether it be at Echuca, Kerang or elsewhere around the state. There are a massive numbers of projects, all delivering additional work.

There are projects at the VCCC, Box Hill, Bendigo, Ballarat and Geelong. Frankston Hospital — the $81 million upgrade there — will see a new emergency department and also an additional 68-bed capacity, including intensive care capacity. This will strengthen the role that hospital plays. Additional capacity has gone into the Northern Hospital, with the new emergency department already open and additional capacity to come on stream. All of these are playing a critical role in refreshing and replacing infrastructure, building new capacity and at the same time creating construction jobs in local communities around the state. We are very proud of the work that is occurring statewide in this respect.

Mr SCOTT — Minister, I refer you to budget paper 3, page 142, and there are two measures there of ambulance code 1 response times: there is 'Proportion of emergency (Code 1) incidents responded to within 15 minutes — statewide', and there is a similar figure for populations of more than 7500. The budget papers show that you have again failed to meet targets for these two measures, both the statewide measure and the population over 7500 measure. Indeed, ambulance response times in these areas have worsened over your time in government. The question is simple: what have you done in this budget to turn around these falling response times?

Mr DAVIS — As you will understand, there is increased funding in the budget this year for ambulance services. There is also a new allocation of money for helicopters — $550 million. There is also the ongoing rollout of the government's $151 million package which sees more paramedics around the state; there will be more than 465 additional paramedics on the road around the state.

What I can say is that this has stabilised and begun to improve, and you will notice that there are significant aspects of the performance of Ambulance Victoria which I think we can all be proud of. One of those relates to the transfer times and the information I read out before about the significant improvement in transfer times at hospital. I pay tribute to our paramedics, but I pay tribute particularly to our hospital emergency department physicians and nurses for that work that they have undertaken.

It is also clear there are important measures in the budget that see outcomes in terms of patient results. If you look further up the same page, you will see, 'Percentage of adult patients suspected of having a stroke who were transported to a stroke unit … within 60 minutes'. Again, we have put in place an important targeted measure that will see thrombolysis facilities available, and that is going to make a significant difference to patients as we roll out thrombolysis further around the state.

Regarding the 'Percentage of adult ventricular fibrillation/ventricular tachycardia cardiac arrest patients with vital signs at hospitals', again there are new approaches, and we are getting results there that are actually world-standard results being delivered by our ambulance services. By any measure, our ambulance service in Victoria is delivering world-standard results.

Regarding the 'Proportion of patients experiencing severe cardiac or traumatic pain whose level of pain is reduced', these are important clinical measures that respond to patients, and it is interesting, when you look at the ROGS data, that it is clear that Victoria performs at the peak in these sorts of areas. The 'Proportion of patients … satisfied with overall services' is also performing at a good level. Our CERT teams are doing well, and the work is there to further enhance the emergency code 1 incidents statewide in the larger population centres. Systems being put in place taking the pressure off the ambulance service by improving the transfer times at hospitals will steadily improve these outcomes. At the same time we will work to put in place the very best clinical systems, and the measurement of clinical systems is also important.

Mr SCOTT — I have a supplementary question. On Tuesday of this week, on budget day, at 4.17 a.m. an ambulance was dispatched to Reservoir to attend the case of a 63-year-old man who was having a heart attack. Despite the time of day and the lack of traffic, it took 17 minutes for the ambulance to arrive. Unfortunately the man died. How does anything you have done in this budget fix the crisis in response times that makes these tragic cases far too common?

Mr DAVIS — Mr Scott, your leader when he was health minister made a number of key points. A key point here is that each individual case needs to be investigated very closely and understood in detail before we begin

to make assertions. Clearly this is a sad case, and our sympathy would always be with the families concerned, but we ought not be quick or hasty to jump to any conclusions.

What I can say with respect to that case is I am informed that the response time was 17 minutes. Three ambulances were dispatched: 7.7 kilometres away, 10.8 kilometres away and 13 kilometres away. They would have been expected to respond more quickly. I think Ambulance Victoria would have expected a quicker response, and I understand that Ambulance Victoria is speaking to paramedics as to why this was the case. We need obviously not to jump to any early conclusions about these matters. We need to be very cautious about the actual details of any case.

Mr Scott, your leader, when he was in my position of health minister, made the point that assertions that are made by unionists, paramedic unionists, in EBAs are only 40 to 50 per cent of the time right. That is an important point. I agree with him that on many occasions the assertions made by patients — —

Mr SCOTT — Confirm the detail of the question.

Mr PAKULA — You said it was 17 minutes.

Mr DAVIS — That is correct.

Mr SCOTT — That is what I said. That is what my question said.

Mr DAVIS — But I am making the point that we do not yet know the details of the case — —

Mr SCOTT — I made no such inference.

Mr DAVIS — As I have said, I am informed that Ambulance Victoria expected a quicker response and is speaking to paramedics as to why there was not a quicker response.

Mr PAKULA — Are you blaming the paramedics?

Mr DAVIS — I am not jumping to any conclusions, Mr Pakula. I am not jumping to any conclusions at all, and my caution to you and Mr Scott is not to jump to any conclusions either.

Mr PAKULA — Your imputation is clear.

Mr DAVIS — My imputation is that you should not jump to conclusions.

The CHAIR — Order! Minister, and particularly colleagues on my left, this is not a conversation. It is an opportunity to ask a question. The supplementary has been asked, the minister will answer it and then we will move on. It is not an opportunity to engage in a conversation or a series of loudly made assertions. Minister, had you concluded?

Mr DAVIS — The one point I think it is important to make is that there are literally 465, or more now, paramedics on the road that were not on the road under the previous government. Whatever difficulties are faced from time to time with response times, imagine how much worse it would be if you took away those 465 paramedics this government has put in place.

Mr ANGUS — Minister, I refer you to budget paper 2, page 27, and chart 3.5, 'Victoria's industry structure relative to the national structure 2012–13'. This diagram shows that the share of Victoria's health care and social assistance sector, on the left-hand side, is larger relative to the share of the sector nationally. Minister, can you please explain to the committee the significance of what this diagram is showing?

Mr DAVIS — Victoria has a very well developed health sector, both public and private, and increasingly the two are working in tandem, in partnership, on a whole range of matters. We also have a very well developed professional, scientific and technical services sector, and that workforce provides a range of services, whether they are legal, accounting, management, consulting, architectural, engineering or scientific research. Employment in this area is concentrated in the city of Melbourne and in some of our large regional cities. Beyond Melbourne, obviously the city of Monash has a significant share of scientific workers as well and key

facilities around our major institutions — our major universities, the CSIRO, the synchrotron and other similar parts of our well-developed system.

This is important because it points to many of the growth opportunities into the future for Victoria, not only providing the very best services and the best clinical results for our patients but actually seeing the opportunity to further the future of mankind through greater focus on research. Victoria does very well as a share of the National Health and Medical Research Council grant allocations, and we seek to do more in that area to strengthen and develop that sector as much as we can. The health and social assistance sector contributed $22.9 billion towards the total industry gross value on a state output of $311 billion. This represents a significant share of the state's total output and is an area that is important for growth into the future, looking at economic opportunities on one hand and research opportunities on the other and the capacity of those to enhance our clinical outcomes for patients statewide.

In some senses the Victorian Comprehensive Cancer Centre exemplifies the bringing together of the university, the WEHI and other key research institutes with our premier clinical institutions to provide the highest level of service, the highest standard of service, in our economy. One thing that I think is increasingly important is to think of health not just as a service delivery but as an economic generator as well and the capacity for both to work and enhance outcomes for the community.

Ms GARRETT — My question also goes to budget paper 3, page 142, regarding ambulance code 1 response time performance. I note in your previous answer your cautioning about quick or hasty jumping to conclusions, but what is clear, in black and white, in your own budget papers is that there is a significant and ongoing failure by this government to meet code 1 response time targets. Clearly code 1 response time targets are there for a reason and failure to meet them can and does cause tragic consequences, which brings me to a series of devastating and tragic cases in Orbost.

You may recall that on 5 January 2013 an ambulance was called at 9.28 a.m. to a gentleman in Orbost. Omeo dispatched an ambulance at 9.48 a.m. The Orbost crew was on interrupted fatigue break and was dispatched at 10.10 a.m. The CFA was then called to do CPR. Unfortunately a doctor declared the patient deceased, and both crews were cancelled at 10.30 a.m.

Another case happened on 30 May 2013, when a 64-year-old man suffered a critical incident. An ambulance was called at 5.46. The Lakes Entrance crew was sent, and they arrived on the scene some 37 minutes later.

In case no. 3 a 71-year-old male in April of this year, an ambulance was called at 8.45 a.m. Again, a Lakes Entrance crew was dispatched at 8.49 a.m., and they arrived on the scene at 10.03 a.m., making it a response time of 1 hour and 18 minutes, clearly well beyond the statewide targets. I ask: how is anything you are doing in this budget fixing ambulance coverage and response times in Orbost?

Mr DAVIS — Let me be quite clear here: there are more than 50 additional paramedics in the Gippsland region since we came to government — more than 50. We have also put in place full MICA shifts, full MICA units, in Sale, Bairnsdale and Wonthaggi. They are the key larger locations in Gippsland.

But what is clear is that from time to time difficult cases will occur. I draw your attention to the case of Rupert Rafferty, a five-year-old boy in Gippsland, where it took 65 minutes in 2010 for a paramedic to attend his Briagolong home in Gippsland. I could go on. At Maffra, retired farmer Laurie Stephenson died after suffering a heart attack while he played pennant bowls at a competition in Maffra on 23 October. Ambulance Victoria and its community officers were on the scene within 23 minutes, but it was another 15 minutes before a full-time paramedic crew arrived from Traralgon 50 kilometres away. This was in 2010.

My point is that we inherited an ambulance service that was in absolute crisis, and what we have done is put in additional resources, and we have put in additional paramedics, and we have put in specialist paramedics, which are slowly, incrementally turning these matters around. My point is that there are some difficult cases that occur. Each of those is investigated appropriately. We need to be very careful not to jump to a conclusion in a particular case that has not been fully investigated, but what I can say is that the additional funding that is in the budget this year will help.

The helicopter announcements are also important. I will help Mr Scott on this. On page 133 you will see the ambulance output group rises by 5.2 per cent. Obviously a key aspect of this is to ensure that we focus on the

clinical outcomes for patients and communities. A key outcome is the performance measures that also relate to those who are suspected of having a stroke and who are transported to a stroke unit. The new measure has been put in there, and the expected outcome is better than the target. The percentage of adult ventricular fibrillation and ventricular tachycardia cardiac arrest patients with vital signs at hospitals is also a new measure where the outcome is better than expected.

In relation to the proportion of patients experiencing severe cardiac pain or traumatic pain where the pain level is reduced, I note this is an example where the government is at loggerheads with the union, which wants to remove some of the key steps in terms of patient experience in terms of support for pain relief. They want to remove the support that is provided by CERT and ACO officers in terms of pain relief, and that would be a retrograde step in my view. Also the proportion of patients satisfied or very satisfied with the services of paramedics overall is above target, and that is an important aspect. Our CERT teams are very effective in getting there as well. All of these are important steps.

Another aspect that the government is introducing is the RefCom service, which we are rolling out around country Victoria now. RefCom under the previous government was only available in metropolitan Melbourne. We have trialled RefCom in Barwon-south western, and that has proved to be helpful. Now we are rolling the RefCom service out into the rest of country Victoria — the other four country regions — and Gippsland is one of those regions that will receive additional support through the RefCom service.

The RefCom service is an important one because it can assist that smallish but important group of patients who request an ambulance when an alternate provider or an alternate solution could be provided. There are those patients who will call for a sore toenail or a cold, and we know there are other alternatives that can be provided there. RefCom has the capacity to do that; it has been shown to do it in the Barwon-south west region. We will roll it out through the other regions, and that will help manage the demand.

Ms GARRETT — I am sure the minister does not need reminding that he has in fact been the minister for close to three and a half years. In terms of jumping to conclusions, I understand he does not want to reach certain conclusions, particularly when they are that code 1 response times under this government have deteriorated. He referred to the Gippsland area, and I think that is important in terms of the supplementary question. Last year, again, we saw an 83-year-old man from Lakes Entrance die after waiting 28 minutes for an ambulance; we saw a 66-year-old man from Metung suffer a heart attack and die after waiting 24 minutes for an ambulance; an 83-year-old woman from Paynesville died after suffering a heart attack and waiting 18 minutes for an ambulance; and a 72-year-old from Lakes Entrance died after he waited 26 minutes for an ambulance — tragic cases, all of them. How will anything you are doing in this budget fix ambulance coverage and response times around Gippsland, Minister?

Mr DAVIS — Let me be quite clear here: there are cases where the system does not work as well as it should, and that has been for a long period. For example, the *Herald Sun* on 10 May 2010 drew attention to a Victorian man who waited more than 2 hours for an ambulance in South Gippsland and joined a chorus of victims calling for a system overhaul. Noel Cowie of Korumburra collapsed at his home in April after complications related to pneumonia and pleurisy. Mr Cowie said his neighbours called an ambulance but he was not picked up for more than 2 hours.

So I am saying that there is a significant challenge with our ambulance service. That has been a longstanding challenge. There was a botched merger through the period of 2008, 2009 and 2010 by the previous government, and we are still doing the work to repair that. We have put more money in and more resources in. Even this year, as we pointed out to Mr Scott a moment ago, there is 5.2 per cent more money and an announcement of $550 million in terms of the new ambulance helicopter contract, which will provide faster air ambulance with more capacity to lift and the ability to travel longer distances. When they come on stream in 2016 they will make a very significant difference, in particular to those in country Victoria.

I also make the point again that the government is rolling out the RefCom system statewide now, and that will help in areas like Gippsland, where some of the cases that are able to be managed by alternate approaches will be managed by alternate approaches, freeing up our paramedics to attend the most urgent cases.

Mr O'BRIEN — I draw the minister's attention to budget paper 3, page 140, which reports against performance measures relating to acute training and development. I note that in the footnotes to some of those

performance measures there is reference to the government's priority to expand services and the government's election commitments regarding rural generalist training positions. I ask the minister to provide an update to the committee about the government's actions to deliver these priorities.

Mr DAVIS — The government certainly is very focused on training and getting the best outcome for the community. I think it might be page 140 that best reflects the training and development section of the output here. You will see, for example, that the number of placements — student days — in medicine, allied health and nursing, a new measure that we have put in place there, is almost 1 million.

The number of rural generalist GP procedural positions is again a new measure that has been put into the budget. The government went to the election with a commitment to put in place five rural generalists, and we have expanded that. They have been very successful and massively oversubscribed in terms of the number of people applying for those rural generalist positions. For the committee's benefit, I perhaps should explain that a rural generalist is a doctor who has undertaken their initial rounds of training and internship but is then provided with a period of formal training in country Victoria to train them and provide them with the full range of skills that are critical for a rural generalist. These are proceduralist skills, particularly obstetrics skills, and also the emergency and other backup skills that will enable them to provide services to what is often a smaller country community where you see a very diverse range of cases, so you need to be greatly prepared. In some ways this is like the old country doctor who is able to deliver babies and perform small procedures as well and has those emergency skills. What I think has happened over many years is a narrowing of professional areas of skill in medicine and perhaps something of a loss of that rural generalist capacity.

This is a policy that we based on a similar program in Queensland. I worked with the Rural Doctors Association to cost that up. That was implemented in our first budget and has now been expanded in its capacity each year to train up doctors through this system. Over time that will help us with a strengthening of the rural medical work force, particularly making sure that the doctors have that skill set that will enable them to perform those rural generalist and proceduralist activities that will make them a very valuable country doctor of this type. We are very proud. The enthusiasm of a lot of the new interns and graduates for these positions is fantastic, and we certainly encourage them and can see the need to expand those places over time.

Mr PAKULA — I also want to talk about budget paper 3, page 142 — code 1 response times — because each and every year under your government more than a quarter of code 1 ambulance callouts have not arrived in 15 minutes. In the case of Matthew Gibbs, a 23-year-old who collapsed and stopped breathing while playing sport in Melton, the ambulance took 16 minutes to arrive. The nearest ambulance was 4 kilometres away. It was not sent; instead one was sent from Caroline Springs. Sadly, Matthew died. Tony Walker, who you have referred to, indicated at the time that it was not acceptable. I think you will remember Matthew's mother, Joanne. Ambulance Victoria has been less than forthcoming with information to help Joanne understand what happened. My question is: what can you do to ensure that Ambulance Victoria will be open, transparent and timely in providing Joanne with the outcome of its investigation into this case?

Mr DAVIS — I think members of the committee will understand the need to exercise caution in each and every particular case. I am informed that it is the pattern that, where there is a case that appears not to have been managed to the best standard, Ambulance Victoria will investigate. If there is something untoward, the coroner might investigate too. Ambulance Victoria does contact patients and families and does in general work very well with patients to explain to the best of its ability what has occurred or why something that should have occurred has not occurred. I must say that in my experience — and obviously you may have some new information — Ambulance Victoria is generally very open and transparent in working with patients and their families to provide information of that type. I suspect your raising this here will ensure that Ambulance Victoria redoubles its efforts in that particular case.

I would say that in the majority of cases that I have seen or been exposed to — and I do not claim to have knowledge of every case, obviously — Ambulance Victoria has been very careful and structured in its approach and has provided as much information as it possibly can as it investigates a particular case and the sequence that has occurred in a particular case.

Mr PAKULA — I have no doubt that Ambulance Victoria will redouble its efforts in regard to this case as a result of it being raised here today. My supplementary question, however, is: what guidelines and criteria do you impose on Ambulance Victoria to direct the manner in which it deals with bereaved families when there has

been a suboptimal effort by Ambulance Victoria? Do you simply rely on it doing the right thing most of the time or being as responsive as it can be, or do you have an expectation that you provide to Ambulance Victoria about the manner in which it should engage with families? My understanding is that in this case it has been quite unsatisfactory.

Mr DAVIS — Again, moving away from the specifics, often these are matters of clinical decision making. Ambulance Victoria has a range of clinicians, medical panels and panels that actually have clinical knowledge. I am not claiming that, and I do not think you are claiming those clinical skills in this matter. Cases where performance is in some way suboptimal are routinely carefully investigated in terms of dispatch and other matters, but in terms of clinical decision making by paramedics or others, they are reviewed in that clinical way. There are longstanding panels of experienced clinicians who provide protocols to the paramedic workforce. The performance in a particular case is measured against those protocols. This is in part a clinical judgement matter, and I know Ambulance Victoria will ask experienced clinicians to provide advice in particular cases.

Mr ONDARCHIE — Minister, I draw your attention to budget paper 3, page 136, and the area associated with 'Public hospitals accredited'. The footnote refers to the introduction of the National Safety and Quality Health Service Standards from 1 July across the country. Could you explain what the new standards are and how they compare to previous standards?

Mr DAVIS — I thank the member for his question. This is one area of the new national arrangements that is perhaps working better than some other areas. I indicate that the government is committed to seeing higher levels of quality and higher levels of safety as a key focus for our health services. Victoria has a requirement that our services be accredited. The National Safety and Quality Health Service Standards form the basis for that accreditation. We are going through the new standards, and the new standards obviously provide a different basis for accreditation to the old standards. There is a challenge under those new standards to ensure that our services do well.

Standard 1 relates to governance for safety and quality in health service organisations. Standard 2 is about partnering with consumers. Standard 3 is preventing and controlling health-care associated infections. You will see elsewhere in our budget that there is a focus on preventing infections — hand hygiene and outcomes that prevent the transmission of infections. These are very important standards. Standard 4 relates to medication and safety. One of the areas of particular importance is that of ensuring that medication management is of the highest standard. The patient identification and procedure matching is standard 5. Clinical handover is standard 6. I think the community and those who are associated with health care will understand the importance of ensuring when shift changes occur that the proper handovers and protocols are adhered to there and that health services have standards in place of this type that meet national standards.

The blood products and blood standard is an important one too, and preventing and managing pressure injuries is also another standard. Standard 9 is recognising and responding to clinical deterioration in acute health care. There is a lot of evidence that where a deterioration occurs, that needs to be recognised and responded to quickly, so health services need to have those standards in place.

Standard 10 is preventing falls and harm from falls. In a lot of evidence a number of outcomes that are suboptimal in health services are related to falls and the lack of prevention of falls within a health service. I think the new standards are good standards; they have applied from 1 January 2013 nationally. Victoria has been doing well. I can indicate that consistently we have achieved 100 per cent of our services being awarded accreditation. A number of services may from time to time need to work in a particular area to reach that standard, but I think it is fair to say that Victoria is recognised nationally as leading the way. Fifty-one health services are scheduled for accreditation in 2014, and 17 community health services are scheduled for an accreditation survey for their dental services in 2014. Victoria has done extremely well and is seen as a leader nationally in having all of our services accredited and having them all achieve accreditation on the basis of the new standards.

The standards have been set in a way that the commission has been rolling this out over a three-year period. Approval to do that was given by health ministers in the period before, but it has been a very good outcome for Victoria and states and territories. In regard to the regulators of standards within jurisdictions, this is a change that we have seen so that there is a national set of standards that have been implemented to date — touch wood, successfully — in Victoria.

Mr SCOTT — Minister, prior to the election the coalition government — then opposition, now government — committed to $85 million for a stand-alone community hospital at Waurn Ponds. I note from your presentation, the budget papers and other documents in my possession that around $50 million has been committed to date. I seek clarification: do you still intend to provide the promised additional $35 million, or is it now a $50 million project?

Mr DAVIS — Some $165 million was promised for the Geelong region, including activity at Geelong Hospital and at the community hospital at Waurn Ponds. The government committed in the election period to ensure that that hospital was built on or adjacent to the campus of Deakin University, because we saw very strongly the need to guarantee access by the medical school and the nursing school to the important facilities at a community hospital. We saw the capacity to create a hub, if you will, on or adjacent to the Deakin University campus, strengthening the medical and research skills and strengthening the training links.

I can indicate that the government went to a registration-of-capability process late last year. There were a number of applicants for that registration-of-capability process. The government has commenced an exclusive negotiation with one provider. I can indicate that that negotiation — that process — is live at the moment, so I will obviously in the circumstances be circumspect about the precise details of the negotiation. But what I can indicate is the government is determined to drive every bit of scope and value that we can out of this contract. We intend to get as much, if not more, than we promised. I believe there is capacity to get more than we promised, so we will commit whatever is needed to get the outcome. I have no doubt that Geelong and the Barwon region will be provided with every single scrap of the promise and more.

Mr SCOTT — The press release I have is quite clear, and it states 'a new $85 million dollar hospital'. It also goes on to discuss that it will be a 32-bed hospital; however, government documents now show that it will be a 20-bed hospital operating with some chemotherapy and renal dialysis services in addition. Can you clarify that, rather than a stand-alone community hospital with 32 beds, this project is now a privately operated, publicly funded ward in a private hospital with 20 beds.

Mr DAVIS — I can guarantee to you that your description is incorrect. What I can guarantee to you is every single bit of scope that was promised will be delivered, and it may well be more. You will have to stay tuned, Chair, because we are in the midst of a negotiation process.

Mr PAKULA — Tell the people of Waurn Ponds that — stay tuned.

Mr DAVIS — I will say to the people of Waurn Ponds, and have said to the people of Barwon and the region, including Waurn Ponds, that I am confident that not just the scope that was promised but more will be delivered. So stay tuned.

Mr PAKULA — A public hospital.

Mr DAVIS — Stay tuned. If you read the news release, every single bit of scope will be delivered.

Mr ANGUS — Minister, going back to ambulance response times and ambulance matters, I refer you to budget paper 3, pages 141 to 143, which report on those ambulance services, with the output narrative stating that the government has a policy:

> … that Victorians deserve the highest quality ambulance services and have the right to expect timely responses to ambulance services during emergencies.

You have outlined some matters in relation to that, but can you further advise the committee how the government is in fact delivering on this policy?

Mr DAVIS — What I can say is that the government is working very hard indeed to deliver ambulance services and the highest quality ambulance services across the state. There is a record $696.5 million, compared to a much lesser figure under the previous government — a very significant increase. The government has delivered on its commitments to properly fund the ambulance service and begin the process of fixing the crisis left by the former government. We did promise the addition of 310 paramedics and 30 patient transport officers statewide. Indeed what we have delivered is much more than that. We promised to deliver the 10 MICA single-responder units in regional Victoria and 100 paramedics across the metropolitan area. All of those have been delivered.

MICA single-responder units are very important statewide. If I just step back for a moment and explain, traditionally full MICA services were only available in metropolitan Melbourne, Geelong, Ballarat, Bendigo and Traralgon. What this government has done is to deliver successively to 10 big regional cities MICA rosters for single-responder unit MICAs that cover a range of 80 to 100 kilometres around those big regional cities: Mildura, Swan Hill, Wodonga, Shepparton, Wangaratta, Sale, Bairnsdale, Wonthaggi — I am hoping I am not going to forget anyone off the list — and Warrnambool. They are very significant commitments that are making a significant difference in outcomes for patients and providing a targeted response service, providing service to those big population centres. The commitment there is a significant one, and we are delivering.

I can say that the government also has got a capital works program around the state — a very significant capital works program. Fifty-five of the total 88 new vehicles have been procured, 56 of a total of 77 new services have been implemented; there are thousands of new shifts across the state and new projects in terms of construction at Caroline Springs, Cobram, Geelong, Hampton Park — the list goes on, with projects going across the state. We are certainly prepared to continue delivering those. Obviously the HEMS contract that I have referred to already — the helicopter contract — is a very important one. It is a $550 million, 10-year contract delivering larger, faster air ambulances that can stretch to a bigger distance and are able to get there quicker, able to winch and lift more — carry two stretchers routinely if required. This will make a big difference for Ambulance Victoria.

There are some risks on the horizon, and one of the risks is the Labor Party's determination to undermine the MICA single-responder units in those 10 regional cities. Wade Noonan has been out repeatedly threatening to allow MICA paramedics to move to whatever spot they wish in the state, thereby preventing the concentration of MICA resources and putting at risk the MICA single-responder units in those 10 cities. I think it is time that Daniel Andrews made this a bipartisan issue and said 'We're going to stick with the MICA concentration of resources in those 10 regional cities' to make sure those MICA units cannot be unpicked or unwound by Labor. One big risk is if the election went a certain direction, Labor would allow MICA paramedics to go to any service they wanted around the state. That is what the imputation, very clearly, out of Wade Noonan's comments is. That would mean that the MICA units in Wodonga, Warrnambool, Mildura, Shepparton, Bairnsdale, Sale and Wonthaggi would all be stripped of MICA personnel.

Mr PAKULA — It does not mean anything of the sort.

Mr DAVIS — He has indeed.

Members interjecting.

Mr DAVIS — If you are stepping away from what he said, you need to say it. You need to be quite clear — —

The CHAIR — Order! There is an appropriate way to raise a concern, and that is to take a point of order, not to try to shout the minister down. If you have a point of order, indicate so, and I will hear it, but I will not have the minister or anyone else shouted down.

Mr DAVIS — There are other areas of risk with Labor's position too, and one of those — —

Mr PAKULA — On a point of order, Chair, it is the minister's responsibility to answer for the actions of his government and his portfolio. He does not have the right during these hearings to simply embark on commentary on his version of the opposition's position on anything.

Mr DAVIS — Tell me it is wrong.

Mr PAKULA — It is wrong.

Mr DAVIS — It is wrong? So MICA paramedics are not able to go to any area in the state; is that what you are saying?

Mr O'BRIEN — On the point of order, Chair, it is permissible for the minister to highlight risks that could occur to these important deliveries if there were to be a return of a Labor government.

Members interjecting.

The CHAIR — Order! It is certainly appropriate for the minister to refer to risks, but in accordance with generally accepted Assembly practice, which are the rules we are operating under today, it is not in order to reflect on the opposition. I recognise there is a fine line there, but the minister needs to walk it if he can.

Mr DAVIS — Chair, thank you. What I can say with respect to the ambulance output group is that one of the policies that Ambulance Victoria has in place allows the dispatch of graduate paramedics to the nearest case, as appropriate. This is a policy that was not in operation a number of years ago, and this led to some terrible and perverse outcomes. We as a government strongly support the dispatch of fully qualified graduate paramedics — they may be new graduate paramedics but fully qualified — to an available location where there is a patient in distress. There was one case in Yarrawonga where a patient waited impaled on a fence for 47 minutes under the previous government.

Mr PAKULA — You have been in government for four years.

Members interjecting.

Mr DAVIS — You want to unwind that policy. They waited 47 minutes impaled on a fence, and there was a fully qualified graduate paramedic down the road. Now we would dispatch that, and we do. Ambulance Victoria under us is dispatching those patients. Let me be quite clear: Wade Noonan and the Labor Party would not implement that policy. They would reverse it and go back to the old policy. That is what they would do.

Members interjecting.

Mr DAVIS — We would make sure, and we do make sure, that fully qualified graduate paramedics are dispatched. The union's position is that they should not be, and Labor supported that position and said, 'We won't dispatch them'. That would see the Yarrawonga case occur again, and I do not want to see that Yarrawonga case occur again, where a woman was impaled for 47 minutes on a fence, and there was a graduate paramedic just around the corner — who would not be dispatched under Labor's policy. That is a disgrace.

Ms GARRETT — Again I remind the minister that he has had responsibility for this area for several years, and I also remind the minister that I understand he gets very agitated about Wade Noonan. Maybe it is because Wade Noonan's extensive work in putting scrutiny and spotlight — —

The CHAIR — There is the opportunity for a little bit of preamble to set the scene for a question, but not — —

Ms GARRETT — I am responding. Moving on, this has been quite the day for the government shirking responsibility, scrutiny, openness and transparency, and I ask a further question arising from budget paper 4, page 36, regarding the Waurn Ponds community hospital. We have all been told to stay tuned, apparently. I tell you the people of Waurn Ponds and the Geelong region are very tuned in to what is going on with this particular project. I ask: can the minister outline on what basis the government made the decision to abandon their election commitment to build a second public hospital in Geelong and award a secret contract to Epworth health to build and operate the hospital?

Mr DAVIS — I completely reject the premise of the question. The government has followed through entirely with its commitment. The government is pushing forward to deliver that service. Let us be quite clear: Labor did not deliver this service; they never delivered it. They had 11 years in government. They did not deliver the upgrade at Geelong Hospital, they did not deliver Barwon Health North and they did not deliver the Waurn Ponds community facility. What this government is determined to do is to deliver the maximum scope and the maximum capacity at Waurn Ponds. We are determined to see that we strike a deal that gets the best outcome for the people in the Waurn Ponds area and Barwon region more generally.

What we decided to do is not build the hospital down in the cow paddocks away from the university. We decided that we would build it, and our election commitment was to build it on or adjacent to Deakin University. Allocations of money have occurred, a registration-of-capability process began last year, there is a live negotiation going with one party — I can tell you it is live and current — and we are determined to get a very good outcome for the people of Geelong. That will stand in stark contrast to what Labor did. Let us be quite clear what was going on down in Armstrong Creek, down in the cow paddocks there: Michael Crutchfield

had some mates who owned some land down there, and there was a crook side deal going on. We know what was going on: a crook side deal.

Ms GARRETT — Come on, start acting like a minister.

Mr PAKULA — You really want to go there this week after the dodgy dealings of your government have been exposed? You want to talk about crooks?

Mr DAVIS — Let me be clear: we know what was going on there. We said we would build it on or adjacent to Deakin University, and that is what we intend to do.

Mr PAKULA — Talk about watch this space!

Mr DAVIS — That is what we intend to do.

Ms GARRETT — On a supplementary — —

The CHAIR — That is stretching it a bit after that.

Mr PAKULA — After that? Crook side deals?

Ms GARRETT — I note your reference to you doing live negotiations with a single provider — RFC all over again, dare we say? We would like to know — I think the Victorian public would like to know what process for assessment was made prior to the department writing to St John of God excluding them from this process and how this led to exclusive negotiations commencing with Epworth?

Mr DAVIS — As you will understand, this is a live process. We are in the process of working our way through this in a structured way that is part of a process that has probity auditors all over it to make sure that this is absolutely crystal clear and absolutely beyond reproach. This will see a range of services delivered, and we are certainly determined to see an outcome for the community. What is clear is that the previous government did not deliver any services there.

Mr PAKULA — Why did you boot St John of God?

The CHAIR — Order!

Mr DAVIS — I think the committee will understand that in a process of this type there are a number of applicants, and the process that is conducted by the department with probity — making sure that every step is beyond reproach — will see not three groups that can deliver the service but perhaps one or another. Sometimes one party will not win an outcome; another will win it. That will be a matter of assessment of value for the government and outcomes for the community, and it will be assessed against proper criteria. That is the way it is conducted.

Members interjecting.

Mr DAVIS — I have got to say, this is a very proper process that is being conducted, with probity orders making sure that every step of it is beyond reproach, and everything that was promised will be delivered and perhaps more.

Mr O'BRIEN — Minister, I want to refer you to budget paper 3, page 139, which is in regard to the government's aim to provide high-quality accessible health and community services, specifically in the area of improving waiting times for emergency services. I ask you, Minister, can you provide the committee with any update on the proportion of ambulance patient transfers within 40 minutes?

Mr DAVIS — Thank you, Chair. What I can say is the transfer time reporting undertaken by the government is new and stands in stark contrast to the previous government's reporting. They actually hid these figures. These figures were not reported by the previous government, and this government instituted a process to report on transfer times. A benchmark was set, and — I can be quite clear — the health services initially found this benchmark quite tough. I can thank the department for advice on this.

An emergency access reference committee was put in place to work through some of the policy directives and roles and responsibilities for health services and Ambulance Victoria. I can thank a number of the members of that committee, including Ambulance Victoria members who contributed to it. Then the government established a task force that was chaired by Andrew Stripp, deputy chief executive and chief operating officer at Alfred Health. It comprised Dr Fergus Kerr, the medical director of medicine and emergency at the Austin; Associate Professor Tony Walker, general manager, regional services, Ambulance Victoria; Melissa Tully, the nurse unit manager of the emergency department at Sunshine Hospital; and obviously, importantly, Andrew Stripp himself.

The task force made a number of clear recommendations about how Ambulance Victoria should deliver patients to the nearest ED in accordance with clinical needs, ensuring an optimal distribution of ambulance arrivals across our hospitals. It made recommendations about emergency departments being advised by Ambulance Victoria of any patient that is en route prior to arrival; how health services chief executives should ensure that the hospital is available to provide assessment, investigations and treatment of patients arriving by ambulance to an ED; and that hospitals should assume immediate responsibility for patient care on arrival of an ambulance to emergency.

I can say that there has been a very significant improvement. If you look at the performance targets, we are not quite there, but we are certainly making very significant strides, and I pay tribute to the work being done by our ambulance paramedics, the emergency departments, particularly their directors, and indeed clinical people across the rest of our major hospitals and the CEOs. By understanding that this is a whole-of-hospital challenge, it is not sufficient to push the pressure onto an emergency department it has got to be worked out at our whole-of-hospital level so that people who can be moved into the hospital, or indeed discharged from the emergency department home, have that support, have the backup to do that, enabling the moving of patients into the emergency departments.

This has been a very successful set of steps. I do pay tribute to the work that Andrew Stripp did. Part of this was, I think, a process of deep engagement with the emergency directors and the CEOs around the state ensuring that there was a very close outcome achieved here. I look forward to further improvement here. I think there is a task — and there have been some figures released today, which I have provided to you, Chair, that actually show that the performance improvement is continuing. Again, this stands in stark contrast to the previous government, which hid these figures. It was not prepared to release the transfer time figures, nor the HEWS, the hospital early warning system, figures, which in my view ought to be properly in the public domain.

One important thing about the transfer time figures is that they do relate to ambulance resources. By enabling clearer and swifter discharge arrangements from ambulance into the emergency department it does help free up ambulances to return to their primary duty. which is to pick up urgent patients and bring them to health services. I think, importantly, that is steadily occurring. I think we need to be quite clear that not every ambulance at a hospital is lining up to discharge patients. Ambulances routinely go to hospital for a range of reasons: sometimes picking up patients, sometimes discharging patients, sometimes restocking their equipment, sometimes doing write-up and case notes — and all of that is appropriate — and sometimes breaking for a well-earnt rest too.

Mr PAKULA — I ask the minister to refer to the statement of finances, budget paper 5, pages 170 and 171, which talks about the national health reform agreement. Minister, yesterday in question time you were asked if you could confirm commonwealth figures in the budget, and your answer, to paraphrase, was that only the commonwealth Treasurer and the cabinet could guarantee what the federal funding figures are.

Mr DAVIS — And you disagree with that?

Mr PAKULA — No, no.

Mr DAVIS — Or you have got a tip on the federal budget?

Mr PAKULA — Minister, I think I am asking the questions, and I am not the minister, so why do we not just stick to me asking you a question? What I want to get the bottom of is: these commonwealth figures that are in the state budget, is it your evidence that none of those figures are actually confirmed?

Mr DAVIS — Chair, I think you have had the Treasurer in this morning, as I understand it, and he will have outlined his principles for laying out the budget in general. If I can perhaps summarise for him in this area and indicate that this has been struck, as I understand it, by Treasury, whose document it is, with advice from Health, that this has been struck in a cautious way, not overstating what could occur but actually looking at areas where we know there will be changes and trying to structure that in the best way that we can to frame a budget.

So if I start at the bottom end of the table, for example, home and community care, or HACC, this is an important little program, a $4 million program that provided additional support for veterans. That falls to zero. That is a significant impact on the budget and the support that we can provide in the HACC area. We have obviously made significant representations to the previous commonwealth government, which in its budgeting took it to zero, and also to the current government. So I do not know what they will do in the commonwealth budget with home and community care, specifically for veterans HACC. I would hope that the money would be restored, but I do not know what will happen, nor does our Treasurer. So he has structured this as best we can in the knowledge that there has been some indication that it will not proceed. I am using that by way of example. Likewise, through these other areas, each area of the interaction has been sought to be tabulated in a reasonable way.

Mr PAKULA — So if we just go to the top figure on 170, because you talk about an estimate based on the best advice you have, but the number that you have got for the national health reform agreement is a very specific number. It is 3756.9 billion, and a specific change of 7.8 per cent, so it does not look like a guesstimate; it looks like a fairly specific number. What I am wondering, given what you have said about not knowing what is going to be in the commonwealth budget next Tuesday, is: what is that number based on? It is an estimate from last year's federal budget, is it based on the MYEFO in December or is it an assessment of what you think will be in the commonwealth budget on Tuesday?

Mr DAVIS — There is an estimate of what the indexation arrangements will be, and there is obviously an estimate also about the various interactions of the uplifts in the different parts of the budget. I might add that none of these are in isolation either. One will impact on the activities in other areas as well, so it is a very complex matrix. I am not pretending to have an absolute answer, and I do think we are going to have to wait until federal budget day, but I might let Lance Wallace respond a bit too.

Mr WALLACE — Until the 14–15 financial year, the way that the commonwealth-state funding arrangements worked was that there was a figure determined by the federal government that was provided to the state on an SPP-based funding determination. Under the new arrangement it is based on indexation and volume estimates. It is a complex set of federal procedures which — the independent pricing authority, the new federal administrator-determined indexation and growth parameters, so you just cannot simply take the forward estimates; you have got to actually work on information that has been provided to us from a number of federal agencies.

So in conjunction with Treasury we have got the best information we can have on indexation levels from the independent pricing authority determinations, and then in conjunction with the state we have got the best estimates we can determine in discussions with the administrator and federal agencies on likely growth funding. That is what has been provided in the budget.

Mr DAVIS — But I do make the point that there can be a different outcome that might be alluded to in the federal budget, so obviously all the state can do is work through each of these areas in the best way it can.

Mr PAKULA — We would all want to hope there are no cuts to this on Tuesday.

Mr DAVIS — I have been very clear that the new federal system has this inherent and problematic complexity. So, for example, we have had a significant fight with the IHPA about indexation. The initial estimate for indexation was 0.24 per cent. We went in to bat very hard to make sure that that was provided at a more sensible level, and there will be a 3.9 per cent number that IHPA is putting into the mix, but as Lance Wallace says, there are other factors, including volume and so forth, that do count here as well. I am actually genuinely just saying this is a very complex mixture.

Mr O'BRIEN — Minister, I refer you to the rural and regional Victoria budget information paper, on page 19, and that refers to the $550 million investment in the helicopter emergency medical service, or HEMS,

fleet which you also touched on in your slide presentation. I ask you, Minister, could you please inform the committee about what benefits to the community, and more specifically Victorians in rural regions, will be delivered as a result of this important investment?

Mr DAVIS — This is a very significant investment. I was very pleased to join the CEO of Ambulance Victoria, Greg Sassella, and representatives at the announcement of the $550 million for our helicopters. They are remarkable helicopters, and they will provide greater capacity to move people around the state, being based at Bendigo, Latrobe, Warrnambool and Essendon, but providing service everywhere, including, importantly, into Ballarat, in the new helipad zone there, when that helipad is completed.

Mr ONDARCHIE — There is a helipad?

Mr DAVIS — There will be. It is being built as we speak — as I said earlier, in conjunction with council. So there is so car parking underneath for the hospital and council car parking as well and then the helipad on top, which will provide the linkages into the hospital so that the emergency helicopters will either be able to bring patients to Ballarat or indeed lift patients from Ballarat to a specific, perhaps city, hospital.

With these helicopters, patients from more than 250 kilometres away can be in Melbourne in less than 1 hour, providing rapid transport to major trauma, cardiac and specialist hospitals. Victoria's remarkable system of trauma management, coming specifically to the Alfred, the Royal Melbourne and the Children's, for paediatric cases, is a system that is being looked at worldwide. I know other jurisdictions have looked at the very strong trauma system we have here. These new helicopters will provide a great outcome in terms of the state. The helicopter emergency medical service, HEMS, has a very proud 50-year history for Victoria's air ambulance. Begun in 1962 with 12 patients transported, it has been through a number of iterations.

Air ambulance retrieval helicopter operations began in 1986, operating from Essendon. In 1987 air ambulance took over control of a second emergency retrieval helicopter, known as Helimed 1 or now HEMS 2, and began a third operation in Bendigo airport. Two more retrieval helicopters were also operating from Essendon and one in Warrnambool from 2009. In 12–13 there were 2283 helicopters that took these cases. These are emergency cases, and there are also basic transport cases.

As I said earlier, the unique thing about this contract is it will put us in the position of having the very best helicopters, the new AgustaWestland AW139 twin-engine helicopters. They have got the latest avionics technology. As I said, they are bigger, faster and can travel much longer distances without refuelling, and this is going to put a significant shot in the arm for our services.

It is also an important point — and I pay tribute to the work of the department here and Health Purchasing Victoria, which actually ran the contract management side of this, bringing their undoubted and regular expertise of contract management into what is a very big contract, with Ambulance Victoria and the highly qualified paramedics providing the scope, the clinical details and the service details of what would be required — that the machinery of the contract was run by Health Purchasing Victoria. I think this has been a good model. It has delivered good value. I mean, they are very expensive items, there is no question, and they are provided as a 10-year contract with maintenance, and I think pilots are in it too. That is a very significant point, but the paramedics are the clinical end of it that make the difference.

Mr SCOTT — In your presentation and at various times through the hearings, including just then, you have made reference to 550 million for air ambulance. Why does this expenditure not appear in either the service delivery or capital budget papers?

Mr DAVIS — As I understand it, this is a contract that came through quite late in the piece, but it is a contract which is accounted for in the budget, as I understand it, into the future, making the point that air ambulance costs are already in some measure within the ambulance base.

Mr SCOTT — Can you please step us through the 10-year cash flow of this investment?

Mr DAVIS — I do not have that to hand, but we can provide information to the committee on that.

Mr PAKULA — Sorry? It is not in the budget; is that what he is saying?

The CHAIR — That is not what I heard him say.

Mr PAKULA — It is not in the budget — the air ambulance?

Mr DAVIS — It is. You can have a look on page 19 of the rural and regional statement.

Mr PAKULA — It is not actually in the budget; it is not accounted for in the budget.

Mr DAVIS — If you look at ambulance services, it is there.

The CHAIR — Order! The minister said clearly, as I understand it, it is accounted for in the budget.

Mr PAKULA — He cannot show us where.

The CHAIR — I think a check of the transcript will deal with that.

Mr DAVIS — The ambulance output group contains air ambulance costs.

Mr ANGUS — Minister, I refer you to budget paper 3, page 132, which lists the government's reform priorities outlined in the *Victorian Health Priorities Framework 2012–2022*. One of the priorities listed is increasing the system's financial sustainability and productivity, and another is expanding service workforce and system capacity. Minister, can you please provide the committee with an update on the progress of the Ambulance Victoria EBA in the context of these priorities?

Mr DAVIS — I can indicate that the ambulance union has in the last 24 hours issued further documentation to Ambulance Victoria. This is very disappointing, I might add, because there was another session at Fair Work yesterday afternoon and we were hopeful that progress would be made. But as I understand it further documents have been issued to Ambulance Victoria indicating that further bans and further industrial action — hardline industrial action — will be taken as of Tuesday. We are obviously concerned about what that might do. That is being closely assessed. This is unfortunate, as we have indicated, because Ambulance Victoria and the government have been closely involved in the negotiations in good faith.

I can indicate that the government's offer through Ambulance Victoria is a very significant offer. It is $1500 in a sign-on bonus, a 6 per cent increase in pay followed by two further tranches of 3 per cent — a total of 12 per cent — and the capacity to negotiate other matters outside those points either through negotiation or ultimately through independent arbitration so that a fair and independent umpire could arbitrate on those matters. But I have got to say, I look around the community, I talk to people widely and there are very few people who are getting 12 per cent pay rises, getting these big uplifts in pay; this is pretty significant. I do not detect that the manufacturing industry or the financial services sector, retailing, the media — wherever you look across the community, 12 per cent pay rises are reasonably abnormal.

The union has got a log of claims which is to the tune of $1.3 billion over four years, a massive lift in terms of what they are seeking for paramedics. I know that the bargaining that has occurred at Fair Work is important bargaining, and we certainly look at this as an important way forward, but it seems that the union is not prepared to do the hard work there. I think there has been a little bit of a go-slow.

I know there are a number of points about this. If you think about what is actually going on here, one sticking point increasingly I think has become the union facilitation clause, and I do not know whether the community knows fully about this. The union facilitation clause is a significant one in the current EBA, but the new proposal by the ambulance union — the hardline ambulance union — would seek more. It would seek 13 weeks per year, an increase in the secondment to the union of ambulance paramedics — these are employed by Ambulance Victoria — from 13 weeks to 26 weeks per year; and an increase in the paid attendance one shift for 15 lots of state councillors to attend six state council meetings per year, including as union delegates. So these would be highly trained paramedics who, instead of being on the road providing response to services, would actually be at various union related matters — —

Mr ONDARCHIE — Paid employees.

Mr DAVIS — As paid, not as part of their leave. Just paid. Their leave is quite additional. This is not a day off, a rostered day off or — —

Mr ONDARCHIE — Just go and work at the union.

Mr DAVIS — You go and work at the union, and you will get paid. This is one of the sticking points — the uplift that is required. They also seek to increase the paid attendance of 55 days per year for workplace relations and training. Now there are millions of dollars of costs that are proposed in this EBA union facilitation clause, and the facilitation clause — —

Mr SCOTT — This will help.

Mr DAVIS — Mr Scott says, 'This will help'. My objective is to make sure that the capacity of Ambulance Victoria is to respond. If you take 15 or 20 or 25 union members off the job, send them to the union conference and they are not able — —

Members interjecting.

The CHAIR — Order!

Mr DAVIS — Well, funded by a membership scheme and taxpayers; these are ambulance members who are forced to pay. That is what the union is pushing for. It is pushing for an expansion of these provisions to see more union members taken off the road and put at union meetings and union state councils rather than being on the road, delivering services. I would rather them not be at the union on secondment. I would rather they get their feet out from under the union desk and actually go back into the ambulance and respond around the state. I mean, this is a key point. It is a sticking point that the union is pushing hard for an expansion, through their log of claims, of union facilitation. They want to double the secondment; they want to increase the number of state councillors who attend meetings every year. I know the Labor Party finds it very hard here because they are major donors. United Voice has donated almost $1 million over the last 11 years. I know it is tricky for them.

Mr PAKULA — How much do you get from tobacco?

Mr DAVIS — We get none, but you get money from tobacco unions.

Members interjecting.

Mr DAVIS — You get money from tobacco unions. I have never taken a cent from tobacco, but you have taken money from a tobacco union, so you need to renounce the votes on your state council for tobacco unions, and you should do that — and on your pre-selections, so let us get into this. The key thing on this EBA, one key aspect is the union is pushing for an expanded facilitation of union activities. They want secondments, they want people travelling to union meetings rather than delivering services to patients.

Mr O'BRIEN — Paid credit cards?

Mr DAVIS — It would weaken the response. Let me look at this, for example. Imagine a major fire day or a major natural disaster. The union's got scores of people taken off to state council on a paid junket to a union conference and not on the road delivering services. We have a real challenge to make sure that these union facilitation provisions are not expanded at huge cost to the community.

Mr PAKULA — So that is why you have not been able to reach agreement?

Members interjecting.

Mr DAVIS — I think it is one reason.

Mr PAKULA — Nothing to do with your customer services.

The CHAIR — When everyone is ready, I am sure Ms Garrett has a question.

Ms GARRETT — I am sure, yes, while we are talking about people's friends.

Mr O'BRIEN — What about the commonwealth cuts?

Ms GARRETT — I think that brings us quite neatly to your friend Tony Abbot, who is about to bring down, from all accounts — —

Mr O'BRIEN — Responding to your friend Wayne Swan.

The CHAIR — Mr O'Brien!

Ms GARRETT — quite a significant budget. I am sure that will go well. I refer to budget paper 5, page 171, 'Payments for health services' and refer you to your friend Tony Abbot's health cuts, and I would you to talk the committee through in a very significant way the full impact of the following commonwealth government cuts from the Victorian health budget: 'Improving public hospital services' — $154.7 million; 'Financial assistance for long-stay older patients' — 4.1 million; 'National Reform Agenda for Organ and Tissue Donation' — 8.2 million; and 'Statewide Enhancements to Regional Cancer Services' — 4 million.

Mr ONDARCHIE — And the carbon tax.

Mr DAVIS — This is a reprise — I will come to the carbon tax in a minute — —

Ms GARRETT — I hope you do come to the carbon tax.

Mr PAKULA — You would have plenty to say about those cuts if it had been Gillard.

Members interjecting.

Mr PAKULA — You would have said plenty about those cuts.

The CHAIR — Order!

Mr DAVIS — Table 4.9. I have said plenty about the risks we face out of the federal budget and the risks that the NPA will not be renewed. The previous Labor government — the now Leader of the Opposition — signed a four-year deal. It was a four-year deal that had no end point; it just dropped off its perch on 30 June. So the 'Improving public hospital services' — it is not 150 million, it is more likely just short of 100 million in fact this financial year.

Ms GARRETT — It is in the budget paper — the budget paper is wrong?

Members interjecting.

Mr DAVIS — No. In terms of current costs, the 154 includes a capital component, so it will drop, both recurrent and capital, to zero unless it is renewed. Daniel Andrews signed the deal dropping to zero and did not negotiate a good outcome in terms of ongoing costs. I believe an outcome should be reached with the federal government, and I have certainly put this very directly to the federal government that we need to get an outcome here that sees a significant ongoing position for the state. We do not want to see subacute beds closed around the state; we do not want to see reduced assistance for long-stay older patients; we do not want to see — the HACC example I gave before — reduced HACC support to veterans. All of that is absolutely the case and health ministers have made that very clear nationally.

Obviously this is, as I said before, a very complex matrix and we are going to be advocating very strongly, as we have to date. I have been very active in making the points about the indexation, which we discussed before, and Victoria and Queensland and New South Wales very clearly indicated that the initial proposals for indexation were completely and utterly unacceptable. This is a complex description here of what we need to do as we go forward and what we need to focus on to get the best outcome. On the current figures, as we can best outline, this would see a 2.9 per cent change in commonwealth funding. That would not keep pace — that is not sufficient — and we are certainly advocating for an outcome that will see some change in those arrangements. This will be a difficult set of negotiations, but we will certainly be making those negotiations.

What is striking about this is that when we go back to the previous commonwealth government, they made a midyear cut — 475 million but 107 million in the 12–13 financial year.

Member interjecting.

Mr DAVIS — It was midyear, and they made this adjustment which saw 107 million pulled out of the Victorian hospital system.

Mr ONDARCHIE — Based on what?

Mr DAVIS — 7 December 2012 saw 15.3 million less go into the pool.

Members interjecting.

Mr DAVIS — You, Mr Pakula — you voted in favour of those cuts. You actually voted in favour of those cuts. You and your members — —

Members interjecting.

The CHAIR — Order! I know we have been going over 2 hours but we have still got almost an hour to go, so let us try and keep it civilised. Minister, can I ask you not to attack the opposition. Commentary on the former government is fine, but attacking the opposition is not.

Members interjecting.

Mr DAVIS — I put a proposal on the National Centre for Farmer Health to Tanya Plibersek.

Mr PAKULA — You should have funded it.

Mr DAVIS — We have got 250 000 on the table. You had nothing on the table.

Members interjecting.

Hearing suspended.

Ms GARRETT — Prior to the break we were talking about Tony Abbott's Christmas present to Victorians of a $277 million cut to our health system.

Mr DAVIS — I do not think that is right. Where is that in there? I cannot see that.

Ms GARRETT — We just went through them. We know Tony Abbott ripped $277 million out of Victoria's health system for Christmas. I know you are getting very agitated about Julia Gillard. It would be nice if you got as agitated about Tony Abbott.

Mr DAVIS — Could you just show me where that is? I cannot see that in here.

Ms GARRETT — It has been a very clear public statement. He ripped $277 million out of Victoria's health budget at Christmas time.

Mr DAVIS — No, it has not. It actually has not. That is quite wrong.

Ms GARRETT — And I ask as a supplementary question: on the same table on page 171 of budget paper 5, there is a reference to a $56.2 million payment for 'Other'. What does that refer to, Minister?

Mr DAVIS — I can provide details of that. It is a number of small programs. We can certainly provide those.

Mr O'BRIEN — Minister, I wish to draw your attention to budget paper 1, Treasurer's speech. On page 9, the Treasurer states:

> Victoria's health system continues to lead the nation in providing responsive, integrated and innovative health-care options.

Minister, could you please inform the committee about the government's plans for the mobile intensive care ambulances — MICA — and crews?

Mr DAVIS — I thank the member for his question. The government has made significant commitments on country ambulance services, particularly the expansion of 210 paramedics plus 30 patient transport officers, and in fact that has been greatly exceeded as part of the 465 that have been put in place statewide. One of the points we made in the election period, and it is being steadily delivered statewide, is the provision of MICA support — mobile intensive care ambulance support — with relevant crews to 10 country centres. As I said before, they are

Warrnambool, Bairnsdale, Horsham, Mildura, Shepparton, Wangaratta, Wodonga, Wonthaggi, Sale and Swan Hill. These are very important additions to country ambulance services. What they do is they ensure that there is a single responder unit MICA team available to provide a response, and we are very much determined to strengthen these things statewide.

I have already alluded to the fact that I am very concerned that this is now not being treated in a bipartisan way and that Wade Noonan and other members of the opposition are seeking to undermine this important commitment. One of the things that this MICA commitment provides to Victoria in an 80 to 100-kilometre radius around those key cities and the population centres contained in those cities is MICA services, and those MICA services are absolutely critical to lifting survival rates and outcomes for country communities.

We have said that we would provide these, and we are doing this. This is being rolled out statewide. It is a very important program. In the fullness of time people will look back and see this as an historic shift and an historic commitment to make sure that those 10 big regional cities and the hinterland around them actually have access to MICA services, which has not traditionally been the case. This is something that the government can point to as a very significant achievement, an achievement that we will look back on with great pride.

What I am concerned about, though, is members of the opposition who seek to say that MICA paramedics will not need to be clustered or concentrated in these areas. They obviously do need to be to make sure that we have significant and full rosters available. of you dissipate the highly qualified MICA paramedics all over the countryside, in a small town there might be a MICA-trained officer but he or she does not have the equipment that is available to a full MICA unit, and also if they are not on at that particular time, there will not be MICA support available. By Ambulance Victoria concentrating that support for MICA coverage in those large cities we can undertake a much greater outcome for the community in terms of community safety. What we do not want to see is this undermined or put at risk.

Other aspects of the ambulance services into country Victoria that will deliver very strong outcomes as well. The rollout of thrombolytic drugs is an important outcome as part of the state's cardiac plan. That cardiac plan, released last year, will see a much better and more integrated, more comprehensive approach to cardiac protection than was the case previously. It is a concentrated plan that actually has preventive steps in terms of health promotion and prevention steps but also the provision statewide of new facilities, so, for example, the Latrobe hospital will have a cardiac catheterisation lab. The federal government has agreed to fund a cardiac catheterisation lab at Albury-Wodonga. All of these are important parts of the system of making sure that we are going to have a much better clinical outcome for patients.

But one key linchpin in that is the single responder MICA units that are being placed in the 10 regional cities. I for one would not want to see Wade Noonan or anyone else undermine those. It is time, I think, Daniel Andrews said, 'No, we are going to stick to the plan and we are not going to undermine these 10 regional cities' MICA single responders'.

Mr PAKULA — I find the minister's obsession with Mr Noonan a little disturbing, particularly given that he is now the police — —

Members interjecting.

Mr PAKULA — Now that he is the police shadow — —

Members interjecting.

Mr PAKULA — Nothing to do with you anymore.

Mr DAVIS — The problem is I am determined to see those MICAs remain; I do not want them unpicked by your side of politics.

Mr PAKULA — He is not even the shadow — —

Members interjecting.

Mr DAVIS — In which case you will be very happy to renounce his statements and say there that you do not stick by that and you do want all 10 MICA services to take up the concentration of MICA officers. Is that what you are saying?

Mr PAKULA — Do you think you are still in opposition or something?

Members interjecting.

Mr PAKULA — I just want to ask a bit about this national health reform agreement, in particular in regards to acute health services. I am interested in the way the minister keeps characterising this as an agreement signed by Daniel Andrews, because my recollection was that it was renegotiated by the minister and Ted Baillieu when he was Premier, and I remember the media release at the time where the minister told us how fantastic it was now since it had been renegotiated. You do seem to have missed that step in your commentary.

Let me just take you to budget paper 3, page 133, and budget paper 5, page 170, because I just want to — —

Mr DAVIS — 130?

Mr PAKULA — 133 of BP3 and 170 of BP5. I just want to ask the minister to compare and contrast something for me. In the table in BP3, 'Acute health services' — you have got that jumping by 439 million from budget 13–14 to budget 14–15 — from 9836 to 10 275, right? That is a jump of 439. Under the 'National health reform agreement' at the top of page 170 you have got the commonwealth contribution jumping by 270 million. It seems to me, unless the minister wants to disabuse me of this, that 270 of the 439 is being provided by the commonwealth, so my question is: why is it, in regards to acute services, that the commonwealth is putting in 61.5 per cent of the growth and the state is only putting in 38.5 per cent of the growth?

Mr DAVIS — I do not think that is a correct characterisation.

Mr PAKULA — Tell me where it is wrong.

Mr DAVIS — Let me explain. If you are looking at improving public hospital services, as things currently stand there is a fall-off in funding. We are obviously advocating for that, and I have put the caveats around the outcome of some of these points, but if subacute beds fall off, that will have an effect on acute health services statewide.

Mr PAKULA — Where are you pointing to?

Mr DAVIS — I am pointing to the second item on page 171, the second there — 'Improving public hospital services'. This is acute health money providing subacute services — —

Mr PAKULA — So you are saying that 154.7 is — —

Mr DAVIS — Yes, which includes a capital component and includes — —

Mr PAKULA — acute?

Mr DAVIS — Acute health services is an output group which covers a whole range of things, including blood products and a large number of other items. So what you have to do in the acute output group is to reconcile a number of these key items which are in play. You have to reconcile the aggregate outcome. If you look at the aggregate outcome down the bottom there, on the table, you see that as things currently stand the commonwealth will increase its aggregate funding by 2.9 per cent. I have indicated, as I said, that there is a number of moving parts, if you will, in this.

Mr PAKULA — As a supp, to the best of your ability then — and I am happy if you want to get Mr Wallace or Dr Philip to jump in — of the $439 million increase that you have budgeted for in acute, how much of that is Victorian money and how much of that is federal money?

Mr DAVIS — Well, 4.2 per cent in aggregate for the portfolio but 4.5 per cent overall, and if you look at the acute side of things, 2.9 is not a bad approximation, with the caveats, of the commonwealth increase.

Mr PAKULA — Sorry, so is it half commonwealth, half state or a bit one way or the other?

Mr DAVIS — I think as things currently stand there will be a greater state increase than commonwealth, but we will have to wait and see what actually occurs.

Mr ONDARCHIE — Minister, budget paper 4, page 34, is the one that lists Department of Health new projects. Particularly, I want to talk about the expansion for the Healesville hospital, which has a special place in my heart, having lived and worked in Healesville for a little while. I was part of the Apex club, and it was a great auxiliary supporter of the Healesville hospital, In fact my first son started his birth process at Healesville hospital, but it did not carry through because of some complications. He moved on to another hospital during that process. Could you talk to the committee about the benefits that will be delivered to that community through that expansion?

Mr DAVIS — The government has committed to a total outcome of a $7.8 million expansion for Healesville hospital, which will set it up for a very good outcome into the future. There will be a new operating theatre; a new 6-chair renal dialysis unit; an expansion and redevelopment of Yarra Valley Community Health; a reconfiguration and refurbishment of the inpatient ward area to provide 12 beds, including one room which can be used as a birthing suite; and bedroom ensuites. There will be consulting suites and associated support and staff amenities.

We have also, to date, increased surgical activity at the site, but there will be further increases in surgical endoscopy and gynaecological procedures at the site as it goes forward, and new specialist clinics will offer additional appointments for cardiology, endocrinology, gastroenterology and respiratory services. The additional services that will be provided at Healesville will constitute a 30 per cent increase in services, and they are being established to meet local community service needs.

I should say that Cindy McLeish, the local member, has been a very strong advocate for the Healesville hospital. She has been very much prepared to fight for her local community. It was clear that we needed to upscale any proposals for expansion of the facilities at Healesville, and the government is very determined to see these outcomes achieved. That is why the additional funding has been provided in this year's budget to see the additional services provided.

Healesville is obviously part of Eastern Health and Eastern Health is also contributing to this expansion, and we look forward to working with Eastern Health to see that expansion and the work. Alan Lilley, the CEO, and a number of the key clinical staff have been very focused on managing an increase in some of the acute health services that are provided at Healesville.

The challenge for services like Healesville often relates to staffing. Whilst many would want to see birthing services at Healesville, and that would be something that I would ideally like to see, one of the challenges is that one of the doctors has decided not to continue in that role. It is part of the longstanding challenge of having proceduralist doctors in position in country Victoria. There is a long 30 or 40-year story of less proceduralist practitioners being available — less who are prepared to undertake anaesthetics, less who are prepared to undertake obstetric services — and the challenge is there across the system. In trying to provide those services we had close contact with Medicare Local and indeed with Dr Carruthers, who is the remaining procedural — —

Member interjecting.

Mr DAVIS — You know Dr Carruthers? He is a very fine individual and a great exponent for his town and community. The task over time is to make sure that there are additional medical services available and ultimately proceduralists who can support some of the new activities that will ultimately occur at the new $7.8 million hospital. I think that will set the town up for a very strong future in terms of acute health services.

The CHAIR — Before I call Mr Scott, can I just remind the gallery that I did indicate right at the outset that they cannot participate in the hearing in any way. I ask you all to just be nice and quiet. Obviously whispering is fine, but there has been a little bit of other activity going on, and that is outside the rules. If people would like to participate in the hearing by just listening, that would be appreciated.

Mr SCOTT — Minister, I draw your attention to budget paper 3, page 135. There is a performance measure 'Subacute bed days', and there is a decline in the number from 733 000 as an expected outcome and target in 2013–14 and a target in 14–15 of 648 000 — a decline of 85 000. I am sure the minister would be aware that on 30 March there was a newspaper report that the Premier had warned the Prime Minister about lapsing commonwealth funding, and you made some references I believe to that particular issue, particularly the 332 subacute beds that were funded for four years as part of the COAG health reform in 2010. I would just like to check with you: are the 85 000 fewer subacute bed days a direct result of this cut?

Mr DAVIS — The risk is that if the NPA is not renewed in some form, and it does not have to be in the precise form that it existed before, and if some accommodation is not made — and there are some potential ways through which we can use to get to an adjustment at a national level that will recognise at least in part the contribution that the NPA has made — there is no question that there will be a fall-off in aggregate activity. The state would be in the position of having less activity in that area and faced with the choice of compensating that in some way or moving resources from another area. I have obviously made the point with respect to table 4.9 in budget paper 5 that there is huge uncertainty in terms of what will occur with the NPA on improving public hospitals and a number of these other agreements as well.

What the state has sought to do in this budget is to represent as fairly as we can the position we think things are at. I have pointed to the uncertainty that we do not know what the commonwealth budget will contain; we do not know what will be there next Tuesday. If you have a way of getting to that, I would be deeply indebted to you, but I do not have the sort of capacity to intuit what Mr Hockey will deliver on Tuesday. It is true to say that the Premier has made the points very directly to the Prime Minister, the Treasurer has made the points to the federal Treasurer directly, including in formal meetings, and I have made the point very directly to the health minister that we believe some discussions are required to get a way forward on the subacute services that are currently delivered through the NPA and which will diminish on 30 June unless there is some accommodation found.

Mr SCOTT — I have a supplementary question. I note that the Premier stated in his letter, according to media reports:

> If commonwealth funding were discontinued, the Victorian government would have little choice but to pass such cuts directly through to the Victorian community via front-line service delivery reductions.

I will ask a supplementary coming from the opposite direction. If — and you used the term 'accommodation' — the funding was restored, would these subacute bed numbers be immediately refunded?

Mr DAVIS — The state has gone to considerable effort to strengthen some of the subacute services that we have around the state, and we are certainly committed to delivering the maximum services in that area. We see it as part of an integrated system. The truth of the matter is that we are going to have to wait to see the overall parameters, because as I have said, if you go back to table 4.9 there are many moving parts, and we do not know what will actually happen. We will have to reassess and make a decision in light of what is actually committed to by the commonwealth or what can be negotiated with the commonwealth. There are a challenging set of positions here, and we will make these decisions in the best interests of Victorian.

I should say that reductions in commonwealth funding are not something new to Victoria. In 2012 we saw a very significant reduction in commonwealth funding and a number of other parts of the system were directly impacted, including the decision by the former commonwealth minister and the former government to remove support for private health insurance. That has impacted on private health insurance, which has a knock-on effect on public services. These decisions are never made in isolation, which is the point I am trying to make. Tanya Plibersek cut 5 billion out of health services in a short two years — 5 billion.

Mr ONDARCHIE — What did the carbon tax do to hospitals?

Mr DAVIS — That is another point. One point that could be made about table 4.9 is that whatever funding comes in it will not all go directly to patient services; some of it will be needed to fund the carbon tax.

Mr ANGUS — Unless they repeal it. Minister, I refer you to budget paper 3, page 141, which deals with ambulance services. Can you inform the committee about what steps the government is taking to ensure that

members of the community who call 000 to request an ambulance receive the right treatment in the right health setting?

Mr DAVIS — One of the things that I think has been problematic about Ambulance Victoria is that some people call 000 when they do not need it. I make the point very strongly that if someone shows signs of a heart attack, signs of a stroke or signs of very significant distress, they should be calling 000. But what is clear is that some people have called 000 when they have much more — if I could describe them as — primary health-care needs that could be met through a GP or some other service. RefCom has been a longstanding service in metropolitan Melbourne. It provides trained nurses and paramedics who work with callers to decide what treatment is best. It is a very conservative service in the sense that there is a triage approach. Patients who ring up with an ingrown toenail may well be provided with alternative support.

Patients who ring up — and there are some who are regular and known callers to 000 — can be provided with inbound support to the home, which is often a better use of ambulance resources than sending a fully fledged ambulance. All those links across the metropolitan area since the trial began through the Barwon-south western region have helped manage demand for ambulance services and ensure that the most acute patients are the ones who get the priority treatment, that the resources of Ambulance Victoria are focused on the most acute patients and that where a more appropriate outcome can be achieved that is, where possible, put in place.

I can indicate that the government is supporting the rollout of RefCom into the four remaining rural regions, and that will help and assist with demand in those regions. That is a complex process, because in each town it is about understanding the specific services that are available — the GPs, the medical locum services in some cases or the situation with aged-care services, where an alternate provision may be possible. The RefCom callers or dispatchers — if I can use that word — who are trained nurses or trained paramedics, have a very good understanding of how they can manage those steps. It has had a very significant outcome. About 70 per cent of the calls managed by RefCom in 12–13 did not require an emergency ambulance to be dispatched. In those cases patients were referred to more appropriate local services — or in some cases inbound services — to assist them.

I certainly support the focus of Ambulance Victoria in taking these steps. I think we will get a very good outcome there — more paramedics being put on the road statewide, more shifts being delivered statewide, more ambulances, more MICA ambulances and the support of RefCom to ensure that those highly trained paramedics are actually able to do what they are trained to do and deliver those emergency services.

Ms GARRETT — Minister, I refer to budget paper 3, page 4, which makes reference to relief and recovery programs regarding the Hazelwood mine fire. I ask: why did it take almost two weeks from the time of the outbreak of the fire in the mine to establish the community respite centre in Moe and the health assessment centre in Morwell, and why did it take three weeks for the government to establish the community information and recovery centre?

Mr DAVIS — I will answer in terms of health response, and I might in a moment get Professor Brook to respond on this, given his role in emergency services statewide as health commander. The chief health officer is the government's — and the previous government's, I might add, too — chief source of advice in these areas. The government acted all the way through this process with the advice of the chief health officer. From a very early point warnings were put into the community about the Morwell fire, so there are obviously two distinct parts or possibly, if I could extend it, three distinct parts. There is obviously the fire itself and the management of that, which is not the portfolio responsibility of me or Health; it is the fire services commissioner and his team at the Country Fire Authority and so forth. Then there is the smoke plume that came out of the fire, initially at one level and later at a stronger level. That is something that we advised the community about. The EPA obviously monitored this and information came from them, but the chief health officer used a battery of scientific experts to respond in the most thoughtful and structured way. The government obviously opened the respite centre to provide good support for the community, so that they could get out.

Advice was issued at an early point about vulnerable people, who were particularly defined as those with respiratory conditions, the very old and the very young. Decisions were communicated to the community via media, via printed communications, via radio, via advertisements in papers and via a whole range of other steps as well, to advise that community. Later, as this continued, there was a decision made by the chief health officer

to advise that certain vulnerable people should relocate, in Morwell South principally, and that decision was also communicated very directly.

The health assessment centre I think has performed remarkably well, and I think Professor Brook will say something about the international awards that it has just recently won. Obviously there is an intention and progress towards establishing an inquiry into the long-term health effects of the short-term exposure that occurred. Health I think has behaved very sharply in the community interest, with the direct input of the chief health officer as the primary determinant of what government did. But she was clearly advised — Doctor Rosemary Lester — by a battery of people who are expert in the area. Professor Brook, you may want to respond to what is an important area.

Prof. BROOK — The question was asked actually in the context of relief and recovery, so I should commence by saying that relief and recovery is the responsibility of the Department of Human Services, not the Department of Health. However, we have for many years had a shared health and human services emergency management arrangement, and certainly at regional level, particularly in every rural region, we work cooperatively and well from the outset, indeed even before any event, in community preparation. One of the axioms of emergency management is that recovery should start at the same time as, if not before, an event emerges. My role in health emergency management is as the state health and medical commander, and I will not go into the complexities of that; you will be able to read all about it in due course when the inquiry report comes down. But I am the person who ensures that whatever services are needed are provided in the most timely manner and in the best possible fashion to meet the needs of the community.

The minister has said quite a lot, and I would only add a few things. This fire did not start full on on 9 February. It certainly commenced on 9 February, coming from the Driffield fire. There were several very large fires near Morwell at the time, but there were many other fires right across the state. The fire progressively increased and, as it were, took off within the mine pit itself, and at one point was burning over a 3-kilometre distance, mostly in the northern and southern batters, as the walls of mines are called. It was really the weekend of the 15th and 16th that this became much more than just a smoke event; it became much more a huge plume of coal smoke and, somewhat later, of coal ash, all of which was clearly both disturbing and disquieting to all members of the community.

There had already been a range of steps taken, particularly regarding information and communication. All of those matters will be inquired into, and I think it is best to wait for the results of the inquiry in relation to what was done well and what might have been done differently. I will only comment that I have never, ever been involved in a major emergency event — and I have been involved in many of them — where there are not lessons to be learnt. There are always lessons to be learnt.

The information sources that we used to determine impact on the community included daily reports from Latrobe Regional Hospital, which I remind you is a major regional hospital virtually adjacent to Morwell; daily reports from Nurse on Call; reports from local government and home and community care service providers; and importantly, twice-weekly reports from the general practitioners in Morwell through their Medicare Local — that system took a few days to set up, remembering of course that we neither fund nor regulate general practitioners — and of course we had daily reports from Ambulance Victoria.

The facts of the situation are that while there was a completely predictable — as we had hopefully communicated — increase in presentations by people to their local general practitioner with, say, an exacerbation of asthma or simply a sore throat, sore nose, runny nose, sore eyes, headache, smoke-related consequences, there was no increase in ambulance call-outs related to this incident. There was no increase in hospital admissions, and there was only a small increase in calls to Nurse on Call. Our first objective, which was to ensure that all people were safe and provided with appropriate services, was met.

The reason that a community health assessment centre was established on 21 February was because we, as the Department of Health, were concerned about the ongoing community concern, not so much necessarily about the capacity of the system to deal with emergencies — which was intact throughout — but we wanted to establish something different. It was novel. It was designed one day and was operational 36 hours later. It was run by paramedics and by nurses. It provided advice, reassurance and primary care checking, and we not infrequently discovered that people had longstanding illnesses that they were not aware of. If they had any reason to be referred, they were referred either to their own general practitioner or to Latrobe Regional Hospital.

The respite care centre was set up on the 19th because it did not take 36 hours to get the full range of equipment that we had to put in place for the community health assessment centre. In the interests of your time, perhaps I will leave that there.

The CHAIR — Thank you for that comprehensive response.

Mr DAVIS — It might be worth just noting that the assessment centre has just recently won an award internationally and explaining that to the committee.

Mr PAKULA — So noted, I think.

Mr DAVIS — An international award.

Mr PAKULA — Yes, so noted. We do not need to spend roughly 10 minutes on it.

Mr DAVIS — It is actually an important point.

Mr PAKULA — The answer has gone for 15 minutes. I am saying it is noted.

Mr ONDARCHIE — Minister, I would like to take you back to budget paper 4 and specifically pages 34 and 35, which I touched on earlier, that relate to the Department of Health capital projects. In doing so, I want also to pass on the thanks of my community for projects that have been completed in my electorate under your watch, such as the eating disorders program in Parkville, the North Richmond community health centre, the Northern Hospital cath lab, the expansion of the emergency department at Northern Hospital, the Olivia Newton-John Cancer and Wellness Centre, the Royal Melbourne Hospital allied health development, the Royal Talbot Rehabilitation Centre, the Mellor ward refurbishment and the planning for the Victorian eye and ear hospital as well. However, specifically, I wonder if you could tell us more about the projects in metropolitan Melbourne, and I note that a number of them are in my electorate.

Mr DAVIS — I am very happy to talk about capital projects statewide and in particular in metropolitan Melbourne. The community will be familiar with the fact that there is more than $4.5 billion worth of capital projects in operation at the moment and more announced in the budget this cycle. I know Mr Ondarchie has been a very strong advocate for the Austin and for Northern in particular and the Olivia Newton-John centre has been one of his great focuses. I know that Northern, which faces significant growth, has always been a point he has put a lot of attention to. What I can say at Northern is the new emergency department is open and functioning. It is a magnificent improvement. More bed capacity has been announced at Northern too, and new capacity to put in place some significant improvement to deal with the growth in population on the northern end of the city.

There are also other key metropolitan hospitals that are playing an important role. The $447.5 million expansion of Box Hill Hospital will be opened in the next few months, and we look forward to seeing the outcomes of that important new hospital. Those who know Box Hill will know it is a very old hospital. It is very run down; I see Mr Angus nodding. He has been up on the — I am just trying to think of the exact phrase they use.

Mr ANGUS — The topping-out ceremony, the de-craning ceremony and the turning-the-first-sod ceremony.

Mr DAVIS — Yes, the topping-out ceremony and de-craning ceremony. All of those ceremonies have been important recognition of milestones as the $447 million build continues. That is ahead of time and ahead of budget, and we have been able to squeeze an extra floor in future capacity out of the tenderers, so it is a very good outcome for the people of the eastern suburbs of Melbourne. Box Hill has clearly got a major role as the hub for Eastern Health.

There are also developments occurring at Healesville, as we have just discussed, and importantly, significant developments at Maroondah. I was out at Maroondah recently looking at the growth there, and this will, I think, make a significant difference for people in the outer east of metropolitan Melbourne. Frankston is moving very fast as well. The $39.9 million emergency department expansion and the inpatient expansion at Frankston of almost $36 million — all of these will provide a very significant increase in capacity at Frankston. I pay tribute to the work done at Frankston in putting together very good practice methods that have managed to deliver good outcomes in difficult circumstances. The emergency department is very crowded and undercapacity for what is delivered through that important emergency department.

There is also the VCCC, the $1.1 billion comprehensive cancer centre, which is going to provide a great outcome for cancer services and linking acute services with the research capacity. I again pay tribute to the partnership that has been developed between Western and Melbourne health and Peter Mac, the WEHI, the university, other key components — increasingly discussions with the Austin as well — as how they can work in as part of the team with the Victorian Comprehensive Cancer Centre. This is, I believe, going to be much more than just simply a very modern and magnificent building; it is going to be a service provision method that integrates research, that actually sees the highest level of clinical standards provided across that group of partners. I look forward to the outcome there.

The Eye and Ear, which is obviously 150 years old now, and a hospital redevelopment of 165 million — not a large hospital by the standards of some of the others but an important hospital, a world-beating hospital that Victoria has that is renowned, particularly with the link to research at the Centre for Eye Research Australia, CERA, and the complex process to rebuild that. There is a series of decanting steps. Those who are familiar with the eye and ear will know the two towers and the infill. That infill area is going to have to be removed and new sections built through there. This is something the committee may well be interested in, to see some explanation of this complex sequence of decanting that is going to occur at the Eye and Ear as the progress of the redevelopment occurs.

Importantly, too, down in the southern suburbs at Monash the new Monash Children's — a massive hospital that will deliver for children in that area but particularly the south-east and further into Gippsland as well.

Mr ONDARCHIE — There is also the IT project.

Mr DAVIS — It is going to be a stunner, I am going to say — a second children's hospital for Victoria. I am certainly very proud to have been associated with this process and look forward to the turning of the sod in a very short period into the future. The work is proceeding well at the Monash Children's. We are getting a very good deal there as well. There are other important steps that are being put in place for proper capital work.

Mr ONDARCHIE — There is also the IT project at the Children's.

Mr DAVIS — The Children's IT project, and I can certainly talk about that commitment of government money that is being made there and the negotiations that are being undertaken with the Epic group at the moment to see a new ICT system put in at the children's. This is an important development statewide.

Mr PAKULA — I am sure all of it was news to you, too. Just to go back to the matter of ambulance services, thank you, Chair. Minister, last year in these hearings you told the committee that there would be a 2013–14 Ambulance Victoria statement of priorities. It still has not been released, nor has one been released, as far as I can tell, for the entire period you have been in government, despite it being required by the Ambulance Services Act. Where is that statement of priorities?

Mr DAVIS — Chair, I think the community will understand the difficulty we faced with Ambulance Victoria, the challenge that we inherited and the need to put Ambulance Victoria into a sustainable position. We are not far from being able to release such a statement of priorities.

Mr PAKULA — You told us that last year.

The CHAIR — Order!

Mr DAVIS — Well, Chair, you need to understand this was a basket case left by the previous government after a botched merger. The financial position of Ambulance Victoria was very grave, and that has taken a lot of work to bring into some semblance of a better outcome. So the work is being done. I pay tribute to the administration of Ambulance Victoria, who have, under Greg Sassella's leadership, sought to put in place a system of proper accounting across the state — a system that actually recognised that — —

In fact, what they did was bring together three ambulance services that had very different cultures, different systems of administration, different pay arrangements, different financial arrangements, and we are working our way through that, and there will be a document that recognises that.

Mr PAKULA — I have to say, Minister, I find it extraordinary that as a minister of the Crown it is clearly your view that observance of the requirements of the act is somehow optional for you. Because you have a

legislative obligation to have released a statement of priorities. It is not enough for you to come in here a year ago and say, 'You will get one' and then come in here a year later and say, 'We're still working on it'. You have a legislative obligation to have released one of those statements of priorities. The act at section 22F says at subsection (5):

> The Minister must cause copies of each statement of priorities and any variation to be made available on request to members of the public.

I would like to use my supplementary to formally request that the minister provide me and any other interested members of this committee with a copy of the 2013–14, 2012–13 and 2011–12 Ambulance Victoria statement of priorities documents — or don't they exist?

Mr DAVIS — Chair, let me be quite clear here.

Mr PAKULA — I wish you would, for a change.

The CHAIR — Order!

Mr DAVIS — When we came to government we inherited an ambulance service that had faced huge difficulties after a botched merger — —

Mr PAKULA — It is not optional; it is a legislative requirement.

The CHAIR — Order!

Members interjecting.

Mr DAVIS — A $56 million deficit, and the government will work with Ambulance Victoria to put it on a sustainable footing, and that is what we are doing. I pay tribute to the work of the administration at Ambulance Victoria in trying to bring this into — —

Mr PAKULA — So you can ignore the law? Is that what you are saying to the committee: you can ignore the law?

The CHAIR — Order!

Mr DAVIS — What I will do, Chair, is as the document is produced I will certainly make that available to the community.

The CHAIR — Thank you, Minister. That concludes the hearing for the health portfolio. I think there were two questions on notice, one relating to the air ambulance and one relating to the national health and hospital reforms.

Mr DAVIS — I can answer the air ambulance one on advice now to say that, as I understand it, the financial arrangements for the air ambulance are actually in the output group now, into the forward estimates.

The CHAIR — Thank you. The second one was the COAG national health and hospitals reform issue. We will obviously follow up in writing in terms of that last issue, and if we can have a response within 21 days, that would be of assistance. I thank the secretary and the departmental staff for their attendance, and the hearing is closed.

Witnesses withdrew.