CHAPTER 4: DEPARTMENT OF HUMAN SERVICES

4.1 Health Transcript

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2009–10

Melbourne — 12 May 2009

Members

Mr R. Dalla-Riva	Mr G. Rich-Phillips
Ms J. Huppert	Mr R. Scott
Ms J. Munt	Mr B. Stensholt
Mr W. Noonan	Dr W. Sykes
Ms S. Pennicuik	Mr K. Wells

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

Staff

Executive Officer: Ms V. Cheong

Witnesses

Mr D. Andrews, Minister for Health,

Ms F. Thorn, Secretary,

Mr A. Hall, Executive Director, Financial and Corporate Services,

Mr L. Wallace, Executive Director, Metropolitan Health and Aged Care Services, and

Dr C. Brook, Executive Director, Rural and Regional Health and Aged Care Services, Department of Human Services.

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the 2009–10 budget estimates for the portfolio of health.

On behalf of the committee I welcome Mr Daniel Andrews, Minister for Health; Ms Fran Thorn, Secretary of the Department of Human Services; Mr Alan Hall, executive director, financial and corporate services; Mr Lance Wallace, executive director, metropolitan health and aged care; and Dr Chris Brook, executive director, rural and regional health and aged care services, Department of Human Services. I also welcome departmental officers, members of the public and the media.

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

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. There is no need for evidence to be sworn. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript, to be verified and returned within two working days. In accordance with past practice, the transcripts and PowerPoint presentations will then be placed on the committee's website.

Following a presentation by the minister, committee members will ask questions relating to the budget estimates. Generally the procedure followed will be that relating to questions in the Legislative Assembly. I ask that all mobile telephones be turned off.

I now call on the minister to give a brief presentation of maybe 10 to 15 minutes, as his is a big department, on the more complex financial and performance information that relates to the budget estimates for the portfolio of Health.

Overheads shown.

Mr ANDREWS — Thank you, Chair, and I thank you for the opportunity to present to the Public Accounts and Estimates Committee on what is, again, a very strong budget for health. I want to go through some background, some of our challenges and the responses that the government has steadily maintained in relation to treating more patients and providing better care.

If you look at life expectancy as a reasonable measure of the health and wellbeing of the Victorian community, it is pleasing to see that for both men and women we rate consistently above the national life expectancy. I think that is a fair measure of the general health and wellbeing of our community, noting of course that there are areas of social disadvantage and health inequalities. Perhaps we will get an opportunity to talk about some of those matters later on.

In terms of challenges we face or changes in profiles, changes in terms of the number and types of patients that are presenting for care, demand is obviously something that challenges health planners and health service professionals the world over. To give you an example of that, this coming financial year we estimate that we will treat 660 000 more patients than was the case in 1999–2000. That gives you a sense of the growth in that particular category. Obviously Victoria is growing at a faster rate than other states and territories, and that is one driver, together with steady and welcome changes and advancements in relation to medical care. Basically we can do more for patients and we can do it for longer.

There is also a challenge and I suppose a trend in terms of that cohort within the community over the age of 65, who are bit more complex to deal with. They present with multiple and complex chronic illnesses, and they do present not only in and of themselves a great challenge but a growing challenge, given that that cohort itself is growing. You will see there a graphic representation of total admissions as opposed to treatments. That does give you a sense of the steady increase off the baseline of 1999–2000.

In terms of the way our health system performs, every single Victorian can be proud of the work that our doctors and nurses do. We do rate very highly against other states and territories and indeed other parts of the world, whether it is in relation to emergency department performance, above the national average as rated by

the commonwealth government, or median waiting time for elective surgery, again above the national average as determined by the commonwealth government. We run far and away Australia's most efficient health services, and one indicator of that is steady decreases in length of stay, making the best use of what are precious resources.

I have already mentioned that growth in the number of patients presenting for care is a real challenge for us and for health systems right across the world. Those numbers in the bottom left-hand corner of this overhead give you some sense of the growth pattern, the total additional effort that is needed this coming year compared to 1999 — for instance, 45 per cent more emergency department presentations. The profile of those patients is changing as well, and I will come to that in the next slide or perhaps the one after.

This gives you a global view of the current financial year and where we think we will finish up in relation to ED presentations, total admissions, outpatient appointments, emergency patient transports — obviously referring to Ambulance Victoria — screens for preventable illness, public dental services and also the total hours of care provided in our community health sector. Those numbers, by any measure, give you a sense of much increased activity right across the system.

I mentioned a moment ago some changes in the nature of patients presenting to emergency departments, what some perhaps a while ago would have referred to as the front door of the health system. That is changing a bit, but we do see a different profile of patients presenting for care, and that throws out a challenge to us as well, both as planners and also in terms of funders. It is good news in some respects.

Fewer low acuity patients are presenting for care, and that in some way I think is an important validation of the measures we have taken both to substitute and to properly divert demand to less acute settings — for instance, our hospital admission risk program that I spoke to the committee about at length last year. I think there are now six GP co-located clinics with emergency departments — some of our busiest emergency departments. Those measures are working to give people who do not need emergency care, but nevertheless need care, proper alternatives.

In terms of urgency, if you look at the table there in the bottom right-hand corner, you have seen a complete switch — a split between 1 to 3 and 4 to 5 has gone from 32/68 to 38/62. That is a clear movement and demonstrates that we have not only more patients presenting but sicker patients are presenting, so an increase in the total number of categories 1, 2 and 3, and that, as I said, throws out a challenge to us. A real challenge for us is to provide those more complex patients with the emergency care that they need and also to have configured behind the emergency department the bed stock and other services that are needed.

Inpatient activity: again that gives you a sense of what we did in 2007–08 across dialysis separations, cardiology, respiratory separations and others. It is important to note that we had an increase in the same-day procedures. These are same-day inpatients as opposed to multi-day inpatients. When we came to government about 48 per cent of the total inpatient experience was of a same-day nature. That is now 55 per cent, and that gives you a sense as well of the changing nature of the profile of the services we offer. I mentioned earlier on important improvements in the total length of stay, and you have got the numbers there, from 3.8 to 3.3 days.

In terms of what we are doing to meet these challenges and what we are doing to properly cater for the future, you can see there a very substantial increase — now a 130 per cent increase — in terms of acute health funding, from just over $3425 million to $7863 million, a very substantial increase. Nobody could argue that that was anything other than a very, very substantial increase in the recurrent resources available to our system.

It is not just about ongoing funding, as important as that is; it is also about capital infrastructure and the asset program, about ensuring that the quality of our buildings matches the quality of care provided by our staff. You can see there, off a very low base in 1999–2000, building to substantial investments. The 2006–07 number there represents the Children's project being brought to book; 2009–10 represents a range of capital projects as well as the orange there, which is the state's important contribution of $426.1 million to the construction of the comprehensive cancer centre to be located on the former Royal Dental Hospital site in Parkville.

In terms of elective surgery, this is a very important area for us. It is important for patients the state over, and we are very keen to ensure that we continue to reduce long waits and that we continue to do more elective surgery. It is not just about volume — again, that is very important — but it is about reforming the system. There are many different ways in which we have done that, whether it is the dedicated statewide elective

surgery centre at the Alfred, whether it is the recently opened elective surgery centre at the Austin Repat campus, whether it is the soon-to-be-opened specialist orthopaedic elective surgery centre at St V's, or a range of other programs, like the OAHKS program here or the OWL program. I think I spoke to you last year about the orthopaedic waiting list program. It is all about ensuring that people get the most appropriate care. That can often mean that the elective surgery a person is listed for, they do not actually need that ultimately. They are important programs as well — the right care at the right time.

Last year, as you know, was a record year in terms of episodes of elective surgery. In partnership with the commonwealth government — there is $35 million from the commonwealth and $25 million from the Victorian government — we had a target of 9400, and we in fact exceeded that almost to 13 500 additional episodes of elective surgery, breaking the 140 000 barrier in a given year for the first time.

In terms of our workforce, obviously we are only as good as our staff and we need to always look to be employing more of them and to be properly rewarding them for the work that they do. These are well-known figures. There are almost 9000 extra nurses, and that is what the graph shows you there — from just over 21 000 EFT to just under 30 000 EFT in our time in government. Hospital doctors are up by 2500. I could quote also a whole range of allied health numbers, together with ambulance paramedics nudging the 900 mark also. Again, I would have thought that on any fair measure that is a very, very substantial boost to the workforce that is so critical and so important to providing the very best care.

In terms of budget highlights this year, there is a $2.6 billion boost across health. It does not include the Parkville money I just spoke about a moment ago. Obviously there is a substantial and well-targeted asset program. There is also just under $826 million for boosting hospital services, whether it is in emergency departments, total inpatient growth or the 9000 elective surgery episodes I spoke about a moment ago, and of course the money that we announced just after the budget in partnership with the commonwealth government in terms of the PCCC.

In the coming year, as opposed to across the full estimates, there is a $220 million boost meeting additional demand and growing the capacity of the system and again boosting some of those important substitution programs I referred to earlier. There is also some additional money to commission new mental health services — $85 million — bringing to book the full effect of the beds package I announced last year. That is very, very important obviously in terms of patient flow and giving people the best care possible. There is the elective surgery boost I just mentioned, and there is a range of other programs totalling $8.3 million. There are some blood initiatives, issues around the reform of cardiac service delivery at the Royal Children's Hospital and some other matters that make up that $8.3 million.

In terms of our COAG commitments, there are many of these obviously in a portfolio as big as this affecting as many Victorians as it does. One example, and I think it is a shining example of what can be achieved in partnership with the commonwealth government, is the Closing the Gap indigenous health NP, which totals $56.1 million when you include a range of housing and other important programs. Our spend is $47.4 million over the next four years. That is real money, new money, and it represents without any shadow of a doubt the biggest boost in terms of indigenous health and wellbeing, or welfare services and programs, that this state has ever seen. We are proud as a government not only to sign the important charter last year to sign up to Closing the Gap, but then to deliver the money that is so central to that. That will be about smoking cessation, increased physical activity, a whole range of food and dietary issues — and, again, physical fitness is an important part of that as well.

Importantly, we are about training a culturally appropriate workforce to work not just for Koori communities but as part of Koori, Aboriginal-controlled health services, and those 35 additional workers will be trained as part of this package. There is also a million dollars to expand the very, very successful Koori maternity service at a further three sites. I hope I will get an opportunity to come back to this. There is a lot to be said in this space, and it is one great example of us doing what we need to do to meet the COAG commitments.

Just quickly, in terms of capital other than for the PCCC**,** the Alexandra hospital redevelopment is very important. That was a commitment made by Labor in 2006. This is obviously in an area that has been touched by the bushfires, and we are delighted to be able to provide, along with contributions from agencies, that $19 million for a brand-new hospital and a co-located ambulance station. The Ballarat Health Service is a very important regional health service. There is a big boost there of $20 million not only to expand the special care nursery but also to bring a new range of heart care, coronary care, to the Ballarat area.

In regard to the Bendigo hospital, again, I am proud of our commitment there: $55 million for a range of works that are all about taking a step towards a new hospital. Additional capacity will be built at the Geelong hospital: a ward, a theatre upgrade and some additional mental health beds. At Warrnambool hospital we are undertaking one of country Victoria's biggest ever capital works projects in the health sector, and stage 1c is funded in this budget as well.

Finally, in terms of infrastructure more broadly, I have mentioned $426.1 million being our government's important contribution. That was matched by the commonwealth government, and we are very pleased to have been able to secure that additional funding to build what we hope will be one of the world's top 10 comprehensive cancer centres. That takes the total state and commonwealth government contribution to $852.2 million. There are other moneys involved in that, and if I get an opportunity I hope to speak in more detail around these issues.

I think the Premier may have had something to say yesterday about Box Hill Hospital. In any event a very clear statement was made on budget day around the fact that as a government we are committed to a further stage in the redevelopment of that hospital. We are committed to the redevelopment of the Box Hill Hospital; we always have been. But we do need to wait and see what sort of further support comes to the state Victoria — beyond the comprehensive cancer centre — in relation to health and hospitals funds. That may well be a subject of the budget which is to be brought down this evening.

Just in summary, I would say to you that this is a strong budget for health. Very substantial increases in terms of ongoing funding, the next important steps in terms of capital funding and some highlight projects like the Parkville comprehensive cancer centre, I think make this, by any measure, a very strong budget for us to continue to support our doctors and nurses, ambulance paramedics and others to treat more patients and indeed provide better care as we go forward.

The CHAIR — Thank you very much, Minister. Let me begin as I have begun with other ministers, by asking you to talk about federal grants, because they make up a very significant part of the state budget, and which ones you are receiving under your portfolio in your department and agencies, both in terms of output and asset issues. I would also like you to provide, perhaps on notice, a departmental list of the details of those grants and the accountability mechanisms which apply to them. But perhaps now you could talk more generally — be as specific as you like — about the grants that you get from the federal government.

Mr ANDREWS — Thank you, Chair. It is a very important question, and we might need to supplement the reply, given the sheer scale of our overall budget. The key part is obviously the national health-care agreement totalling $60 billion. It is the most important of those agreements signed with the commonwealth government. That comes into effect on 1 July 2009. Victoria obviously has a very substantial share of that.

In terms of, I suppose, other important agreements, I can give you some general comments, but again these are national partnership payments, and many of them — in fact, all of them — are the subject of implementation plans that are to be agreed between state and territory governments and the commonwealth. But to run through those broadly, the national health-care agreement is one of those; that is signed off. But in terms of the national partnership agreements for hospitals and the health workforce reform, the provision of extra money is very important to help train and support states in terms of additional undergraduate places, clinical placements and all the other supports that are necessary to train the workforce that we will need going forward.

There is also the national partnership agreement for important preventative health. As you would know, Rob Moodie, a great Victorian, has been chairing the national Preventative Health Task force. It has brought down at least one comprehensive report. It is due to do more work. Perhaps we will hear a bit more in tonight's federal budget about some of the recommendations it has made. That is the second of the major national partnership payments. Thirdly, the national partnership agreement for Closing the Gap, which I have already referred to, and our matching component is there and is a highlight of this year's budget.

Finally, we have the national partnership agreement for NEHTA — or the National E-Health Transition Authority — for the core functions of that body, as we move towards a seamless IT system, basically an e-health system that links state-funded acute care and commonwealth-funded primary care, with all those wonderful benefits of your medical records following you rather than you having to tell your story a hundred times.

I can go through each of those in a bit more detail, but it may be best if we come back to you once the implementation plans have been signed off and give you further details. Obviously the commonwealth government and our government are very keenly aware that we are fundamentally accountable to the communities we serve in terms of the spending of that money and delivering outcomes against the important agreements that were struck at COAG last year.

Again we can probably give you a greater sense of the detail of those matters once the implementation plans have been signed off. Unless the secretary would like to supplement that answer, that gives you an overview of different areas in which additional effort will be made, and we are happy to come back to you with further details.

The CHAIR — That would be good. We are particularly interested in the accountability mechanisms. Of course you have a whole range of agencies — whatever the right word is — all the hospitals and — —

Mr ANDREWS — Funded agencies.

The CHAIR — Funded agencies, and they all have responsibilities, and we are interested in the accountability mechanisms that you put on them to achieve their outcomes.

Mr ANDREWS — We will be happy to come back to the committee with that.

Mr WELLS — Minister, I refer you to budget paper 3, page 90, outputs. I am very concerned about the accuracy of these numbers, something that you have a problem with — the accuracy of data. I am not sure if it is because you are incompetent or whether you are deliberately misleading Victorians — —

The CHAIR — I would like you to withdraw that. We said this morning we do not wish to use unparliamentary language.

Mr WELLS — I was just stating a fact. What are you talking about?

The CHAIR — So I urge you to take care in your language, please.

Mr WELLS — Which part of it was inaccurate?

The CHAIR — We are trying to not use language which causes offence.

Mr WELLS — Minister, I refer you to budget paper 3 page 90 and the accuracy of these figures. On 3 April this year Kathy Jackson, from the national secretariat of the health services union, claimed it was not true that you did not know about the issue of hospitals reporting incorrect data. She said that in a meeting with you in your office and your chief of staff in January 2008 she told you about inaccurate data reported by hospitals. She further said, 'But I did not really think I was telling the minister something he did not already know. On 5 May — —

Ms MUNT — Chair, I just seek clarification on whether this does relate to the budget estimates.

Mr WELLS — Hang on; I am getting to my question.

The CHAIR — Can you get to your question about the budget estimates fairly quickly?

Mr WELLS — On 5 May in Parliament you stated that the claims from Ms Jackson were incorrect; she was wrong. What is your version of the conversation you had with Kathy Jackson in your office in January 2008 and what impact did this conversation have on the figures that have been provided on page 90?

Ms MUNT — That is a fairly long bow to draw.

The CHAIR — I rule that question out of order and go to the next question. Ms Munt?

Ms MUNT — My question relates to the Parkville comprehensive cancer centre. Last Sunday a member for Southern Metropolitan Region and I walked in the Mother's Day Classic for cancer research. I think they were very excited about this wonderful new facility, as am I for all Victorians who unfortunately suffer from cancer.

You mentioned in your introduction you would like to give some more details about that, and I am very interested in hearing a fuller explanation of the what the centre will be and will mean.

Mr ANDREWS — That is a very good question, Ms Munt. I am pleased to answer it. I am very pleased to illuminate the committee on our government's record investment in cancer and saving lives, a question about the outputs and a question about health. I am very pleased.

This investment needs to be seen in the context of the $150 million cancer action plan which we very proudly launched last year, the Premier and I. This is about supporting the growing number of Victorians who are diagnosed with cancer each and every day, sadly, and trying to do more in terms of the total number of people who sadly pass away from cancer each year — the $150 million of new money and a comprehensive action plan with hard targets around saving lives and improving outcomes between now and 2015.

It is also important that we have the capital infrastructure, the physical infrastructure to support the world-leading research and the advances in treatment, and that we build a centre where all that is good in cancer, all the great work that goes on across the cancer control community, can be brought together under one roof, and we can get the economies of scale and efficiency dividends and benefits of that, and we can build what we hope will be one of the world's top 10 comprehensive cancer centres. This is only possible because of a partnership with the commonwealth government — $426 million each, together with some additional moneys. To give you some sense of the scale of this particular project, it will not just be Australia's biggest comprehensive cancer centre, it may well be the biggest in the Southern Hemisphere, and we are very proud to have been able to provide the record support needed for this important project.

In terms of the new facility, there will be 194 inpatient beds, 110 same-day treatment places, 8 medi-hotel beds as well, noting the increasingly ambulant nature of cancer care. There will also be — and this is very important linking back to some of the targets and the action within the Victorian cancer action plan — a dedicated, I think, if memory serves, 24-bed clinical trial space there as well, which is all about trying to do more to give more patients access to the latest therapies and the latest treatments, not just for their benefit but in an evidence-building way to, in an ongoing way, develop the cancer care that will save lives as we go forward.

In terms of growing the overall size of this particular facility, if we look at how much more work it will be able to do, it will have an important capacity to treat about 25 per cent more patients than are currently treated at the Peter MacCallum Cancer Centre or at the Royal Melbourne Hospital — from about 31 000 to a capacity of around 46 500. That again is an important boost in terms of giving our cancer doctors, nurses and others the physical space that they need to treat a growing number of cancer patients.

It is also about important cancer research. An important point to note is that there will be room, there will be the physical capacity to house up to 1400 cancer researchers — again making it Australia's biggest centre for important cancer research. So whether it is in terms of research, treatment and also training the workforce as necessary — so bringing those three important parts of cancer control together under the one roof — it is a truly unique and very important project, one we are proud to support and one where we are very grateful the commonwealth has entered into this partnership with us. It should be seen in the context of the Victorian cancer action plan.

Again this is for many in the cancer community a dream come true, something they have long wished for and worked very hard for. If I can take this opportunity, Chair, to thank all those involved at all those different agencies and the many others who, for so many years, have lobbied hard and worked hard to build the business case for this particular facility. It will be one that we can be proud of because it will be one that will be central to saving lives, both now and for many years to come.

The CHAIR — Mr Wells, have you had time to reconsider in light of Mr Dalla-Riva's — —

Mr WELLS — Mr Rich-Phillips will take the next question because it appears that this witness will receive the full protection of the Chair when it comes to questions from the opposition — —

The CHAIR — That statement is out of order.

Mr WELLS — It has been a waste of time.

The CHAIR — That statement is out of order. Mr Rich-Phillips

Mr RICH-PHILLIPS — Thank you, Chair. I do want to go to the issue of the accuracy of the emergency department and hospital data, which of course is the basis of a number of performance measures in the acute health output area. It was reported last May that as a consequence of the Australian College for Emergency Medicine survey you had undertaken to conduct a review of the performance data from emergency departments. It was then reported in August of last year in an article published in the *Age* that you would not set up an investigation because, to quote, you did 'not believe that this is happening' — being the issue of phantom wards. A month after that your department let a tender for an audit of emergency department data. My question is: firstly, did you undertake that review in May as reported; and secondly, what information came to you between your statement in August that you did not believe it was happening and September, when you commissioned the audit?

The CHAIR — Insofar as it relates to the forward estimates and the forward estimate targets and expected outcomes and actuals for the VEMD — —

Mr ANDREWS — Thank you, Chair. I think Mr Rich-Phillips confuses what is the audit of the Victorian emergency minimum dataset, or the VEMD audit, with the issues raised, which were many and varied — and I will come to them in a moment — from the college of emergency medicine. The VEMD audit does not come from issues raised by the college of emergency medicine — and I would have thought members of this committee would know this — it comes from not one, but in fact two reports of the Auditor-General. And the department and I felt that it was important, in an ongoing sense, and there has been much work done on this, to, as recommended by the Auditor-General, properly audit all data in the Victorian emergency minimum dataset — that is, all emergency department data right across the Victorian public health system. So the linkage is not right.

In terms of the integrity of data in emergency departments or anywhere else, I have made a range of important changes following issues at the Royal Women's and following issues that were outlined in the Auditor-General's report. They are separate in some respects to the college of emergency medicine's concerns.

The Department of Human Services — and Mr Wallace, who has direct dealings with the college in a broader sense, may want to supplement this — has always taken seriously issues raised by the college of emergency medicine. They relate to a whole range of different issues. Principally they relate to the way in which observation medicine units work — things like short-stay units — and much work has been done through our clinical network and through a range of different processes to deal with those important issues.

To bundle those issues together with the other issues raised that underpin the VEMD audit is simply wrong. I have met with the college on a number of different occasions, and I will continue to do so. We take their concerns seriously, and we have acted to deal with the important concerns they have raised. I ask Mr Wallace if he wants to add to that.

Mr WALLACE — I just add that the college wrote to me about some issues of concern that they had. They were mainly about definitional issues and clarification of departmental policy positions. Some of those were issues like when does treatment commence under departmental policy. For example, if you are in an emergency department and you then get taken to a cubicle, does your treatment commence when you are taken to the cubicle or does your treatment commence when a nurse first comes to take some more information about diagnosis? Does your treatment commence when an ED physician actually starts some other procedures, whether or not it be medication of some form? There were those sorts of definitional issues that they were concerned about. There were also some definitional issues they were concerned about with short-stay units, which were a relatively new introduction during the 2000s when Victoria introduced those along with other states in Australia.

We had a process to work through with them. We established a process. I met with senior people from the college. We established a process with departmental officers to actually work through to clarify guidelines, to try to get better treatment protocols for a range of conditions, to define very accurately when treatment first commences and to try to get a more consistent application of departmental policy across our emergency departments.

Mr ANDREWS — Chair, can I just say that if you went to the college of emergency medicine and asked them whether they were happy with the response that the department has provided to the issues they have raised, I think they would say that they were. It is a matter for them, but I think they would say they were. We

remain committed to working through issues that they raise. There were those that were raised in the past; there will be others raised in the future. We have a very good working relationship with the college, as we do with all learned colleges, and we will continue to work with them, because their aim is no different to ours — providing the very best care.

Mr RICH-PHILLIPS — When were those issues raised by the college resolved with the college — the issues that Mr Wallace spoke about?

Mr ANDREWS — There were a range of different issues. We have, for instance, put in place guidelines around the way short-stay units operate. Can I say to you — and it should come as no surprise — that perhaps the main concern at the college of emergency medicine was to see more beds funded. I was very proud, in addressing their concern before the end of last year, Mr Rich-Phillips, to announce $321.5 million worth of extra beds. I was very pleased to meet with the college and talk about that, and it would not be wrong for me to submit that they were pretty pleased about it too. That remains an ongoing concern of the college.

We work through issues that are raised by this college and other learned colleges each and every day, and obviously we will do that as we go forward.

Mr NOONAN — Minister, I want to ask about the dental package as part of this budget, and you made reference to it in your presentation. I refer you to budget paper 3, page 317, under 'Improving access to dental care', and I note some additional places there and better access, particularly in regional Victoria. I wonder whether you can outline for us what new funding exists in this budget and how access to dental care as part of this budget will be improved as part of that funding investment.

Mr ANDREWS — Thank you, Mr Noonan. That is a very good question and one that I know is of interest to you and your local community, and indeed to all of us, but certainly in the west of Melbourne the socioeconomic factors and other issues make oral health care even more important than it is perhaps across the board.

We have worked very hard as a government in partnership with our dentists, with the other health professionals who work in the oral health workforce and with Dental Health Services Victoria to grow the total amount of money we spend in terms of oral health. We have invested something like $1.1 billion in terms of oral health since we came to government in 1999. This year alone represents a $149 million investment, and, as you rightly point to, there is very important growth in terms of providing access to those patients who have waited longest in a number of different areas, and I will come to that in just a moment.

Again, as important as ongoing funding is, building the infrastructure is also important, and we proudly have increased the total number of chairs to 373 publicly funded dental chairs across the state; that is 110 more than was the case in 1999. We have also, importantly, supported a second dental school. The University of Melbourne does a fine job, but it has been the sole trader, if you like, in terms of training dentists and others. We have supported La Trobe University to grow its courses, and that is very important, particularly given that the majority of that training is in fact conducted in rural and regional areas.

The growth that you referred to relates to that. There are obviously a number of teaching clinics and teaching chairs that will have patient flow through them, and that represents around 14 400 additional treatments over the next two years. There is also a $3.5 million blitz, if you like, to provide just under 10 000 additional treatments — in fact 9600,or 9700, or around that mark — over the next two years in those areas where we have had the longest waits. I can confirm for you that includes Ballarat Health Service, Barwon as well, and Central Gippsland. The Knox Community Health Service will share in that as well, which I am sure will be of interest to those in the outer east, and the Latrobe Community Health Service in Moe. Frankston Hospital will also benefit, and so will Peninsula Health. Southern Health at Dandenong have got a very large clinic there, and they will benefit. Also in your own local community, Mr Noonan, the Western Region Health Centre at Footscray, which does a great job providing a range of different services and supports, often to some of the most vulnerable members in your area and indeed across the state, will benefit.

I will just go back to a point I made before about the second school or the second university being engaged in the training of our dental workforce. Many of the challenges we face around time to treatment and access are about putting the right workforce in place at the right time. Putting the second school in place and supporting that was the right thing to do.

That started both in terms of the bachelor of health science, dentistry and the master of dentistry at the Bendigo campus in 2008, with an initial intake of 50 students. We have also supported some of the critical training and treatment infrastructure in Mildura, in Wodonga and indeed in Melton. Last year's budget had $13 million in capital funding for those important satellite clinics, but also I very recently announced a 10-chair training clinic which is also a treatment clinic up in Bendigo.

Again, these initiatives are important and we should fully acknowledge that this will mean that more people will get access to the dental care that they need faster than they otherwise would have, but they should be seen again in the context of more than $1 billion worth of oral health care investment since we came to government. I acknowledge and the government acknowledges that we have more to do in this space, and this package is an important step forward.

Dr SYKES — My question relates to the provision of ambulance services in country Victoria, which can be comparable with the services provided to people in the metropolitan areas. I should say at the outset that I welcome the funding for Alexandra hospital and the co-location of the ambulance station there.

The situation in country Victoria is that there is a limited number of MICA-qualified ambos stationed in country Victoria, and they are often there without actually filling MICA positions. The word has gone around that those positions are now required in Melbourne, and so those MICA-qualified people feel under threat and see those MICA-qualified people who are in country Victoria, perhaps by default, being removed from the area.

There is a second issue of the reliance on community emergency response teams, known as CERTs, to meet primary response needs in growing communities such as Nagambie. My question is: what action are you taking to address this important issue of delivering equitable ambulance services to people who choose to live in country Victoria, I guess from a budget allocation point of view but I have also heard that there may be a review of service delivery going on out there?

Mr ANDREWS — Thank you, Dr Sykes. I acknowledge your long-term interest in ambulance services, and I think we had a bit to say about this last year. As you know, last year's budget had almost $186 million in additional funding, the biggest boost that ambulance services have ever seen. From a country point of view, very importantly, we brought together the three separate ambulance services to create one new Ambulance Victoria, so that every single Victorian could get access to the very best care. The planning, policy development and service delivery have been as consistent as possible, and having them driven by one agency is exactly the right way to go. I think that country communities, both large and small, have welcomed the move. We are rolling out services not just in the outer suburbs or interface communities but in regional cities and in small rural towns. A lot is happening in terms of ambulance services.

As I said, we are very pleased to have provided that funding last year. I am happy to come back to you on notice with some further details of rollouts in particular areas, but there were around 50 additional services provided, many of those in rural and regional Victoria. In terms of MICA, you have a situation where we are in the process and quite close to being able to roll out the single responder units, those rapid responder units, in Bendigo, Ballarat, the Barwon region and also in the Latrobe Valley. That is a model of care, if you like, that people in the inner city, in Melbourne, have had for years, since the mid-1990s. We are very keen to have that rolled out — I had a fair bit to say about this last year — and to be delivering that parity, if you like, the same access to the most rapid response for a mobile intensive-care ambulance paramedic in a car, not transporting patients but treating them. I think that is a great example of where our ambulance package and our efforts in ambulance are very much about ensuring that no matter where you live you get access to the best possible care. That MICA example is a very powerful one. I am happy to come back to you in more detail around our complete asset investment program and our additional paramedics.

You would remember that as part of trying to balance the workload, last year the former Rural Ambulance Victoria, now Ambulance Victoria, took a pool of money from overtime and determined to employ an additional 100 ambulance paramedics across rural and regional areas. That is very important for smaller towns. They are progressing quite well with in excess of 80 — I think 88 of those 100 are in fact on the ground now. I can get you some more details around that and again provide you with some further details around the rollout of our ambulance package. Can I just say in terms of MICA paramedics — and I have met many MICA paramedics and I have nothing but praise for the work they do — it is my experience that MICA paramedics are very keen to work as a MICA ambulance paramedics; they are keen to do the work that they are trained for.

It may be that, for instance, as part of opening the new helicopter emergency medical service down at Warrnambool, a paramedic from another country community, a flight paramedic in this instance, might seek to go and work there to get access into that brand new service. It may be that MICA paramedics who are not doing a lot of MICA work now may move into one of these single-responder units. Again, this is a pretty dynamic workforce. It may well be also that having one service means that one barrier for metropolitan paramedics who, for lifestyle reasons, might want to go and work in country Victoria, is now gone. There is one employer; there is one service.

Again, I think there is a litany of examples where we are trying to make sure that no matter where you live you get the best possible pre-hospital emergency care and the transport services you need, whether it is through the retrieval chopper, the Warrnambool chopper, the MICA SRU rollout out in large regional centres, additional branches, additional vehicles — additional ambulance paramedics in the broad sense. I hope that gives you some comfort in terms of the issue. We are very committed to country communities, not just in relation to ambulance services but right across health care, and I think our record is a very strong one. I know that part of AV's charter, part of the clear guidance that I gave the board when we formed the single service was to ensure that we continued to provide first-class care in regional areas, and that if we could improve it, we did.

Dr SYKES — Is there any actual review of service delivery, given the concerns that there is a perceived contraction of the MICAs back to Melbourne? You have given an explanation, but is there any actual review or restructuring of service delivery over and above the larger regional communities that you have mentioned?

Mr ANDREWS — Again, there is no review that would see country communities with less ambulance paramedics or anything other than boosted services.

AV would do reviews on a whole range of different things almost each and every day. I would think that there would be review work going on around the transition from three services to one. We are coming up to the first anniversary of that. I am happy to come back to you. I am not aware of any review that would do anything other than boost services to rural and regional areas. Again that is my commitment, it is the government's commitment and I think AV are equally committed to doing that. But in terms of critically looking at the way we deploy services across the board, I am happy to come back to you on that. That is probably the best way to go.

The CHAIR — All right. We will take that on notice.

Ms HUPPERT — Minister, I am interested in the BreastScreen digital mammography rollout. As Ms Munt mentioned, she and I have an interest in improvements in the detection and treatment of breast cancer. I notice on page 321 of budget paper 3 there is a line that there will be $10 million TEI invested in that program. Can you outline how this initiative will enhance breast screening services in Victoria and improve the early detection of breast cancer?

Mr ANDREWS — That is a very important question and one that is important not only in terms of cancer care but also important to Victorian women in a broader sense. At the election in 2006 we committed to the $10 million to roll out digital technology for BreastScreen Victoria. They do a fantastic job and are very well trusted, very well thought of by Victorian women and have been so for many years.

Just in terms of background to this, this is a very important initiative but it comes on top of very strong support from our government. The BreastScreen Victoria budget has gone from somewhere around $19 million to $31 million since 1999, and we are proud to have done that, noting of course that breast cancer is the no. 1 cancer killer of women. Around 703 women will die this year in our state from breast cancer, and I think there is something in the order of 3200 to 3500 cases diagnosed newly each year. This is a very substantial challenge in a cancer sense, in a women's health sense, and indeed in terms of health and welfare for the community in a broader sense.

We should be pleased to note the five-year symptom-free rates, so five-year cancer survival rates of breast cancer have improved markedly in recent years from 74 per cent in 1990 to 87 per cent in 2004. We would hope to improve that going forward. The way in which you do that is to provide the screening to do that early diagnostic work and to provide care and support to women in an absolutely comprehensive way, and that is what the Victorian cancer action plan does.

Part of that is supporting the workforce to make the best use of the best skills and giving the staff at BreastScreen Victoria and at many private providers that will be linked to this digital technology — that is, the hardware and software we are going to fund for them — is all about making the best use of those best skills.

There are a number of sites: six major screening centres will be upgraded as well as the urban mobile screening van — we have two screening vans and they are Australia's only mobile screening vans for breast screening — St Vincent's at Fitzroy, Monash Moorabbin, Monash Casey, NorthWestern at Parkville, NorthWestern Moonee Ponds as well as Gippsland at the Latrobe Regional Hospital, and the urban van — although I note that it is better described as the second van given that it supports communities like Kyneton, Seymour, Belgrave and Cranbourne. They are all important.

As I also mentioned there will be a link through software to 20 private and other public screening services that will get supporting IT so they can link into the new digital BreastScreen service. What this essentially means is it is a great outcome for women in terms of getting their screens faster, far more detailed screens, the ability to change those images, contrast and enlarge images — things of that nature.

Obviously there is no longer a need to develop film. It is not just good for women, it is much easier and simpler. It is great for staff also; some of the very dangerous chemicals that are currently used to develop the old film will not need to be used or there will be less of them.

I think this is a win-win for everybody — the workforce and women. We are absolutely delighted to be able to provide this $10 million boost. There were some who had raised concerns about us delivering this commitment. We have always maintained that we would deliver this. We honour the commitments we make and that is what we have done here. I know BreastScreen Victoria is very pleased to have received this money, and I know women who will benefit from this high-quality service will also be very pleased with it.

Ms MUNT — Will that allow the onsite screening facilities to integrate with the local health services, too, in a digital manner?

Mr ANDREWS — That is a very good point, Ms Munt. Rather than having to develop films, send it physically via a courier or give it to the woman to take where it needed to go, which is not a 21st century way of doing things, at the press of a button, via broadband connections, through basically an internet connection, they will be able to send that image in all of its detail to whomever needs to view that.

So a radiographer in a regional centre or in the mobile van would take the shot; it is then emailed to the radiologist in Melbourne — it could be anywhere, in fact — to then read that image and make a determination about whether that woman needs further testing and indeed further care. It is all about efficiency. As I said, it is all about making the best use of the best skills noting that we do have some workforce challenges in this part of the health system. This is just about giving our dedicated professionals the tools that they need.

Ms MUNT — That is fabulous.

Ms PENNICUIK — Minister, I am looking through the big area of your portfolio, and there are some statements in the overview and throughout the budget paper regarding preventive health measures with public health and immunisation scattered through. Are you able to give us an idea as to the proportion of the public health dollar that is spent on preventive measures as opposed to treatment measures, and whether that is going to increase as we move through the years given that obviously preventive health is a good way of reducing the other cost?

Mr ANDREWS — That is a very good question.

Ms PENNICUIK — Are there benchmarks that your department looks at from around the world or anywhere?

Mr ANDREWS — I will definitely get Dr Brook to supplement this. This is very much his area but it is of equal importance to me, and the point you make is a very good one: that unless we invest more both in terms of money, time and policy effort as well in terms of preventing — and that is both primary prevention, so trying to stop people ever getting type 2 diabetes; let us use that example for instance — or secondary prevention which is about the effective management of type 2 diabetes. That is all about better outcomes for that person, their

family, their workmates, their teammates, the community that they live in. But it also better for the overall health system. This is about, if you like, safeguarding the overall sustainability of the health system.

Ms PENNICUIK — I asked the question because it is a bit hard to tell from here where we are heading in that direction.

Mr ANDREWS — The public health output group will give you a sense of a number of different things that we do. I have just been talking about prevention. It is not quite linked to BreastScreen Victoria. That is more about screening and basically detecting breast cancer — it is about preventing death, if you like. But in terms of preventing illness, from a true health prevention point of view, there are a range of different things we do. If I can draw your attention to the Victorian Tobacco Control Strategy last year. There are some tobacco-related enforcement outputs here that are measured.

As part of the $150 million cancer plan we also announced the tobacco control strategy. That talks about a range of different changes. There are changes to the law around smoking in cars. There is a whole range of things we are doing. There is also a $10 million social marketing campaign — the biggest Quit campaign that Victoria has ever seen. That is directly about decreasing the adult rate of daily smoking from 17 per cent 14 per cent.

That is about saving lives, that is about prevention of cancer, respiratory illness, coronary disease and so forth. There are many different examples. As part of the national preventive health national partnership — the NP — there will be a new raft of different measures that we sign up to. There will be consistent accountability measures between each and every state. That is important as well. I am wondering whether Dr Brook wants to add to that answer. It is an important area. It is a very good question.

Dr BROOK — There is a methodological problem in trying to put a figure on who spends what on prevention. First of all, the state's responsibility in this area lies in several different parts of different output groups. For example, within the public health output group you could classify everything as prevention in one way — that would include immunisation and would include screening programs. They are really important early detection or secondary prevention issues.

But also there is a considerable amount of money but on a smaller scale which is spent on prevention research, such as the investment of $32 million a year into the Victorian Health Promotion Foundation, funding of initiatives like Life! for diabetes and funding of Go for Your Life.

The methodological problem is that the great majority of prevention and particularly secondary prevention spending actually occurs outside of the state health portfolio. If we look at the broader Go for Your Life program, where does one count bike paths or walking tracks in parks or beside roads? They are arguably far more important. Where does one count exercise and sport programs that are not counted in health?

The AIHW has been struggling with this for years. We sit on a group which is looking at national estimates of public health expenditure. All I can say of that is we would hope that we have better methodology next year, because no-one around the country seems to have been able to accurately estimate those elements of government expenditure outside of health which are genuinely part of improving health and improving socialisation.

You may look even within different portfolios of government, perhaps some unexpected. There is the $600 million committed for the WorkHealth initiative. That is a crucially important and very big initiative. You may also look to the COAG commitment of many hundreds of millions of dollars over a six-year time frame for the national prevention partnership, which will really not roll out at a state level until three years hence. But there will be commonwealth money going into social marketing campaigns regarding obesity, regarding child health and regarding smoking within the next year.

Having said that, you have also got to consider the non-government organisations, which are actually quite fundamental here, whether it is groups like the Cancer Council, which we sponsor for subsidiary activities, as it were, in Quit or SunSmart; whether it is the National Heart Foundation; whether it is other organisations like that or whether it is in fact the common or garden media.

The direct answer to your question is: the best way to look at it is to include the whole of the public health output group within our portfolio — that is, about $250 million — and about one-third of community health expenditure which goes directly on health promotion.

Mr ANDREWS — Could I just add to that: obviously, Ms Pennicuik, if you look at pages 104 and 105 there is the health protection output group with 183.3 and then the health advancement output at 68.9. Perhaps if I was to write to the committee and to you with just a few further examples of our primary prevention, secondary prevention and the other behavioural change work that we are doing, together with some of the other diversion programs which sometimes do not make it into the basket or are not counted or called primary or secondary prevention.

They are more about demand management in the acute sector, but they do have some added benefits in terms of preventing the onset and preventing some of the really complicated and adverse impacts of multiple and chronic illness.

The CHAIR — Write to the committee, actually.

Mr ANDREWS — Yes, of course.

Ms PENNICUIK — Could I just clarify one thing quickly, Chair? Thank you, Dr Brook. I understand the methodological problems. This has been a long interest of mine, but I was prompted very much to ask it today, because I was listening to someone on Radio National this morning, a doctor who has come over from the UK who has done a lot of work on cardiac prevention. They have collected a lot of data and it is pretty well encapsulated in their health. Anyway, I will be interested to see what the minister writes.

Mr ANDREWS — I will be happy to write to the committee.

Mr SCOTT — My question is in regard to the Bendigo Hospital. In budget paper 3, page 322, the government has outlined an initiative to redevelop the Bendigo Hospital. What steps have been taken towards this project and how will it benefit the Bendigo community?

Mr ANDREWS — We are very pleased to provide support to the Bendigo Health Care Group. It is obviously a very large regional hospital, providing support and care not only to people in the Bendigo region but also right throughout north-west Victoria, as people in Swan Hill and other communities to the north-west of Bendigo look to Bendigo for the specialist care that they often need.

As you would know, as all members of the committee would know, we were — the Labor Party, that is — the only party in 2006 to commit to a new hospital for Bendigo. We proudly made that commitment. We committed firstly to provide, I think, around $2 million in planning money. In the very first budget after the election we delivered that. That planning work was done. It identified the top priority for Bendigo Health Care Group was just under $10 million for an expanded emergency department. We funded that in the very next budget after the planning work had been done.

We are now into the third budget of this term, and we have provided $55 million, an important boost. We have basically determined the site of a new Bendigo Hospital.

We have provided the moneys within that $55 million to relocate an ambulance station that currently sits within that site. There are other enabling works, but there is also an important boost that will help to maintain, expand and improve the current fabric of what I hope will soon become the old Bendigo Hospital.

All of this has been met with the acclaim of the Bendigo community. I think the people in Bendigo, particularly at the health service — doctors, nurses, the other health service administrators there — are very pleased with this outcome. It is important to note that they have worked extremely hard over the last two and a half years and even going back before then, to make the case for this investment. It is a substantial investment.

As important as it is, I think it should be seen in the context of the support we have provided to Bendigo Health Care Group and the patients who turn to it for the care that they need. It is a very substantial boost of nearly 120 per cent more ongoing funding this 2008–09 year compared to 1999. It has gone from $58 million in the current support to $127 million. That is a very big boost. It is through that support that they are able to treat a growing number of patients.

This $55 million is not the only capital support we have provided. I have mentioned the $10 million for the emergency department. There is also $7.9 million for the Amcor redevelopment of a new 60-bed nursing home out at Eaglehawk. There was also — and this is a fantastic service in partnership with Peter MacCallum — the regional radiotherapy service, regional cancer service there. It is not just one linear accelerator and bunker; there are two providing care and support to a growing number of cancer patients right throughout the north-west.

On from that, in last year's budget I know Minister Neville was very pleased to secure $13.6 million for the Stella Anderson nursing home. That is about replacing that 60-bed nursing home adjacent to the existing one in Eaglehawk, together with a whole range of other important equipment — the tools, if you like, that our health service needs. I was very pleased to open the second linear accelerator in that second bunker.

One of the very first things I did when I became health minister was to travel to Bendigo to open that. The MRI machine, CT scanner, other equipment associated with elective surgery, the PAC (picture archiving and communication) system is about putting medical records online and some of the digital imaging we just spoke about in terms of breast screen. The list goes on.

There has been very strong support for the Bendigo Health Care Group, and that is the context of this $55 million going forward. When we do the policy and funding guidelines for the new financial year, they will again receive a funding boost, as every single health service across the state has in every single year. We are committed to the Bendigo Hospital, because we are committed to the community that looks to that hospital for the care that it needs, and it is no wonder that the community is pleased with this announcement, because it is about the next step towards a brand new hospital for that growing part of rural and regional Victoria.

Mr DALLA-RIVA — Minister, I refer you to budget paper 3, pages 89 and 90 — in particular at the top of page 90. It is under the performance measure of admitted services under acute health services, and in particular relating to elective surgery and the targets that are provided there.

I want some clarification that, given accusations about the secret waiting lists and particular issues about use of 'not ready for care' lists, which go back as far as October 2007, and further allegations raised over the ensuing year about data manipulation of waiting lists by public hospitals, can you inform the committee of the accuracy of the data provided in the forward estimates — in particular, where you are expecting targets of 90 per cent, 80 per cent and indeed 100 per cent — to ensure that those data figures are not being manipulated and, if they are and have been, can you explain what action you have taken to ensure that this does not occur in the future?

Mr ANDREWS — Thanks, Mr Dalla-Riva. This is aggregate data and the department stands by this aggregate data, as do I. Following issues at the Royal Women's Hospital and a report from the Auditor-General tabled in the Parliament a few weeks ago, I made a number of announcements, and if I can run through those for you, that will give you a sense of what I have done and what the department has done to ensure and to enhance community confidence about the integrity of the data that in so many ways represents the performance of our system.

I announced that we would do six unannounced spot audits. That work has already started, and we are well on the way to having those six spot audits completed, and I will come back to that in a moment. I announced that a director of data integrity would be appointed, a senior public servant, who would have but one role, and that was simply to oversee the audit of those six spot audits and other audit work.

That other audit work was the important completion of the VEMD data audit that Mr Rich-Phillips asked about earlier on, the full ESIS audit — that is, the elective surgery information system audit — so that is all the elective surgery data: six spot audits, ESIS audit, the VEMD audit and any other audits that we might need to do. That director of data integrity would be in charge of that process and would drive that process.

The Auditor-General's report also raised some issues at the Latrobe Regional Hospital, and Paxton Partners, if they have not already completed, are certainly in the process of completing an audit down there around those issues, and that will again go to the director of data integrity. They are the audit steps I have taken.

I have also announced a raft of measures that are important in terms of the administration at a local health service level. For instance, I have made it very clear to chairs that it is my expectation and the expectation of the community that hospitals record their data accurately and that they have systems and processes in place to ensure the robustness or efficacy of any and all data that they provide.

Around those issues I have made it clear that I will require each and every hospital and each and every health service to make a statement in their annual report tabled in the Parliament as to the sufficiency of their processes. I will also make issues of data integrity a key theme in the statement of priorities to be signed for the 2009-10 year.

That, I think, is a substantial suite of important measures, but there are more. I have also disbanded the roughly $40 million bonus pool because there was a perception among the community that people may have been acting inappropriately in order to secure additional funds. That bonus pool has gone.

A small matter but I think an important one is our change towards making sure that every health service, where a patient's status changes, that patient will receive a letter notifying them and asking them to note that their status has changed. That effectively makes each and every patient an auditor of their own care. On any fair reading of that, that is a comprehensive range of steps.

They are important. They are about making sure that the community can have complete confidence as to the integrity of the data. This is aggregate data. The department stands by it, and I stand by it. In terms of individual health services, as will be reported in the Your Hospitals report, I await the completion of those six spot audits a certification from the director of data integrity about the results of those spot audits, and then we will make further announcements around the Your Hospitals report for the first two quarters of the current financial year.

I reject the premise of your question, and I stand by the data that is before you in terms of expected outcomes as reported on page 90 and right throughout the budget papers.

Mr DALLA-RIVA — You reject what I have said, and I understand what you have explained to me in terms of the process. The first thing is that it has taken a fair time to get it enacted but you have enacted a range of activities. The target outcomes for 2008–09 are 90 per cent, and in 2009–10 they are 90 per cent in terms of category 3 elective surgery. They are the same targets for category 2 and category 1.

What I am trying to get at is that the Auditor-General has identified a range of issues. Surely you are that confident that the target measures that you are achieving for 2009–10 — —

Mr ANDREWS — The Auditor-General has found an issue at one hospital, and that is the Latrobe Regional Hospital. That does not relate to elective surgery, it relates to emergency. It was not the Auditor-General but the women's hospital itself that found an issue which was then the subject of auditors appointed by me — —

Mr WELLS — So there are a number of issues that — —

Mr ANDREWS — The way this works is that you ask the questions, and I answer them. I am trying to get to answer your question but now you are talking over me.

Mr WELLS — The issue is the accuracy of the data.

The CHAIR — The minister is answering the question.

Mr ANDREWS — I am attempting to answer the question, Chair. Do I have the call?

The CHAIR — You have the call.

Mr ANDREWS — Very good, thank you. The women's hospital itself identified issues and auditors were appointed. So this notion that the Auditor-General has found inappropriate or manipulation in aggregate data is simply wrong; it is simply wrong.

Mr WELLS — He has found it.

Mr ANDREWS — Again, you have asked your question, and I will answer the question. It is simply wrong. The department stands by this data, I stand by this data. The auditors of the Royal Women's Hospital, Paxton Partners, found — and if I can quote:

> This understatement will not translate to a material misstatement of the statewide elective surgery information and indicators published in the DHS 'Your Hospitals' report.

Mr DALLA-RIVA — So there will be no not-ready-for-care lists floating anywhere?

Mr ANDREWS — I do not think you understand.

Mr WELLS — Answer the question.

Mr ANDREWS — I am answering the question.

Mr WELLS — Just answer it.

Mr ANDREWS — I am answering the question. Patients are made 'not ready for care' each and every day based on their clinical circumstances and based on their personal circumstances. They are not judgements that are made by me, they are judgements that are made by appropriately trained staff. People who are not ready for care at a local health service level may well be listed as 'not ready for care'. In the main that is a clinical judgement, or it is a reflection of personal circumstances experienced by that particular person. That is not something that I have any involvement in. I am not quite sure about the link that you are drawing. I think I have answered the question.

The CHAIR — Okay. I think we have answered the question. We will have some other answers in the immediate future.

Minister, I refer you to page 22 of budget paper 3 where it talks about your key initiatives. They are further elaborated on in the appendix to budget paper 3. I am particularly interested in beds, both additional acute beds and new sub-acute beds. Can you tell us a bit more about that, including the recurrent funding for this going forward, because it is obviously pretty important when it comes to meeting the growing demand on public hospitals?

Mr ANDREWS — This is a really important issue. It is about growing the raw capacity of the system. Late last year as part of the, I think, fair and balanced resolution to the medical enterprise bargaining agreement we also announced a very substantial boost to the overall capacity of our health system, $321.5 million over four years — a very substantial boost. That is to fund 276 additional beds: 100 additional acute beds and 170 additional sub-acute beds. That is the great strength of our system. No other state has the number of sub-acute beds that we have.

The CHAIR — That was 170?

Mr ANDREWS — It is 170; 100 in acute, 170 in sub-acute and 6 critical-care. It is a mixture of PICU, NICU and also adult intensive-care beds. That is a very big boost. That was a 'bring forward'. Basically, that money flowed from 1 January this year, and we bring that to book. That is why some of the numbers in the budget papers refer to the five-year effect of that beds package — basically, quarters three and four of the current financial year and then right across the forward estimates.

That is a substantial boost. It will allow us to treat many more patients, indeed up to 63 000 additional patients. In many respects it is the biggest single boost to hospital capacity that I can remember having been in and around this portfolio for a number of years, but it is a very substantial boost, certainly in dollar terms.

It is not just more beds in one part of the system. As I said, it is a balanced investment. There is a bit of policy thought gone into this as well. It is not just about growing the overall capacity, it is about models of care, driving efficiency, boosting each of the component parts of the inpatient experience, acute, sub-acute, critical care, playing to our strengths if you like. I should also say there is some money around adult retrieval and also newborn emergency transport services as well funded out of this package.

If I can give you a couple of examples of what this means for local health services: if you look to Melbourne's north the Austin Hospital shares in just under $7.9 million. That opens 34 beds — 10 acute and 24 sub-acute. If you look at Eastern Health, which I am sure is of interest to some committee members, just under $3.2 million. That opens 18 beds — 4 acute and 14 sub-acute. In my local community, which I share with a number of committee members — Southern Health — it has the biggest boost across the system for our biggest health service with 51 beds. Some have been critical of this; I cannot think why you would be critical of this. The health service certainly is not in any way critical of this; they welcome it, they are delighted with it. There are 51 beds — just over $12.7 million with 23 and 28 sub-acute, and I think there may even be some additional capacity in terms of critical care.

Again, it is not just in metropolitan Melbourne. Our large regional health services have benefited in this as well. All of them: Barwon, Ballarat, Bendigo, Shepparton and Goulburn Valley and also the Latrobe Regional Hospital.

I will give you one example: Barwon Health, $4.4 million, 20 additional beds, 12 acute and 8 sub-acute. This is a package that grows the capacity of the system at each of our major metropolitan health services, not just in the centre of Melbourne but in the outer suburbs and at our big regional health services. It is about treating more patients, it is about better patient flow and it is about moving people through emergency departments by growing the bed stock that sits behind those emergency departments.

But it is not just more of the same. It is playing to our strengths, it is investing in the different component parts of the system. It is a big boost, it is the right thing to do, and it will mean better outcomes for patients both now and in the years to come, Chair. Thank you for the question. This is a very important boost.

Mr WELLS — Minister, I again refer you to budget paper 3, page 90, regarding the accuracy of figures. It was claimed in March of this year that — the minister said that the secretary of DHS would take legal advice on what action would be taken against those involved in data manipulation in Victoria's hospitals. What is the result of this advice? Has action been taken against any staff involved in data manipulation in Victoria's hospitals to ensure that the data provided on page 90 is accurate?

The CHAIR — As far as it relates to the estimates — I really think it needs to relate to the estimates.

Mr ANDREWS — It is pushing it, but I am happy to answer it.

Mr WELLS — He said he is happy to answer it, so let us see if we can get an answer.

The CHAIR — I really do think it is pushing it. You really need to be about the estimates.

Mr ANDREWS — I preface that by saying the question is pushing it, but let me say — —

Mr WELLS — Let us see if we can get an answer.

Mr ANDREWS — Have I got the call, Chair?

The CHAIR — As far as it relates to the estimates, Minister.

Mr ANDREWS — Thanks very much, Chair. I might ask the secretary to supplement this given that it is she who has sought legal advice. The advice is not on disciplinary action against any individual. We do not employ people who work in health services, Mr Wells. I would have thought you would know that. The health service employs people; we do not employ people in health services, and there is no allegation that any member of DHS staff has done anything other than act in a fully appropriate way in relation to data — just to clear that up.

As a matter of course, if any report comes to the Department of Human Services that has any issue of malfeasance or inappropriate behaviour, it is as I understand it rudimentary, it is simply custom and practice that the secretary would forward it to Victoria Police or get legal advice, if you like, and then take appropriate steps. I would ask the secretary to supplement that.

Ms THORN — If I can add to that, the health service in question is undertaking a very detailed review of what happened, and its board will consider the findings of that review and whatever action it needs to take in consequence of that. I did seek legal advice about: was their any reason for me to make a reference to Victoria Police because of fraud or any other activity?

The advice I have received says that in order for anyone to prove fraud, you have to prove that someone, an individual, has individually benefited from the actions. There is no reason for any of us to believe that anyone has individually benefited from the actions, and indeed the Paxton report that the minister referred to before makes it very clear that there was in fact no benefit from the actions that were undertaken.

On that basis and given the action that has already been taken by the minister both in respect of broader issues around data and about that health service, I have made a decision that there is no need to refer this to Victoria Police, because my legal advice tells me it will not pass a test of fraud.

The CHAIR — In relation to the — —

Mr WELLS — Hang on, this is my question. Do you want me to ask a follow-up?

The CHAIR — I was just asking in relation to the forward estimates and the accuracy of the figures; you have not answered that, Minister.

Mr ANDREWS — I again stand by my comments earlier on. The department stands behind these figures, as does Paxton Partners in terms of making no link between issues of inappropriate behaviour at the women's and aggregate data. This is aggregate data. In terms of individual, health service by health service, data we await the findings of the six spot audits that I have set in place and a determination by the director of data integrity, appointed by the secretary, in coming weeks. Again I stand by the data, as does the department.

Mr WELLS — Just to pick up a point from the secretary, you are saying you are confident that no-one has personally benefited and as a result of that it would not be referred to Victoria Police on the legal advice that you received?

Ms THORN — On the legal advice I have received.

Mr WELLS — That is fine. The minister, though, has scrapped the $40 million bonus staff pool because — —

Mr ANDREWS — No, it is a pool to treat patients, Kim. It is not a staff pool. It is not a bonus pool for executives.

Mr WELLS — So there was no extra funding — —

Mr ANDREWS — No, it is to treat patients.

Mr WELLS — I am actually asking — — you the question about — —

Mr ANDREWS — It is a bonus pool for health services to treat additional patients. It is not a personal bonus pool.

The CHAIR — All right, I think you have answered that one.

Mr ANDREWS — Which I think you probably already knew.

Mr WELLS — I was just asking the question.

Mr ANDREWS — It is wonderful theatre, but I think you already know that.

Mr WELLS — I was just waiting for you to answer the question to make sure we were very clear about it all across the board.

Ms MUNT — Minister, could I refer you to page 104 of budget paper 3 under the heading of 'Health protection'. It is my understanding, and you can tell me if I am wrong, that the first confirmed case of H1N1 influenza has just been determined in Australia. Can you please advise me how you are addressing this particular issue; what measures are being put in place?

The CHAIR — And what measures are in the budget too, Minister?

Mr ANDREWS — Thanks, Chair, and thanks, Ms Munt, for the question. It is a very good question. This is a real public health challenge and one that has got a lot of media attention and a lot of policy attention as well in recent times, not just here in Australia but indeed right across the world. Ms Munt is correct to say that Australia now has its first confirmed case. A 28-year-old female who is actually a New South Wales resident travelling from Los Angeles to Brisbane was swabbed at the airport as part of the positive pratique process that has been put in place by the commonwealth government at each of our airports.

She was later found, using the good offices of the World Health Organisation collaborative at the Victorian infectious diseases reference lab, funded and supported by our government, to be positive for H1N1. It is what

is called a weak positive — that is, she was no longer infectious. It is also believed that she was at no point infectious while she was on the plane, having been ill on or about 27 April, having flown and arrived on 7 May.

As I understand it, there was a range of contact tracing measures put in place. She was, if you like, quarantined to home, but now that order, or that process, has been lifted. So that is a great outcome for her. It is also great for public health more broadly. But it does show you that what has consistently been said by the chief health officer, Dr John Carnie, by the federal minister and by the federal chief medical officer, as that person is known, that this would ultimately arrive here, was in fact accurate.

There has been a whole range of processes and different pieces of work done and different arrangements put in place. First of all, the most important thing in dealing with these pandemic threats is to have the full cooperation of the Victorian public. The Victorian public has been fantastic in coming forward to get tested — those who had a relevant travel history and those who had flu-like systems — and that has been very important, and the full cooperation also of the Victorian community and the Australian community in terms of time delays at airports, the thermal scanning and all those different systems and processes that are time consuming. I think people have been very accommodating and have understood that this is a serious public health issue.

In terms of steps that we have taken at a Victorian level, the chief health officer has written to all general practitioners informing them of these issues and giving them a sense of what the processes and protocols are. He has also written to various health professionals who work in our health and hospital system. They have been updated regularly, either through circular or through the DHS website, www.health.vic.gov.au. There have been many detailed briefings. Of particular importance are briefings with senior clinical staff from the 16 designated hospitals that have got negative-pressure rooms and that have got other services and supports and protocols in place to deal with a pandemic.

We have also ensured that a proper protocol existed between private pathology providers, GPs and the Victorian Infectious Diseases Reference Laboratory so that we did not have samples going missing, it was a properly coordinated process and we could have an accurate picture at any one time of how many were being tested, how many were negative to H1N1 and how many were pending. As I have mentioned, we fully cooperated by providing public health nurses and other staff as part of those positive pratique arrangements at Melbourne Airport, and we have also been very keen to do all that we can to properly cooperate with the commonwealth government.

Politics ought not come into these matters, and it never does. These are issues for the whole Victorian community and the whole Australian community. We are very pleased to have been able to provide substantial support in past years around the Victorian health management plan for pandemic flu — things like the upgraded at VIDRL, things like our own $4.5 million stockpile of medical supplies, not to be confused with the national stockpile that has something like 8.7 million courses of Tamiflu and similar antivirals and other medical supplies, and also very substantial investments around negative-pressure rooms and other physical facilities that are important in terms of dealing with a potential pandemic threat such as this one. Again we are on high alert, if you like. We are at phase — Dr Brook?

Dr BROOK — We are at delay phase.

Mr ANDREWS — It is important that we continue to do the work we are doing, but what is really important is that if any Victorian has got a travel history and has symptoms: visit your doctor, visit the hospital, ring Nurse-On-Call, get tested and then we will provide you with the care that you need.

Ms THORN — If I could just add to that, as an example of the alertness, one of our very senior staff had occasion to take his very small daughter to the Children's yesterday with flu symptoms. In the course of the examination it emerged that she had probably caught the flu from the child of someone who had recently returned from the United States. She was automatically treated separately and differently — you might call it mystery shopping; he was not intending to do that. The hospitals are certainly on alert and keeping their eye on anyone who attends with symptoms and examining not just their immediate family but who they are in contact with.

The CHAIR — Thank you, Secretary.

Mr RICH-PHILLIPS — Minister, you spoke earlier about additional funding for BreastScreen Victoria. I would like to ask you about the targets on page 105 of BP 3, which show a reduction in the target population

screened within the specified time frame for breast cancer. The target has been reduced from 60 per cent in 2008–09 to 56 per cent in 2009–10, and there is a footnote which states:

(b) 2008–09 expected outcome reflects the higher demand for breast screening services and ongoing workforce pressures. 2009–10 target has been revised to align with the current national average.

My question is, firstly, what does the reference to 'workforce pressures' mean and why would you be reducing the target to a national average?

Mr ANDREWS — This is a good question. Obviously there are pressures in this system, and I did allude to those a moment ago, in terms of the radiologist and radiographer workforce and others that are involved in this. I will get Dr Brook to supplement this answer in just a moment. He is most expert in these matters.

That is why, can I say, the investment of $10 million in terms of digital is so important, as I said earlier, in making the best use of the workforce we have, together with a range of other initiatives. We spend $40 million a year on a whole range of different workforce programs. I announced very substantial boosts only a couple of weeks ago in terms of rural and urban specialist posts for the next couple of years. There is a lot of activity in terms of training not just the generalist medical workforce but the specialist workforce as well. That is not just our responsibility, it is also the commonwealth's, but there is no doubt that there are workforce pressures, together with the fact that we have a growing cohort of women — that is, the target group of women between the ages of 50 and 69 is getting bigger and bigger each year.

Whilst our funding as a state government has grown, as I said before, from around $19 million to $31 million and there have been things like digital and some service delivery changes like the two vans and things like that, the commonwealth's contribution has remained reasonably stable. We would like to see that perhaps go up over time. There is a challenge here. One of the ways you meet it is through things like digital, through the other workforce programs that we have put in place in a broad sense, but also the Victorian cancer action plan — although it is towards the end of these forward estimates — funds 20 000 additional breast screens. This is a very important area, but it is challenging because the cohort is getting bigger and bigger each year. There is a review, as I understand it, of mammography or breast screening services that is currently being run by the commonwealth government, and we will eagerly await that. I think that probably answers the question in broad terms. But I will ask Dr Brook to supplement that.

Dr BROOK — Thank you, Chair. There is an Australia-wide shortage of both radiographers and radiologists in providing this and a number of other like services. This is a very big program. Ideally, every woman between the ages of 50 and 69 is targeted for mammographic screening every second year. It dwarfs any other radiological program of its type. It is a very big program. Not all women wish to participate, so the national objective in this arena is in fact only 60 per cent participation because it is not anticipated that every woman will participate.

The minister's statement about the nature of what is happening here is absolutely correct: it is something of a squeeze play. The cohort of women who are reaching the target age range of 50 to 69 is growing considerably as the baby boomer group moves through, and the capacity of the system to be able to respond to that is in fact quite limited. Things that we are doing, along with other jurisdictions, include looking at different models of workforce provision, so that rather than relying only on radiographers, who are the biggest problem group, we can look at a differently trained workforce, a more specifically trained workforce, under supervision, to look at better ways of using the available radiology — that is, the people who read the films — workforce. There are a number of ways that can be done.

That can be done through, and I think it has been discussed, using the benefits of modern technology and compressing data and being able to transfer images from one place to another where they can more easily be read. I do not think we should underestimate just how significant the provision of the first mobile digital service in Australia is. Using basically Telstra 3G — without the ad — we are able to transmit large packets of information such as have never been appreciated before and get a service performed in, say, Shepparton, read in, say, St Vincent's and almost instantly answered.

We are making use of that. There is a major review of what is called BreastScreen Australia, which is the overarching program, and we understand that the final report of that is with the commonwealth at this point in time, but it has not been publicly released. We are hoping that the reason for delay in its public release is because the commonwealth wishes to invest further in this area, but that is their call, and so we are not in a

position to confirm that. We actually have some significant issues to work through ourselves to try and generate more services to meet the growth in population in this area.

Just to remind you, this is a screening program; this is a program for women who have no symptoms, who do not have a family history of or think that they have breast cancer — for them going to other services is recommended. This is for people who are entirely asymptomatic, so as long as we can get this sorted we hopefully lose very, very little. That would be the ideal — that there is very little slippage in the program.

Mr RICH-PHILLIPS — Can I conclude from both your answers that the decline in the expected outcome for the current year which was expected to be 55 per cent versus the 60 per cent target last year reflects a constraint in supply for breast screening services?

Mr ANDREWS — I think what has been alluded to is a constraint in supply of an appropriately trained workforce. There is no constraint in supply in terms of funding, for instance, that is provided to agencies.

Mr RICH-PHILLIPS — No, availability.

Mr ANDREWS — It is the availability of the staff we need in order to provide these services. I will just add this: Dr Brook mentioned the mobile van, and I recently had the opportunity to be briefed on that van going into a number of remote indigenous communities if we have such a thing. We probably do not, technically, but some communities in rural and regional Victoria that have large numbers of indigenous women, and it is such a powerful example of where smart investment can really drive changes in culture, changes in outlook. That mobile van has now visited that particular community twice, and it is not just about breast screening; it is a whole range of health services, whether it is cervical screening, running tobacco cessation programs — all sorts of women's health programs now that run from that van. It is only possible because the van is there, so it should not be lost on anyone, the significance of that. It is a really important investment; we are really proud of it, and BreastScreen Victoria did a wonderful job with it. That is the rural one; there is also the urban one as well.

Mr NOONAN — My question follows on from the comments you have just made, because I wanted to ask a question about indigenous health on which you also presented us with some information in your overheads. I think you described it as the biggest boost the state has ever seen in this area. So with reference to budget paper 3, page 39, which outlines the National Partnership on Closing the Gap in Indigenous Health Outcomes, I wonder whether you can explain how the government is investing to achieve this outcome and what the government is expecting to achieve as a result of that significant investment.

Mr ANDREWS — That is a very good question, Mr Noonan. There are many fine words spoken about these issues, and words are important and it is important to say and to be clear about the fact that we all as a community are really concerned and fundamentally committed to closing the gap, the 17-year life expectancy gap, which is no different whether you are in Fitzroy Crossing or in downtown Fitzroy. These are as much issues for Victoria as they are for remote Western Australia, the Northern Territory or Queensland. It does not matter where you are in Australia, 17 years is the life expectancy gap. That is shameful, and again as I have said many times about many different issues, we can often be well measured by the way in which we provide for the most vulnerable — our Kooris, our indigenous men, women and children, can I say. With that life expectancy gap we do not measure up very well at all.

There are some good programs, and we are proud to have supported them, certainly during our time in government and I am sure there were equally good programs under the previous government. Whether it is the Koori maternity service or a range of other targeted programs to support indigenous citizens in terms of chronic disease, whether it is in general terms policies and programs that may make particularly our rural and regional health services but also our urban health services more culturally appropriate, I think there is a good story to tell here.

But fine words are one thing; good policy and good intent is one thing, but it is the funding that makes the real difference. I am really proud to be able to say that this year's budget delivers nearly $47.5 million as part of our contribution to the national partnership — concrete, important steps forward, whether it is in terms of smoking cessation, birth weight, diet, physical exercise, alcohol and other substance abuse; a whole range of different supports and programs that I think will pay dividends and will really empower indigenous citizens through improving their overall health status.

If I can just give you a couple of examples of programs we will be able to grow as a result of this additional funding before I talk about workforce to wrap up: this year — only very recently, a couple of weeks ago — I was pleased to go out to Dandenong North just outside my own local electorate and celebrate the 10th birthday of Koori Maternity Services. This is a really important program; one we are very proud of and one that is delivering results. It is about midwife and team-based care, where Koori women who were previously often getting no antenatal care at all and would present, for instance, to a metropolitan health service whilst in labour, are now getting access — a vastly higher number are now getting access — to the antenatal care, the birthing care that they need, and also importantly for their health and the life opportunities of their baby, the post-natal care that they need.

I will give you one practical example of what that means for Koori women and their babies. For participating mothers something like 85 per cent of babies born in this program have a birth weight of over 2500 grams. To compare that, it is a mere fraction of that if you do not participate. So this is all about really tangible outcomes, better outcomes for the mother, for the baby and indeed for indigenous communities in a broader sense. That is just one example. That has celebrated its 10th year. One million dollars of this money goes towards expanding that for a further three sites. That is literally, over a period of time, hundreds and hundreds of indigenous babies and their mothers better supported than they previously were.

I have spoken about smoking cessation. Just recently I announced outside these moneys — but, again, it is another example of our absolute commitment to these issues — $1.5 million over three years for two important demonstration projects that are about better integrating primary and other disease management care with a proper evidence base. All too often we do not have the evidence base we need in terms of indigenous health — what works, what will not work, how you make the case for further investment? Those demonstration projects are an important part of that, both the one at VAHS in Fitzroy and the one up in Mildura at the co-op there.

Again, as I said at the outset, words are one thing and they are important, but practical investment, effort and energy in partnership with the commonwealth government really is the key to closing that gap, to making a dent in that, to doing more to empower people. It is all about dignity, it is all about looking after the most vulnerable, and often our indigenous communities are the most vulnerable across our state.

I will just finish by saying in terms of workforce, as I said before, whether it is in terms of breast screening services or so many other parts of the health system, we are as good as the staff that we can recruit, and we are as good as the staff that we can keep in our system. So having the right staff in the right place is really very important — even more so when it comes to providing culturally appropriate care, not just for indigenous consumers but also those from a culturally and linguistically diverse background in many different ways, but certainly in terms of indigenous health care and providing culturally appropriate care, where there is trust, where there is support, where there is a bond and where there is a confidence to come forward and get the care that is necessary.

This package also supports the training of 35 of those staff to work in Aboriginal-controlled health organisations. That again should not be underestimated in terms of the power of that, again as we look to close the gap and provide better and far more appropriate care and, in turn, better outcomes for indigenous men and women and children across Victoria.

The CHAIR — Thank you for that, Minister.

Dr SYKES — Minister, my question relates to the tables on pages 89 and 90 of budget paper 3. It goes to the issue of areas of underperformance in achieving some targets and yet the preparedness of the government to commit more money to those sorts of programs. For example, on page 89 at the bottom of the page, you have 'Emergency patients transferred to ward within 8 hours'. For 2008–09 the target was 80 per cent and the expected outcome was 69 per cent. Similarly on the top of page 90, for 'Semi-urgent (category 2) elective surgery patients admitted within 90 days' the expected outcome was only 74 per cent compared with a target of 80 per cent. What is the situation there? You are getting underperformance compared with targets. Is that because of lack of money or is it because of lack of efficiency? In other words, is just throwing money at it going to solve the problem, or is there something else that needs to be addressed?

Mr ANDREWS — Dr Sykes, it is important to — —

The CHAIR — Minister.

Mr ANDREWS — Sorry. It is important, Chair, to acknowledge that we are faced with a situation where more people are presenting for the care that they need, increasingly. I spoke in my slides about the notion that that sort of acuity profile is changing. So sicker people are coming to us to get the care that they need. These targets are about trying to drive improvement. These targets are meaningful targets, but no-one has ever said that they are easy; no-one has ever said that they can be easily achieved. What I have always said is that my aim is to try to deliver improvement, to try to treat record numbers of additional patients and to treat them faster. That is not an easy thing; it is not an easy thing at all.

My real task, Dr Sykes, is to make sure that our doctors and nurses and the other dedicated professionals in the system have the resources that they need — and you alluded to money, and money is always important. That is why there is 130 per cent more money in the system today than on the very first day that we came to government. There is always more to do, there are always challenges, whether it is in relation to the workforce, in relation to the infrastructure, in relation to the — —

Mr WELLS — More to be done.

Mr ANDREWS — Yes, there is more to be done, with record funding from this government.

Mr DALLA-RIVA — More to do, more to be done — —

The CHAIR — Ignore the comments, Minister.

Mr ANDREWS — Dr Sykes has asked a very serious question.

The CHAIR — Please continue to answer it.

Mr ANDREWS — Dr Sykes, what I would say to you is: these targets are important; they are about trying to drive improvement. The two that you mentioned, for instance, if you look at — I think you referred to the bottom of page 89, which says 'Emergency patients transferred to ward within 8 hours'. If you look at the 2007–08 actual and the expected outcome in 2008–09, that is a 2 per cent increase — from 67 to 69 per cent. I fully admit that that is below the 80 per cent. But the other point to remember is, of course, that many more patients have been treated within the clinically appropriate time, given the total growth in the number of patients who are actually presenting for care. So there is more money, there is a real commitment — from the government, from the department, from individual health services and from the doctors and nurses who work in them — to achieve these targets and to bring about improvement. That indicator shows important improvement.

I think you also mentioned category 2 elective surgery and if you look at semi-urgent elective surgery, I think was the one you raised Dr Sykes, you look at the 2007–08 actual it is 70 per cent, the expected 2008–09 outcome is 74 per cent. Again, I fully acknowledge we have not met the 80 per cent target, but we are seeing improvement all the while we treat more patients in terms of elective surgery, record numbers of additional patients, as I alluded to in my presentation earlier.

Ms HUPPERT — I refer to the Nurse on Call program that you referred to in one of your previous answers. In budget paper 3 on page 89 we have been given the output for acute health services. We know that the Nurse on Call program has been designed to assist particularly with lower acuitive patients. Minister, could you give the committee an update on how Nurse on Call is operating?

Mr ANDREWS — That is a very good question, Ms Huppert. We have, as you know, supported Nurse on Call and Nurse on Call today has taken more than 1 million calls. It is a trusted resource, a trusted source of health information and advice. What it means is that more people are ringing to get the advice and support that they need. That is all about empowering people, giving people the information in a timely way. That is important.

What is also important is that it effectively saves time, saves resources, saves effort in our emergency departments and in our public hospital system. Previously, before Nurse on Call it would be not uncommon, in fact many thousands of calls were made each and every month, each and every year, to local emergency departments, seeking the information, the advice, the assistance that Nurse on Call can provide now, discreet and separate from the emergency department.

It is a very trusted resource, a trusted service. I note that a recent customer satisfaction survey indicated that 99 per cent of those who responded were satisfied with the service they got, so it is very highly and well thought of, and that is important.

I mention again that there is an issue about saving time and saving resources; making best use of our hospital resources, in terms of them providing care rather than providing information to people. I am advised that since Nurse on Call first began, just under 21 700 hours have been saved that would otherwise have been nurse time, other emergency department staff, and other health service staff — that is 21 700 hours saved that they have not had to spend on the phone providing advice, they have been able to get on with providing care to people.

That represents just over 2700 days in terms of effective time. That is another way of looking at it. It is a great service for individuals, for families, but it is also a great service for the health system more broadly.

I think that was seen very clearly throughout the heatwave that we experienced earlier this year when Nurse on Call and other telephone-based diversionary programs, if you like, to substitute for acute health care and the misuse of those important resources, coped very well and was a great source of comfort and advice to people.

In terms of bushfires, not so much during bushfires, but in the weeks and months afterwards, Nurse on Call has been a powerful resource there as well and most notably, as I referred to earlier, the H1N1 issue, there have been many calls to Nurse on Call as well, seeking advice.

So whether it is about the individual, the family or the health system and the sustainability of the health system, Nurse on Call is doing very well and we are very pleased to celebrate its birthday recently, and to celebrate more than a million calls. In fact, I am advised, for the record, that there have been 1 072 725 calls at last count. It is working and it is working very well.

Ms PENNICUIK — Minister, I am wondering will the government be providing resources to implement the recommendations of the *Rural Directions for a Better State of Health* report in relation to maternity services? And are you expecting any more rural and regional obstetric units to close in 2009–10, and if so, which ones?

Mr ANDREWS — This is a very topical question. The commonwealth government is currently conducting a maternity services review that has been the subject of a lot of press attention and stakeholder attention. There has also been, in our own media, recent reports around one particular rural and regional service that had to temporarily close because of senior staff going, one to sit his fellowship exams and another one that was simply on annual leave.

What I would say to you is that individual health services make very difficult decisions about the services they offer in their local area. They are charged, as individual statutory authorities, with providing safe and relevant care. Sometimes there are shortages of relevant workforce, sometimes it is simply the number of women seeking to birth at a given health service.

There is simply not enough demand to either retain the right staff or to give staff who are willing to continue to work there enough recency of practice and enough throughput, if you like, to keep their skills up. Those boards do have to make, in those circumstances, very difficult decisions at a local community level, and some of those decisions have been made.

Again, I think every health service, both executive but also the board, takes those responsibilities very seriously. The safety of the patient has got to come first. It is only if you can provide appropriate and relevant care that you would seek to offer that care.

I will get Dr Brook to supplement this. This is an area of expertise for him, in terms of his responsibilities with Rural and Regional Health. Whether it is the rural maternity initiative, whether it is last year's baby-boom budget in terms of capital works across the states and in the outer suburbs but also the very substantial growth funding — I think, if memory serves, $40 million across the four years — in terms of additional capacity, we are providing more women with choice, albeit there are challenges in some communities, and safety has always got to drive those issues; and it has got to be the main consideration.

I think boards and their senior executives discharge those functions, which are very difficult, well, and they are today supported in record terms. Never before has a state government provided more support for rural maternity services than our government does. We can always do more and we are committed to doing that.

Dr Brook might be able to add, just in terms of any trends, and any other comments he might want to make.

Dr BROOK — We did have some discussion about this last year, as you may recall, but I think it is important always in discussions of rural maternity to have a context in which to place the picture of rural maternity services.

People talk a lot about closure of rural maternity services, but they do not talk about the 43 health services that continue to provide maternity services — that is, births — across rural Victoria, and the seven hospitals that, while not providing births, do actually provide antenatal and postnatal care in their local community and refer to a reasonably close hospital for antenatal care.

Whilst it is true that there are services which have over time, for demographic reasons almost exclusively, not continued with maternity services, I think we can take great pride in the preservation and enhancement of rural maternity services to the extent that we are able. In fact, 85 per cent of women giving birth in rural Victoria choose one of 17 bigger hospitals, so there is an element here of personal choice, not just whether a service is available or not.

The main determinant of whether a hospital can or should provide obstetric services is most often not doctors. I have made this point a number of times. It is actually the capacity of the hospital to field a team of midwives, and to do that properly you need to be able to have three shifts of midwives in continuity. Three shifts of midwives does not sound much, but if you are a very small community with a very small hospital, and if that community has a workforce profile which is itself ageing, then that becomes a major problem for it.

Of course you need to have doctors who provide care, and if you are going to provide any form of complex obstetrics, you need to have some form of anaesthetic coverage and an operating theatre and the like. None of those things is any use unless both doctors and nurses have appropriate recency of practice, especially midwives.

As the minister said, what we have done in relation to rural maternity services, quite unlike other jurisdictions, is rather than saying, 'Here is a number' or 'Here is a place', we say, 'We are prepared to offer you what the sort of capability requirements you need to think about are; and if you have those capabilities, then certainly we will support you in the provision of the services that are appropriate for your local community. But if you determine that you do not have those capabilities — and one of those capabilities might be, for example, can you cope with an emergency and how would you would deal with that emergency; if you determine that or if your doctors quite genuinely are struggling because they themselves are growing old and they cannot field an out-of-hours group — then there are all sorts of local issues that might determine whether somebody does or does not'.

But when it comes to the major regional hospitals; when it comes to the further 11 or 12 major sub-regional hospitals, all of them provide vibrant obstetric services. That is not to say that we have not had some times — for example, a brief period at Seymour, and most recently a very brief period at Portland — where the services had to withdraw from low-level obstetrics for a period. We then try and offer all the support we can to recruit staff, whatever the case may be.

Mr ANDREWS — It is important to note, Chair, that the Seymour example is a very good one, where through a lot of hard work — and the department was involved in that — we have now got birthing services back at Seymour hospital, and that is very important.

What I would say is that I am happy to write to the committee around the rural maternity initiative, which is a wonderful program that links women, and often small country health services, with larger country health services and with a medical and midwifery workforce in teams to provide choice and provide care.

There are a lot of really great examples, particularly in the Goulburn Valley, over in the far west of the state as well, where we have some very great outcomes where we have linked the hubs both ways, if you like — larger hospitals, which themselves are not big, with smaller health services, team-based care, obviously for low-risk pregnancies: that 70 per cent are low risk. It is not just a matter of reading some report written by

somebody, and I am pleased to do it, it is speaking with mothers, speaking with midwives and with doctors in those communities, and they are very pleased with the outcome. Chair, we might provide you with an update on how the RMI is working.

The CHAIR — Thank you for that.

Ms PENNICUIK — My question was: were you expecting any to close? I accept the answer you have given, particularly Dr Brook's, but I would like to know: are you expecting any more to close?

Dr BROOK — Are you asking: are there any planned closures or restrictions? No, there are no planned closures. The only recent issue we had was at Hepburn health. That is a decision that hospital has made where it is very close indeed to other service providers. We do not have any program of closure of obstetric services at all — quite the reverse.

Mr ANDREWS — There were literally, in that example, a handful of women who were seeking to birth at Hepburn.

Mr SCOTT — My question is regarding palliative care, and I refer the minister to page 89 of budget paper 3, which indicates the output 'Palliative care bed days'. Can you outline how the government is supporting patients requiring palliative care through inpatient and home-based or community based care? I will declare a slight conflict of interest in that my mother has worked in this particular area with the mentally ill over a long number of years, but not in palliative care.

Mr ANDREWS — That is a very good interest to have to declare. That is a great question from Mr Scott, and I acknowledge his long-term interest in these matters. Providing dignified end-of-life care and support, not just to the consumer, the client or the patient but also their loved ones is all about empowering people. It is about giving people choice; it is about really supporting people at their most vulnerable, and there can be no time when you are more vulnerable than in those last weeks, months and years, even, of a terminal illness.

Cancer is often the focus of palliative care, but it is not just cancer, it is a range of other important conditions, and across the board we have been pleased to boost palliative care hours and palliative care bed days but also to support greater choice in terms of palliative care, whether it is inpatient or acute services or what is referred to as community palliative care.

There has been a substantial boost there as well. What we know from talking to consumers, from talking to their loved ones — from listening, basically — is that people want choice; they want to die in the place of their choice, and they want to be supported to do that. That is not an easy thing. That is a very big challenge, particularly in the outer suburbs and particularly in rural and regional areas. We have proudly supported that choice, whether it is through infrastructure investments — Wantirna Health in the member for Scoresby's electorate, or if not, very close to it — —

Mr WELLS — Very close to it.

Mr ANDREWS — The old Wantirna drive-in site, a fantastic facility — 50 per cent subacute beds for aged care, 50 per cent palliative care beds — with the co-location of outer eastern community palliative care, a fantastic facility from the ground up. It is about choice; it is also about recognising the new model of the way palliative care is offered. It is often referred to — people will go in for a tune-up, if you like — as episodic care. It is not necessarily one block of care. People go in, get the care that they need, and that kind of sustains them for a period of time. There will come an end-of-life period, and that can be inpatient or at home.

What I am saying is more money, brand new and important facilities, more choice and innovative models of care, innovative ways of providing what really is so important to so many people. In terms of additional hours, there is an important boost in the budget this year. One example is $1.7 million for palliative care funding for Melbourne Health which will support in your own local community, Mr Scott, out in Melbourne's north, 10 new palliative care beds at Melbourne Health. That will provide around 3000 additional palliative care bed days. It is very substantial; many patients and their families will get the support they need through that model.

This year — in 2009–10 — we will invest around $80 million on palliative care across all different settings. It is not just about direct care; it is also about medical and nursing, often nurse practitioner consulting services, so putting in the expert workforce. This is a growing discipline and one where there are certain needs, and you

need to have the skills and expertise to provide this care. It is a very challenging environment to work in and we are very grateful to a growing workforce. But those moneys include workforce strategies as well.

I did note that it is not just about cancer. There are many other conditions to which palliative care is important but the Victorian cancer action plan did provide a $3.6 million boost for these services as well as some workforce supports, particularly in rural and regional communities, noting that that is very important to providing care and to providing options.

Whether it is a fact that by 2011 we will provide a minimum of five medical palliative care trainee opportunities each year in accredited palliative care training facilities, or things like the nurse practitioner program which we have supported and will continue to, there are many different examples, many different ways in which we are supporting with not only additional funding but also additional training opportunities. We have the right workforce as well as capital works to grow these services because we know how important they are to people, often at the darkest hour in their lives.

Listening to the consumer voice is very important as well, and we do that to try to make sure that we build the best possible service system.

Can I say that it is not just in Melbourne or the outer suburbs, regional Victoria really has benefited not just in cancer, but that is a leader in it, in terms of additional effort around palliative care, and we remain committed to growing the overall funding that we offer, growing the workforce, growing the supports that we offer to both inpatient palliative care and also community-based palliative care.

As I said before, the most vulnerable and how you provide for them can sometimes be a fair measure. I think this is a good outcome but one where we can do more and indeed we are committed, through the VCAP and through other processes, whether it is in terms of paediatric palliative care, whether it is in terms of the overall palliative care framework which we are in the process of looking at, together with budget outcomes. I think there are some good stories here of providing support to people when they are at their most vulnerable but we can always improve; we can always drive better outcomes and we are committed to doing that.

The CHAIR — Thank you, Minister.

Mr DALLA-RIVA — I refer the minister to budget paper 2, page 49 and if I could have a look at the last PowerPoint slide.

Overhead 'Investment in health infrastructure' shown.

Mr DALLA-RIVA — Just in the last dot point, Minister, and budget paper 2. It relates to the use of cash resources and the application of cash resources, in particular the Box Hill Hospital redevelopment proposal. I understand from the Premier's presentation yesterday, in which there was reference to the Box Hill Hospital being a consideration, I want to get some clarification into the forward estimates.

There are two lines in terms of 'net investment in fixed assets' and 'expenditure on approved projects', which are $4.5 billion and $7.1 billion et cetera. Under that is 'capital provision approved but not yet allocated', and that is in the forward estimates of $262 million in 2010–11.

I am trying to get some clarification from you, given that you have said 'committed to a further stage'. I would assume you obviously have some money allocated. Where is it within the budget you are proposing it would come from? Is it from expenditure on approved projects or is it from capital provision approved but not yet allocated? Depending upon which one it is coming from, when do you expect the rollout of the Box Hill Hospital to proceed?

Mr ANDREWS — Can I say to you, Mr Dalla-Riva, that issues around the allocation of unallocated capital are not matters for me. They are matters for the Treasurer, and I think you had him before you for 3½ hours this morning; the Premier before you for about that time yesterday, and I understand there was a debate about these matters, as there usually is. It is not for me to unpack unallocated capital or to rebuild the budget for you. That is not my job. What is my job is to ensure that we have the best possible fabric, the best possible facilities right across the state.

Mr DALLA-RIVA — I am talking about Box Hill.

Mr ANDREWS — I will come to Box Hill. We have consistently said that we are committed to the redevelopment of the Box Hill Hospital. Stage 1 is completed — very important. In terms of further stages, as the slide shows there and as a media release not from me but from the Premier and me on budget day made very clear, we remain committed to a further stage of the redevelopment of the Box Hill Hospital.

Mr DALLA-RIVA — So it has not come out of — —

Mr ANDREWS — It is not for me — —

Mr DALLA-RIVA — It is not in the approved projects?

Mr ANDREWS — Hang on. Let us read the slide 'awaiting details of first round funding allocated by commonwealth government from the health and hospitals fund'. That is very clear. We are awaiting — and we will only have to wait a few more hours — in relation to the commonwealth budget to see not just whether there are allocations for this project. That point is making a broader point. What are the moneys that will come to our state for health?

Indeed it will not just be health that people wait on tonight; it will be a whole range of other important infrastructure projects — from the Building Australia Fund, from the education fund I think, from all manner of different funds that the commonwealth government has set up.

What is clear is that there can be no doubt that this government is committed to the redevelopment of the Box Hill Hospital.

Mr DALLA-RIVA — When?

Mr ANDREWS — There is no doubt about that.

Mr DALLA-RIVA — I have asked you pretty much — —

Mr ANDREWS — Would you like me to read the slide again?

Mr DALLA-RIVA — Yes, read it.

Mr ANDREWS — 'Awaiting details of first round funding'.

Mr DALLA-RIVA — That is great.

Mr ANDREWS — Could I be any clearer?

Mr DALLA-RIVA — But I have also given you the forward estimates on page 49 of budget paper 2, there are — —

Mr ANDREWS — And I have indicated to you that it is not for me to unpack those issues.

Mr DALLA-RIVA — So I gather from your statement, Minister, there is no state funding in the forward estimates for this statement here?

Mr ANDREWS — How can you gather that?

Mr DALLA-RIVA — Because I have just asked you the question! I have asked you the question about expenditure on approved projects. You said there is none for Box Hill and the provision — —

Mr ANDREWS — The allocation of unallocated capital is not a responsibility of the health minister. Can I put it to you with the greatest respect that that does not mean what you have just said it means.

Mr DALLA-RIVA — But you have not answered the question that I asked.

Mr ANDREWS — It is not a question for me to answer. It does not fall within my responsibility.

Mr DALLA-RIVA — So who should answer it?

Mr ANDREWS — The witness you had before you for 3½ hours this morning, Mr Dalla-Riva. If you did not have the presence of mind to ask him, that is not my responsibility.

Mr DALLA-RIVA — I guess there is more to be done in this committee. The realities are that Box Hill Hospital is not going to get developed.

Mr ANDREWS — You want to do a bit of work on your questions, because it is not for me to answer for the Treasurer. I have made that point.

Mr DALLA-RIVA — You have got all this money allocated and you are not going to do it, you are not going to build it. It is just more spin. There is no money. You are waiting for Rudd money again.

Mr ANDREWS — Where this has finished up, Chair, is where Mr Dalla-Riva always hoped it would — that is, him being able to make a claim that this government is not committed to the redevelopment of the Box Hill Hospital.

Mr DALLA-RIVA — You are not.

Mr ANDREWS — In saying that, he is wrong.

The CHAIR — I want to ask you about major trauma patients. I refer you to page 89 of budget paper 3. You will see there, under 'quality major outputs and deliverables', 'major trauma patients transferred to a major trauma service'. There are percentage targets there. I just want to ask you: what in the budget do you have to deliver that particular output and to support trauma services here in Victoria?

Mr ANDREWS — Thank you, Chair, that is a very good question. Can I say to you that I think all of us across the state are very proud of the work of our trauma surgeons, our other medical staff, nurses. But can I single out — sometimes it is unfair to do this — our ambulance paramedics, particularly our flight paramedics, both rotary and fixed wing. We are all proud of the work they do. We see it on television. There are many different TV shows that are dedicated to this really important part of the overall health care system. We can be very proud of the work that they do, but it is important to support them, and it is important as well to gather evidence and see what the outcomes of that investment mean.

There are about 2000 major trauma patients treated at one of the state's major trauma centres every year, noting we have three major trauma services — the Children's, the Royal Melbourne and the Alfred. On from that, though, under some work — to give credit where it is due — that was done by the previous government and implemented by our government under the RoTES review, there is an integrated system, a statewide system, where you get properly escalated levels of care.

The whole health system works together to provide you with the trauma care that you need no matter where in fact the injury occurs — noting that it is not just motor vehicle, it can be an industrial accident; it can be any manner of different issues.

The CHAIR — Bushfires.

Mr ANDREWS — Bushfires, indeed, and I will come to that in a moment. Great staff, the best trained in the world, very strong support, a proper service framework where the whole system does not operate as individual health services but truly as a system, including ambulance and really substantial outcomes, really important results. You see those numbers reported in the budget, as you referred to them.

The bushfires — there were around 800 fire-related emergency department presentations and about 130 fire-related admissions. Within that number there was a cohort of very seriously injured people. The Alfred, both in its capacity as one of the three statewide trauma services but also our burns centre and one of Australia's leading burns centres, provided care to 21 of those most critically injured patients — 9 in intensive care and 11 in the burns unit.

We saw the pictures of the Ambulance Victoria choppers landing on the helipad at the Alfred, transporting those critically ill patients. Ambulance Victoria was a very important part of that. That is just one example of the kind of support that the Alfred and its contemporaries can offer.

Importantly — and this bears out the example around the system working together — in order that the Alfred could focus on those burns patients, the Royal Melbourne Hospital stepped up and took much of the trauma load, the non-bushfire-related trauma load that the Alfred would normally have had to share. The Alfred stepped up in a true system-wide sense and created the room, if you like, for the Alfred, both the ICU and other services, to cater for those critically ill burns patients.

I am very pleased to note that, as announced in the budget, there is a $1.1 million boost— a modest boost, but it will be of real importance to the Alfred burns unit — to upgrade the very important facilities there. These are inpatient facilities up on the ward as distinct from the ICU. That is an important development around improving infection control. We know people who have got very severe burns are the most prone to infection. It is about improved patient amenities and also some support around rehabilitation facilities — their own dedicated gym, for instance.

We are very pleased to have supported trauma services, pleased to have implemented and supported in an ongoing way a really good policy framework — it is a great system — and also to give all the component parts of that system the support that they need.

To give you a couple of further examples, in due course we will open the biggest ever emergency department redevelopment in the state's history at Melbourne Health — one of our state trauma services. Earlier this year I was really pleased to officially open the new Alfred intensive care unit — $25 million; an absolutely magnificent facility with more space, three dedicated pods to do the cardiothoracic transplant work, trauma and the non-trauma work; so three discrete areas, a lot of preparation and a lot of research. It is a fantastic facility to work in and provide care to the most critically ill.

I have already mentioned in answer to Dr Sykes' question earlier around air ambulance services that there will be not one but two new emergency helicopters — one adult retrieval, neonatal and also paediatric — but also putting the additional chopper down at Warrnambool and also providing ongoing support for the fixed-wing fleet — nearly $46 million. The list goes on and on.

The beds package I spoke about before is also about growing our capacity. The budget papers again do not show investment but they show above-target outcomes and we are very pleased with that. The real credit belongs to our dedicated workforce across the spectrum of trauma care who work in such a high-pressure environment, such a personally challenging environment, providing care and saving lives.

Mr WELLS — In relation to the Royal Children's Hospital project, given the claim in March of this year by the project director that there would be an additional $150 million in extra design and construction costs and, further, that the Auditor-General raised a concern that a $35 million donation expected to come from the Royal Children's Hospital Foundation and underwritten by Babcock and Brown International has not been paid by the due date, can the minister show us where in the budget papers these funds have been accounted for?

Mr ANDREWS — Let me indicate that there are some who have a very long history of criticising this project.

Mr WELLS — Who are you referring to?

Mr ANDREWS — Nobody in the Labor Party.

Mr WELLS — Who are you referring to?

Mr ANDREWS — We have funded this project — —

Mr WELLS — Who are you referring to?

The CHAIR — Can you allow me to chair this, thank you very much.

Mr WELLS — Who are you referring to?

Mr ANDREWS — You know who I am referring to.

The CHAIR — The minister, to answer the question.

Mr WELLS — I have asked you a question. Just tell me who you are referring to.

The CHAIR — Please do not interrupt.

Mr ANDREWS — We are proud supporters of this project. This is an important project. Mr Wells quotes from the Auditor-General's report. He fails of course to mention that the Auditor-General made it very clear that this project is on time, is on budget, is a first-class project and represents best value for every single Victorian.

Mr WELLS — Are you going to start addressing the part of my question, please?

Mr ANDREWS — Again, you have asked your question and I will answer it — —

Mr WELLS — You have given me the spin and the rhetoric. What I want is an answer to my question.

Mr ANDREWS — I hardly think — —

The CHAIR — Just a second, Minister. Mr Wells, could you desist from interruption?

Mr WELLS — He made an accusation about who supported and did not support it, so you must expect interjections when the minister is going down that path. Are you going to bring him back to answering the question?

Mr ANDREWS — I am answering the question. If I can get a word in, I am answering the question.

The CHAIR — All you are doing is causing problems for Hansard and interrupting. The minister to answer the question please, without assistance?

Mr ANDREWS — Thank you, Chair. I hardly think the Auditor-General is into spin. I am quoting from the Auditor-General. I am referring to the Auditor-General.

Mr WELLS — No, I am accusing you of the spin.

Mr ANDREWS — I am referring to the Auditor-General who finds that this is a best-value project and is a first-class project and one that we as a government are absolutely proud to have been able to provide support for.

The premise of the question is that a payment from Babcock and Brown has fallen due. It has not fallen due. That is the advice I have. What is more, my department is working with the board of both the Royal Children's Hospital Foundation and the Royal Children's Hospital itself around these issues, and we are very confident that there will be no shortfall in relation to this project. The Auditor-General himself finds that the project is on time, is on budget and is a first-class project — and one we are delighted to support. Again, others have been critical of this project. I am not one of them. I am a proud supporter of it and the first-class paediatric care that it will offer.

Mr WELLS — With respect, the first part of the question was in relation to the blow-out in costs of $150 million in extra design and construction costs.

Mr ANDREWS — There is no blow-out. I have just indicated to you that the Auditor-General finds that it is on time and on budget. Could I be any clearer?

Mr WELLS — So you are saying that there is not a $150 million blow-out in extra design and construction costs?

Mr ANDREWS — What I am saying to you, Mr Wells — —

Mr WELLS — Is that a yes or a no?

The CHAIR — The minister to answer, please, without assistance.

Mr ANDREWS — Mr Wells, I can hardly be clearer. If you do not want to take my word for it, that is fine.

Mr WELLS — It is just that you have trouble with numbers. That is why I am querying you about it.

Mr ANDREWS — Do I? Tell us about the unallocated capital? How are you going with that? Have you got capital and recurrent worked out yet?

The CHAIR — Thank you, Minister; that is unnecessary.

Mr ANDREWS — Let's be very clear about this.

Mr WELLS — What are you talking about? Unallocated capital? We have moved on from the Box Hill Hospital. Unallocated capital in regards to Box Hill Hospital — —

Mr ANDREWS — There is no $150 million.

The CHAIR — Mr Wells — —

Mr WELLS — He is asking me about unallocated capital. What has that got to do with $150 million for the Royal Children's Hospital?

Mr ANDREWS — Have you worked it out yet? There is no $150 million issue, as you describe it.

Mr WELLS — What are you on about?

Mr ANDREWS — Do you want an answer or don't you?

Mr WELLS — What's the $150 million?

The CHAIR — Mr Wells, thank you. I do not wish for any more assistance from you. The minister to concentrate on the answer, please, without any distraction.

Mr WELLS — Thank you. It is about time you brought him back to the question.

The CHAIR — Just a second. I have said six times in the last five minutes to you, Deputy Chair, stop interrupting, and as soon as I asked the minister to answer the question, you again interrupted, so I ask you once again to desist, please. The minister to answer.

Mr ANDREWS — Mr Wells has referred to, as he sees it, a $150 million shortfall. If he is not prepared to accept an assurance from me that that is not the case, then he need only read the Auditor-General's report that was tabled in the Parliament last week, which clearly he has not done. He has read only the bits that have been provided to him by the shadow minister. It is on time and on budget.

Mr WELLS — So are you saying — —

Mr ANDREWS — The Auditor-General is saying that.

Mr WELLS — So there is not a blow-out of $150 million. Are you saying that there is not a $150 million blow-out at the Royal Children's Hospital?

Mr ANDREWS — Read the report.

Mr WELLS — Are you saying — I am asking you the question.

The CHAIR — The minister has answered question.

Mr ANDREWS — I have answered the question.

Mr WELLS — Can you summarise what he said, then?

Mr ANDREWS — On time and on budget. That is my answer.

Mr WELLS — You are not very good at numbers; that is why I thought I would check it.

Ms MUNT — You have referred in passing to the ambulance services in Victoria. I would like to refer you to budget paper 3, page 93, that details a range of performance measures, outputs and deliverables. Can you please outline what the government is doing to ensure that Victorians continue to have access to the highest possible ambulance services?

Mr ANDREWS — Thanks very much, Ms Munt. This is an important question and these are important services, as we have already alluded to I think in the context of trauma and some other answers, particularly for rural communities, but right across the state. As you know, last year, the biggest ever boost of nearly $186 million, 258 extra paramedics, new and upgraded services right across the state, both in the air and on the ground. I have already referred to some of the air ambulance investments.

That additional money is very important and it is appropriate, given that our paramedics, the best paramedics in the world, are in fact responding to record numbers of cases — 706 000-odd last year. That is 29 500 up on the previous year. We have also seen that paramedics are spending more time in terms of case time with those they are caring for, and that is indicative of both an expanded scope of practice for our ambulance paramedics, but also people perhaps needing more care. There are many challenges across ambulance services, and it is not easy to provide the world's best pre-hospital emergency care and transport, but that is what our ambulance service does, with support from our government.

In terms of progress towards the rollout of those investments, I think it is fair to say we have made very good progress — that is, Ambulance Victoria has — with the additional funding that we have provided. Just topical today in relation to the air ambulance discussion we have been having, the important retrieval chopper for neo-nates, for paediatrics and adults, so linking people almost exclusively in regional Victoria with the specialist care that they need in Melbourne is up and running, is going, and is providing that service 24/7. It is the first time we have had a 24/7 statewide retrieval helicopter. That is hangared out at Essendon in a new $20 million-plus, purpose-built hangar out at the Essendon Airport. It is the fifth chopper. When we came to government there were but two, and there was a cloud over one of them. There are now five, or there will be by June, when Warrnambool comes on line. I was very pleased to be able to visit a little while ago the Warrnambool Airport to see progress on the hangar and the ambulance branch, and that will be a reality, thanks to this government's support, later this year.

Mr WELLS — If it wasn't for Napthine, you would have never done it. You were so opposed to it every step of the way.

The CHAIR — Without assistance.

Mr ANDREWS — Hot air does not build these things — from Mr Wells — it is investment — —

Mr WELLS — You were dragged kicking and screaming.

The CHAIR — Without assistance!

Mr ANDREWS — And it is only this government that has provided the money to make the south-west chopper a reality. On from that, I have mentioned fixed-wing upgrades as well. Also, in terms of road crews, we are making good progress against those 258 additional paramedics and the additional services that we promised last year.

There is also an important commitment around fatigue, managing workload, as well. The former Rural Ambulance Victoria had committed to 100 additional paramedics funded out of less overtime, if you like. We have made very good progress. As I referred to before, 88 of those 100 are now in stations, in branches, providing care and, if you like, better balancing the workload, particularly in rural and regional areas.

In terms of capital works our investment is second to none: new stations or improved stations right across rural Victoria and right across metropolitan Melbourne. I was pleased to be in your local community not that long ago to open a brand-new branch there. Again, there are literally too many for me to mention, Chair. In the electorate of almost every member of this committee there are substantial boosts in terms of either upgrades to existing ambulance stations or new branches being put in, and that is indicative of the record funding that we have provided to the now Ambulance Victoria to do that.

Can I just finish by saying that there is one other very important investment in the budget. Ambulance is a small component of it. This would not have escaped your attention, Chair. As you would know, there is $56.2 million for an upgrade to a second emergency services telecommunications authority, if you like a second ESTA; not just in Tally Ho in your local electorate, but there will be a second mirroring call-taking and dispatch centre in Ballarat. That is part of the $56.2 million and ambulance shares in that. That completes, or will complete, the upgrade of common call-taking and dispatch services between both metropolitan ambulance and rural and regional ambulance. That has been a very long process. This piece of infrastructure is central to that and, whilst ambulance is a small part of the overall $56 million, I think it will be to the benefit of consistency and to the benefit of patients who need emergency care in rural and regional areas. I suppose it also provides redundant capacity in the event that there is a need to supplement the Melbourne-based call-taking services that ESTA runs not just for us but for other emergency services as well.

I am very pleased, Ms Munt, to provide you with that update, a very consistent rollout of additional paramedics, additional services, new branches, vehicle replacement and air ambulance upgrades. We are getting in there and AV is doing the hard work to roll out the money, and that should be of comfort to all of us. This government has provided the funding, and AV as the service is wasting no time in delivering additional services and I think some forecast improvements in ambulance response times. I hope a further improvement in ambulance response times will be closely linked to the additional asset investments that we have made.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the funding for the HealthSMART platforms. I remember in the budget last year there was some output funding over four years for what was described as the rollout of the HealthSMART systems, as distinct from the installation or setup of them. Can you tell the committee, please, if hospitals and/or health services are being funded for the ongoing maintenance of those platforms and the training of their staff; and are all health services and/or hospitals implementing the HealthSMART platforms?

Mr ANDREWS — What do you mean by maintenance, ongoing operating costs or physical maintenance of hardware, or — —

Mr RICH-PHILLIPS — Essentially, ongoing operating costs.

Mr ANDREWS — Okay. I might provide some general comments and then Mr Wallace can perhaps supplement those in some detail. This is an important project. When we came to government there was very, very poor IT right across the health system. I am not making a point about it; I am simply saying it is a fact. It was very, very poor after a lot of underinvestment for a very long period of time. We made a decision that a common IT architecture was very important, and that the efficiencies that would come from that meant that substantial investment was the right thing to do.

I note that the Auditor-General brought down a report last year that made it very clear that whilst this project was over time it was within the budget that had been allocated, and he confirmed, I think, as do most fair-minded people — as I am sure you do, Mr Rich-Phillips — that this is a good project to be investing in. These services are very important in terms of modern and efficient health care.

In terms of support to health services, you are right; there were allocations last year. As you would understand, the rollout of HealthSMART is a complex process. I am happy to provide an update to you around each of the different HealthSMART applications, whether it is in relation to the Oracle finance and supply management information system that is operational in eight health agencies, or the rural and regional FMIS — if I can be permitted to abbreviate — which is operational at 15 campuses. If we go to PCMS, which is patient and client management system — the iSOFT system — it is operational in six health services, and four more are to be implemented. The implementations are under way. Just to be clear about the point I made a moment ago about the 15 campuses within the Gippsland region, it has been rolled out in those 15 campuses.

To go on to community health, the client management system, or Track Health, as it is known, is operational in 17 community health services; a further five stand-alone community health agencies are at various stages of the implementation. In terms of radiology and imaging, the PAC system I referred to in an earlier answer — the picture and archiving communications system — which is a very powerful tool, has been implemented in six health services. That is a very complex business, but it is important and powerful in terms of efficiency. Statewide-shared infrastructure is currently supporting over 28 000 users across 31 health agencies from an imaging and radiology point of view.

In terms of human resources, so payroll and rostering, the HR management system — Frontier, as it is known — is operational in seven health services and paying over 50 000 health workers each pay cycle. Similarly, rostering is embedded across a number of different health services as well and being further rolled out.

I can go on to ambulance and we can have a long and I hope informative discussion about the Victorian ambulance clinical information system, or VACIS, as it is known, replacing paper with a tablet where basically data is entered roadside, bedside, and so on and so forth.

There are other benefits in relation to dental. I can go on further around the rollout of this important program. We remain committed to it. It is a complex process and I have made it clear that this had my close attention in terms of meeting the milestones within the overall project, and I remain committed to that, as does the secretary. In terms of drilling down into individual supports for health services, and particularly in the context of last year, perhaps Mr Wallace can provide us with an update.

Mr WALLACE — The specific answer to the question, 'Are we funding health services for operating costs?', the simple answer is yes.

Mr RICH-PHILLIPS — And training?

Mr WALLACE — Training is usually involved as a project cost. Project costs involve the implementation team and training that goes on of health staff, so that is usually considered an implementation cost. The operating costs: we are running shared services for most of the applications, so there is additional funding that is going in to cover the costs of shared services. It was always a sharing arrangement, but the funds that were provided in the budget last year have been allocated to meet those costs.

Mr RICH-PHILLIPS — At the health service level?

Mr WALLACE — That is correct, at the health service level — with the understanding, with the shared service providers, sometimes the funding is going into the shared service provider because the health service is not incurring the costs, it is being incurred in the shared service provider.

Mr RICH-PHILLIPS — Is there an expectation that all health services will take up HealthSMART platforms?

Mr ANDREWS — Part of a common architecture is having that architecture common to as many participants as possible. There are some legacy that are ready to be replaced, there are others that are not. There are some investments that have been made quite recently. It is not a matter of replacing things that do not need replacing, but it is the mission of this project to have a common IT architecture in place. That is not easy; it is very challenging, but there is a good team in place, there is a sound budget and, as the auditor finds, worthy work that, whilst it has had its time challenges, is operating within the budget that was allocated.

Mr NOONAN — I want to ask a question about workforce investment. I note from your presentation literature overall numbers since 1999, but in budget paper 3, page 91, there is a list of outputs for the training and development of health workers. My question really goes to whether you can outline how the government will use the budget in order to recruit and retain health professionals and, in light of Dr Brook's earlier answer to Ms Pennicuik, perhaps with somewhat of a focus on country Victoria in your answer.

Mr ANDREWS — Thanks, Mr Noonan. I think this has been a bit of a theme today, that training the right workforce, employing them at appropriate rates and then keeping them in areas of need and deploying them as efficiently and effectively as possible really is a very large part of the story of providing modern health care. These are big challenges for us. I think it is important to acknowledge that we have a partner in the current commonwealth government toward meeting these challenges. Admittedly at the end of the previous federal government's term we did get some support around the Deakin medical school, but we had to take some pretty unusual steps ourselves as a state government to support that, which is pretty much an unheard of investment.

Workforce — can I say there is a big challenge across the board, not just in rural communities but in the outer suburbs often as well. To attract and retain the right profile staff is a challenge there also. So this budget provides a very substantial boost. In terms of clinical placement there is more than $70 million to support clinical placements of medical students, nursing students and also allied health students. That is very important.

There are obviously costs involved in training the biggest undergraduate cohort across those three areas that we have ever had. It is an entirely good problem to have. We have got more medical students, for instance, then we have ever had, through the Melbourne-Monash consortium, the third school at Deakin and other programs, other growth.

Barwon, as the third medical school, is operating very well, and we know that a very substantial number of the undergraduate — sorry, they are actually postgraduate students there; it is a degree beyond their bachelor's degree — I think, from memory, around a third of those students are from rural and regional areas. All of them are having the majority of their training in rural and regional settings. As we know, if you train in the country, you are more likely to work in the country. If you then put the additional overlay of having been born and having lived in the country — if you are from the country — then almost certainly you will go back and practise in rural and regional areas.

So there is a big challenge, but I suppose we had an important win, if you like, in terms of securing the third school, and that was one challenge dealt with. Now that throws up additional challenges in terms of clinical placement and hours, in terms of recurrent funding and also capital. You have to have the physical space to be able to train those doctors, and so on and so forth. But they are all good challenges to have to meet, and there is a good, strong budget outcome this year with more than $70 million in terms of clinical placements.

There is also a whole range of other important measures that again are about building on our record. You do not recruit 9000 extra nurses unless you are committed to giving our health services the budgets they need to do that important work. You do not recruit 2500 extra hospital doctors if, again, you do not have a commitment to the patients they treat. There is a lot of money and a lot of numbers used in health, often to describe investments. That is a great way, I think, of describing where that money goes to: thousands more highly trained staff treating record numbers of patients and delivering better outcomes — and not just in the city but in the regions, in small communities right across the state. So the additional training places, the supports for those additional clinical placements, supporting 4500 med students, 12 000 nursing students, 600 dental students — I think I neglected to mention them a moment ago — and 6500 allied health students right across the state, that is a very substantial boost.

I did mention earlier on in another answer that last week I made some announcements around $21 million for strengthening medical specialist training posts. More than half those allocations are in the bush: 57 out of the total of 111, that I think goes to 113, are in fact in rural and regional areas, so half of those. That is a good outcome for country Victoria.

Again, there are many other things I could talk about around our consistent investment in workforce, particularly in rural and regional areas. We know it is a big challenge, we know it is important and we are committed to working with our partners, with those health services locally and with the commonwealth government, not just in health but in terms of education and training as well, to ensure we have the right workforce in the right places, providing the right care, with all the other associated linkages that make that possible.

Whether it is HealthSMART and telemedicine or digital breast screening, as we spoke about, there are many different ways you can support clinicians to do their work in areas other than urban Melbourne, and we are committed to always looking for those. Dr Brook, did you want to add to that at all in terms of rural workforce strategies?

Dr BROOK — Thanks, Minister. The only comment I would make is that you made reference in your question to initiatives to support workforce in the areas — I do not know whether you actually referred to maternity, but you talked to our earlier matter.

Mr NOONAN — I just referred to your earlier answer, where you did make reference to maternity in particular.

Dr BROOK — The minister has talked very strongly about the initiatives that are occurring at the entry level, but there are a number of initiatives that are also occurring at the graduate level. I just draw your attention to two of them that are specific to maternity. As part of the rural maternity initiative $1.4 million is allocated this year, and it will continue, specifically to support maternity in-line training and continuity-of-care models — very important to maintain team-based approaches in the larger, particularly regional and subregional, hospitals.

A total built up over a couple of years of $950 000 — just short of a million a year — now goes on specific postgraduate medical positions, which we have really tried to boost so that people training in obstetrics, whether they are specialists, of which there will be five posts, or general practitioners, of which there will be six posts, actually receive their training in rural Victoria for all the reasons described with the expectation that they will find the lifestyle very attractive and they will actually stay in rural communities, where certainly they are welcome.

The CHAIR — There is food for thought there for you.

Dr SYKES — Minister, my question relates to the collection of performance data. I apologise for having missed some of the session, and it is possible that you have covered in part the question I am about to ask.

I understand that hospitals are required to make performance data reports available to DHS in relation to their activity for the compilation of an integrated performance and activities report, which may form part of the budget papers — budget paper no. 3. I am asking if the minister can briefly explain the purpose of this report, the integrated performance and activities report, and make available to the committee the reports since July 2008 which have been produced and/or sent to hospital networks or other relevant stakeholders. It is about the exercise of pulling together the information to underpin your budget reports, discussing that and making some of it available.

Mr ANDREWS — Dr Sykes, there is a whole range of performance monitoring frameworks and other reports that are provided. I am happy to take some advice on that. There are obviously issues about audited performance and unaudited performance. We have annual reporting, we have *Your Hospitals*, we have the budget papers, we have any number of different reports that are about monitoring the performance of health services — and business units within health services even — and then they are pulled together to provide aggregated data.

Some of those are about recording performance, some of those are about driving improvements in performance and some of those are about finding outliers, if you like, to then go and work with them and, based on that evidence, to fix problems and provide additional supports. I will get some advice on that particular reporting framework. I would say to you that it is one of many. Again I am always loath to provide commentary on unaudited information. I would need to get some advice on whether I would be doing that in making any further commitments to you.

The CHAIR — Thank you. We have time for two more questions.

Ms HUPPERT — Minister, I have a question about immunisation. On page 104 of budget paper 3 there are a number of major outputs specified around the area of immunisation which indicate that Victoria's childhood immunisation rates have consistently met targets. Can the minister advise the committee how the government will continue to be a national leader in this important area of public health?

Mr ANDREWS — This is a very good question, and I am very pleased to be able to provide the committee with an update. We did have a similar discussion last year. I am very pleased to be able to provide an update and say that we have continued our national leadership. We are the only jurisdiction Australia-wide to consistently record 90 per cent immunisation rates or above for the three key milestone vaccinations — 12 months, 2 years and 5 years. That is something we can all be very proud of.

In celebration of that milestone and also to commission a new statewide immunisation service at the Royal Children's Hospital, I was very pleased recently to be there with Sir Gus Nossal — not only Victoria's chief scientist, but a Nobel laureate and someone of great standing and someone who knows more about these issues and the clear public health benefits that come from an immunisation and vaccination program than perhaps anyone. About 5000 children are vaccinated there each year. This is part of a modern health system. This is part of protecting not just those children but protecting all of us. The lower the cohort of unvaccinated individuals at any age, the lower the risk of latent diseases, latent viruses and latent conditions coming back with quite catastrophic consequences. Whether it is in terms of whooping cough or measles, there are many and quite recent examples where we have had those two conditions — pertussis and also measles — on the rise. That is another example of why vaccination rates at this high level serve all of us well. People are free to make a choice, but I and others are free to make the case that this is a good thing to do. We are very pleased to say that

more than 90 per cent of kids are getting those three milestone shots and all the public health benefits for them and for the rest of us that come from it.

I will give you another example of where we have seen really strong improvement. It is around meningococcal C. If you look back at 2001, very early on in our term of government, there were 88 cases in that year and 10 deaths that were notified and were directly attributable to meningococcal C. We put in place the statewide immunisation program. Across 2007 and 2008 — I think that is calendar years — there were only two reported cases, and pleasingly there were no adverse outcomes. Certainly there was no mortality recorded as a result of meningococcal C confirmed cases. That is just one example of the power of the these programs.

We are very keen to continue to work with our partners, the commonwealth, around this. This is perhaps the most cost-effective and important public health measure — and modern health-care measure — that any government could put in place. It perhaps picks up on some of the points that Ms Pennicuik was making before about the need to perhaps focus more on the prevention of ill health rather than just the treatment of illness.

Ms PENNICUIK — Minister, my question follows on from the question from Ms Munt on the ambulance service and the partial answer you gave, or a comment you made in your answer about fatigue. A longstanding issue of concern to me is the relationship between working hours, shift work, fatigue, and occupational health and safety. I know that in negotiations for its enterprise agreement the Ambulance Employees Association of Victoria wants to increase the rest break from 8 to 10 hours, bearing in mind that a break of 10 hours still means you have worked 14 hours, which is not recommended, particularly for night shift.

Mr ANDREWS — You are rostered on for 14 hours.

Ms PENNICUIK — You are rostered on for 14 hours, but you only get 10 off; but if you get 8 off, you are rostered on for 16. But given the research and the knowledge about fatigue and its effects on health and safety — and we know particularly that about 20 per cent, if not 25 per cent, of road accidents are attributed to fatigue — the government and Ambulance Victoria should be moving towards that longer rest break. I want to know what is happening there.

The CHAIR — As far as it relates to the estimates, of course.

Ms PENNICUIK — So far as it relates to the estimates.

Mr ANDREWS — It is a very good question. Its principal relationship to the estimates, Chair, is that the budget papers in many different ways chronicle the substantial investment that we have made. It is through extra paramedics, extra vehicles and extra services that you can better balance a growing workload. That is not to say the workload is not growing. I went through some numbers before that show very substantial growth not just in code 1s and 2s but also some of the non-emergency work. Right across the board our paramedics are doing a fantastic job, with record support from us.

In terms of fatigue, there are a range of different approaches and policies and different measures that Ambulance Victoria has put in place. I am happy to take this on further notice, and I can give you a further answer, but I think you would be interested to learn that there are 24 teams with blended rosters. That is all about removing consecutive night shifts. In the main, ambulance paramedics work a 10-14 roster, and if you can break up the two consecutive night shifts, that is to everybody's benefit. Some progress has been made there.

There is the issue of additional operational staff, whether it is those already committed out of the 258, or the 88 out of the 100 in rural areas. That is again about sharing the workload as much as we can, albeit a growing workload. There is also an important measure introduced by Ambulance Victoria — formerly it was a MAS initiative — and that is the call referral service, where those who have rung 000 for an ambulance, thinking that was the appropriate thing to do, but not needing an ambulance, are then referred off to the call referral service. They are referred a bit further than the Nurse on Call service; it is not just advice or information. They can be referred on to a medical locum service so that a doctor can visit them; they can be referred to RDNS; they can be referred to any number of drug and alcohol service providers or mental health service providers. That basically dealt with the best part of 30 000 cases last year. That is case load that otherwise, through an abundance of caution and through the dispatch grid, would have made it to an operational branch. It would have been a call-out, albeit one where, when the paramedic arrived, it would be clear at that point that it was not as coded. That is about removing — I will not call it unnecessary work — but it is about simply appropriately

triaging and categorising calls. That is about lightening or sharing the workload, if you like, and making sure there is an appropriate response.

Education and training programs around forums to engage the staff around fatigue issues have been a feature in recent times. There have been some meal break management initiatives as well, including specific meal break cars; and some staggering around start and end times for rosters, and certainly start times, so you have more meal break windows, greater opportunities for meal breaks, and so on and so forth. I am happy to write to the committee, or perhaps have AV write to the committee around these issues.

We are committed to a fair, reasonable and balanced outcome with our ambulance paramedics. There have been many hours of talks. The industrial relations commission is perhaps the way to go. We are certainly urging the union to be involved in a mediation with the commission. It is unwilling to do that; that is a matter for it. But we have a proud record of supporting our paramedic workforce. This is but one of a number of issues that have been raised, and we will continue to support them.

The CHAIR — Thank you, Minister. That concludes consideration of budget estimates for the portfolio of health. I thank the minister and departmental officers for their attendance today. Where questions have been taken on notice, the committee will follow up with you in writing at a later date, and it requests that written responses to those matters be provided within 30 days.

Mr ANDREWS — Thank you, Chair.

4.2 Housing Transcript

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2009–10

Melbourne — 18 May 2009

Members

Mr R. Dalla-Riva	Mr G. Rich-Phillips
Ms J. Huppert	Mr R. Scott
Ms J. Munt	Mr B. Stensholt
Mr W. Noonan	Dr W. Sykes
Ms S. Pennicuik	Mr K. Wells

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

Staff

Executive Officer: Ms V. Cheong

Witnesses

Mr R. Wynne, Minister for Housing,

Ms F. Thorn, Secretary,

Mr A. Hall, Executive Director, Financial and Corporate Services,

Ms M. Crawford, Executive Director, Housing and Community Building Division, and

Mr K. Downie, Director, Policy, Strategy and Communications Division, Department of Human Services.

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the 2009–10 budget estimates for the portfolio of housing. On behalf of the committee I welcome Richard Wynne, Minister for Housing; Ms Fran Thorn, Secretary of the Department of Human Services; Mr Alan Hall, executive director, financial and corporate services, Ms Margaret Crawford, director of housing and community building; and Mr Ken Downie, director, policy, strategy and communications, all from the Department of Human Services. Departmental officers, members of the public and media are also welcome.

In accordance with the guidelines for public hearings I remind members of the public they cannot participate in committee proceedings. Only officers of the PAEC secretariat are to approach the PAEC members. Departmental officers, as requested by the minister or his chief of staff, can approach the table during the hearing. Members of the media are also requested to observe the guidelines for filming or recording proceedings in the Legislative Council committee room.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. There is no need for evidence to be sworn. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript to be verified and returned within two working days of this hearing.

According to past practice, the transcripts and PowerPoint presentation will be placed on the committee's website. Following a presentation by the minister committee members will ask questions relating to the budget estimates. Generally the procedure followed will be that relating to questions in the Legislative Assembly. I ask that all mobile telephones be turned off. I now call on the minister to give a brief presentation of no more than 5 minutes on the more complex financial performance information relating to the budget estimates for the portfolio of housing.

Overheads shown.

Mr WYNNE — Thank you very much, Chair. I am pleased to be here today with my colleagues to present in relation to the housing budget. We have got two slides that I will briefly go through. The first slide really paints the picture of the budgetary situation that we are in. The National Affordable Housing Agreement was resolved in November 2008 at COAG by the heads of government. That, of course, is the successor to the commonwealth-state housing agreement. As members of the committee would know, we have had the commonwealth-state housing agreement now for more than 50 years, and it has served both the states and the commonwealth extremely well. We have got $1.4 billion in the base funding over five years with indexation. But the budget now reflects COAG's decision in November to create the new NAHA, and we have one base source for commonwealth funding.

I think in that context, Chair, it is a good result in terms of the base proposition for housing going forward. It does mean we can integrate our programs to an even greater degree than what we have in the past, and we do not need to talk about SAAP initiatives separate from housing initiatives, like transitional housing. We can focus on delivering projects, I think, in a more comprehensive way.

As part of that, the social housing NP was also negotiated in November, which delivers $99.2 million, delivering 488 social housing units. Similarly, Chair, in November we had the homeless national partnership — $104.8 million over four years for homelessness, with some very ambitious targets that were established between the commonwealth and the states, basically, as is indicated there, to end rough sleeping by 2020 and reduce homelessness by 50 per cent by 2020. These are quite significant targets. As members of the committee would recall, this is the first time that you have had a national leader signing up to really significant targets in relation to reducing homelessness. I think it is fantastic leadership that has been shown by the Prime Minister himself. His commitment, I think, is a very genuine commitment in relation to reducing homelessness. These are ambitious targets, but we are certainly committed to them as a Victorian government.

The remote indigenous housing national partnership is there. As you know, Chair, this is the first time that we have had Aboriginal housing transferred back to the states as part of the agreement. We have indicated to the commonwealth that we accept the national partnership, but we will not be absorbing in the order of 500 properties back into the state portfolio. We will be supporting local indigenous cooperatives, which in fact now manage those properties, to continue on that path. Other states, in fact, have taken those properties back into their housing stock. We have taken the alternative and, in our view, the right policy setting — that is, to

maintain those properties within the cooperative sector, the Aboriginal housing cooperatives. In fact if those organisations do not wish to continue on with the management of those properties, Aboriginal Housing Victoria is a potential management source for them.

The really huge big-ticket items, of course, Chair, are the Nation Building and jobs plan. This is $1.5 billion that is being provided to Victoria as part of the national share to construct 5000 social housing units. Again, this is a very ambitious target where we are expected to have delivered 75 per cent of those units on the ground by December 2010. The other component, which I know has been very welcomed, is the near enough to $100 million — $99.2 million — for urgent maintenance benefiting in the order of 5600 properties, and I am happy to elaborate on that further during my presentation.

Just briefly, neighbourhood renewal, as members of this committee know, is a huge success story of this government and one that I am pleased to see with a further $17.1 million for neighbourhood renewal going forward. The NRAS scheme I am happy to elaborate further on as well. Funding for the first 3000 properties is assured, and already in the order of 918, I think it is, incentives have been allocated.

Chair, that is the broad brush of what the budget looks like going forward. Of course I am happy to elaborate further in detail.

The CHAIR — Thank you, Minister. Around 55 minutes has been allocated for questions. I would like to begin, as I have begun with other ministers, by asking what federal grants or funding — both output and asset — will your portfolio, department or agencies receive in the budget, and can the department provide the committee with a list and description of these grants, including what accountability mechanisms there are in respect of these grants, both upwards to the federal government and downwards to the people who might supply services?

Mr WYNNE — There are two components to our funding. The first is internally-generated funds through the activities of the housing department itself, but the broader funding to housing is through the national partnerships we have that I have already indicated here today. Essentially, working our way down the page, we have the core funding, the $1.4 billion, which, as I indicated, is the new national affordability housing agreement, the successor to the CSHA, which also incorporates supported accommodation; the homeless national partnership, the $104 million over the four.

The indigenous housing, as I indicated, is a new program which has now been assumed back by the states. That is, in effect, a capital program over the five years to upgrade the level of amenity for the 500-odd — what are called — CHIP houses, managed by Aboriginal organisations. There is the Nation Building program, a huge amount of $1.5 billion for the construction of housing.

That will be very welcomed over the next few years, with near enough to $100 million for renovation of public housing properties; and the NRAS scheme, which members of committee will recall is a joint scheme where the federal government has set a target over five years to put into the marketplace 50 000 units of private rental accommodation. This is probably, I would have thought, the most significant impetus into the private rental market, certainly in our time, because it means that this product will go into the market at 20 per cent below the market value for the areas where people are investing in.

In return the investor will receive a grant of $2000 from the state and $6000 from the commonwealth government for that 10 year period, so an $8000 subsidy to have that property in the marketplace for that 10 year period. Obviously the investor gets the rent from the property, less management fees and so forth, and any capital gain at the end of that 10 year period. So it is $2000 from the state government.

The commonwealth has indicated that if the program is as successful as they think it will be, they will look at doubling it again, so over 10 years you could, in effect, see potentially up to 100 000 units of private rental accommodation going into the market. For Victoria, just on population share, if it rolled over to a second tranche we would be looking at getting 25 000 units into the market.

That will make a really significant difference to freeing up what people I am sure are well aware is an incredibly tight private rental market. While things have eased off a little bit and the private rental vacancy rate at the moment is in the order of 1.4 per cent, it was at 0.9 per cent, so it has eased back a little bit. The truth is if you are on a low income and are living anywhere within 10 kilometres to 15 kilometres of where we are today,

you cannot get accommodation; you cannot get into the private rental market, and that is a really significant problem going forward.

We very much welcome the NRAS scheme. We think it is a good initiative and one that the government is very much partnering with the commonwealth on.

The CHAIR — Thank you, Minister, will you give a list of these and a description, particularly going forward over the life of these, and the accountability mechanisms? We would appreciate that.

Mr WYNNE — Yes, we would be happy to do that — in detail.

Mr WELLS — Minister, I refer you to page 320 of budget paper 3, where it refers to Nation Building — which you have been discussing — Economic Stimulus Plan: New Construction Stage 1 and social Housing National Partnership, both of which state that the significant proportion of these properties will be delivered and managed by the not-for-profit housing association sector.

As housing associations are not required to house the most vulnerable of tenants first and are also, as they openly advertise for tenants on incomes up to $87 400, who have the ability to pay higher rents, this raises concerns about the availability of properties to some of Victoria's most vulnerable tenants, such as those on a disability support pension, those with mental illness and other extremely low-income earners.

How will you ensure that people on disability support pensions, those with mental illness and extremely low income earners have access to properties through the housing associations, and how will the extent of the access be monitored and reported? Does the department have the necessary assistance in place to provide transparent data about housing allocations?

Mr WYNNE — Thanks, Mr Wells, that is an excellent question.

Mr WELLS — Thank you, and there will be a lot more to come.

Mr WYNNE — It is a good question because it goes to the heart of the ongoing development of housing associations. I talked in the past, as you know, about the importance of having an alternative not-for-profit provider. It is part of the government's broader strategy to develop the not-for-profit sector.

We have eight housing associations currently registered, and they are required to report to the registrar of housing associations on their activities going forward. We transferred, as you know, last year a significant number of properties to housing associations which have been, in effect, under community management by housing associations — in the order of 500 properties — at no consideration, to boost their balance sheet, to give them capacity to borrow going forward.

As I have indicated publicly, we do intend to split the allocation of the federal funding basically 50–50 between housing associations and the public housing sector — so that is 50 per cent in housing associations and 50 per cent to public housing, which is my department. In that context we have also indicated that all housing associations must take residents who are public-housing eligible, and they have to take 50 per cent of their tenancies off the public housing waiting list.

Mr WELLS — So that will deal with the issue of the 87 400. That will be only the other 50 per cent.

Ms MUNT — I refer you to budget paper 3, page 84. Under 'Significant challenges facing the department in the medium term' you have listed the facilitation of the provision of short and medium-term accommodation to victims of the bushfires in February. You briefly touched on the response in your introduction, but I was wondering if you could please elaborate on what you are doing to respond to the needs of bushfire victims in relation to housing.

Mr WYNNE — I am sure members of the committee were looking at last night's news. It is hard to believe that it is 100 days since the bushfires ravaged the state. We all know the scope and severity of those fires. In a very appropriate response from both sides of the Parliament the shadow Minister for Housing— I think she might be here — and I visited a number of bushfire-affected communities, along with the federal Minister for Housing, the Honourable Tanya Plibersek, to really see the devastation of those fires. Dr Sykes is here; it has been up in his part of the world. It was really quite overwhelming to see communities completely devastated.

The secretary of my department is here with me, and she would attest to the extraordinary efforts that were undertaken by DHS as a whole. We put in place for the first time the case management process, which was really to work with communities not just through the initial crisis but in fact work with communities on an ongoing basis as they sought to start to repair their lives. Now, 100 days in, we have the temporary villages at Marysville and Flowerdale, and Kinglake will be coming on in the next short while.

From the point of my department, we have had really overwhelming support from the community, particularly in very practical ways in terms of offers of support from people who were prepared to provide rooms and indeed provide their holiday houses. We have a huge number of caravans that are available to us, and we have used those as people have sought alternative accommodation, and of course public housing and the private rental market were important elements of that as well.

After the first few days I think it would be fair to say that we have delivered a really significant level of support to all of the bushfire-affected people from a housing perspective. As people know, over 2000 houses were lost in Victoria. All victims who requested emergency accommodation have received it — all who requested it. Over 1300 families have been assessed for housing need, and we of course have made available all of the public housing stock within the broader regions of all the fire-affected communities. We have made available 560-odd caravans and a number of movable units.

As I think members of the committee would be aware, the government is undertaking a very significant cleaning program, and the reports on the news last night were only slightly inaccurate: they talked about, I think, 1000 blocks having been cleared. I am advised today that it is in fact better than that: it is on the order of 1300 blocks, so they are well advanced on that work. I think the planning processes are being smoothed out. This is an unprecedented situation we find ourselves in, but going forward I can indicate to the committee that my department, the Office of Housing and DHS more generally through its case work efforts continue to work with all of those fire-affected communities, and we will continue in that effort.

Mr RICH-PHILLIPS — I take you to page 120 of budget paper 3, the measure of 'Average waiting time for public rental housing for those clients who have received early housing allocation …'. The target for this year is a waiting period of seven months. In 1999 that same measure was 2.8 months. In 2003 the Auditor-General, in his report on public sector agencies, made some comments about waiting times, and the response from the Office of Housing then was that, 'the Office of Housing has advised that a number of initiatives have been developed to ensure that the early housing waiting times target on a statewide basis of four months continues to be achieved'.

In 2003 strategies were put in place to keep it to four months — it has now gone out to seven months. Why? Why has it increased seven months, do you expect it to continue to increase, and what strategies have been put in place to prevent it increasing further?

Mr WYNNE — This is reflective of what is an incredibly difficult housing market that we are experiencing. Normally you would get a greater churn of people through public housing as other options open up for them, but the practical reality is that the market is incredibly tight. As I indicated earlier, the rental market, while it has eased off a bit, is still at 1.4 per cent and it is unlikely to improve. That is not just reflective of the Melbourne metropolitan area; it is reflective of the broader regional rental market as well.

For many people public housing has played a really significant role as a stepping-off point to other housing options. But when those other housing options are closed off, the whole system basically tightens up. Emerging migrant communities, particularly, use public housing to get themselves established; they are a classic example, and I think I have talked about this in the past.

The high-rises have played an incredibly important role in that respect, where public housing is often the first port of call, particularly for migrant communities coming into Victoria, and they use it as a point to stabilise their families, get employment and then move on to other housing options, whether in the private rental market or indeed in home purchase. That whole system has closed down because the options going forward for people are severely diminished. The total allocations have declined — I think you talked about 1999, Mr Rich-Phillips?

Mr RICH-PHILLIPS — Yes.

Mr WYNNE — From 11 000 in 1999 to 6000. So that tells you, really, that gap, about how the whole system has tightened itself up.

You asked what the options are going forward. I guess there are two elements to that. The first element is obviously the NRAS scheme. We think there is really serious potential here to loosen up the system by the subsidy scheme that is a joint federal-state scheme, the $8000. In that context we were a bit slow out of the blocks in Victoria. People were still trying to come to terms with what this was all about, what this new scheme was, but I think we should have confidence that there will be a significant take-up in this next tranche, which is being offered out now.

Particularly with some of the larger investment vehicles, the superannuation funds and so forth, who in the past have sort of looked at this and said, 'Well, housing, is this really where we want to be?', I think we can have some optimism that the slower start-up in Victoria will catch up in the next tranche of offers.

The other element of it, self-evidently, is the core-based funding that we have got through the NAHA, which is the general business of the provision of housing, but really the massive stimulus is the Rudd government's $1.5 billion. That is going to put 5000 units on the ground and 3750 of them will be on the ground in the next 20 months.

That is a significant improvement, and as I said earlier, if the Rudd government is re-elected in future terms, it has indicated that over the next five years it will look at putting a further 50 000 units through the NRAS scheme as well — again, 25 000 units. That is a big number; that is a very big intervention in the private rental market. If you think about that — remember it is mandated at 20 per cent below market value — it really starts to offer opportunities for people who want to use public housing as a stepping-off point and get into other housing options going forward.

I think we should remain optimistic, because I think the settings are good. I think the policy settings are right and the investments that are being put into public and social housing and the not-for-profit sector will reap benefits going forward and will loosen up the public housing system.

Mr RICH-PHILLIPS — Have you got targets in the forward estimates to reduce that waiting period of seven months?

Mr WYNNE — The targets are, as indicated here for 2009–10 — —

Mr RICH-PHILLIPS — Seven months.

Mr WYNNE — Again seven, yes.

Mr RICH-PHILLIPS — Out to 2012–13 or whatever?

Mr WYNNE — There is a lag with this so it does take time to get the product on the ground. Obviously we do not want it to be seven; we want it to be significantly less than that but we have to measure it year by year.

Mr NOONAN — Minister, I wanted to ask a question about the homelessness national partnership. You provided some information in your presentation about it, and I think you described the targets as ambitious. I do not think there would be anyone on this committee who would think that to have ambitious targets in homelessness areas is not important. Given that $104.8 million is allocated over the next four years of the estimates period, I wonder whether the minister can outline what the funding under this partnership agreement will do for those in greatest need?

Proceedings interrupted.

Mr WYNNE — Thanks, Mr Noonan. You have raised with me the question of essentially what we hope to achieve with the national partnership in relation to homelessness. It is made up a number of elements. Firstly, there was a white paper target to reduce homelessness by 20 per cent by 2013, and our government had signed on to the national partnership target of 7 per cent. The white paper also seeks to deal with, again, I think, a very laudable target to end rough sleeping by 2020.

If you talk to those people in Victoria — and I will go into some further detail about how the funds are being allocated — who are very experienced in the homeless area, they would regard the response by Victoria as the most sophisticated of any state in Australia. Certainly in my time as Minister for Housing in the last 2½ years it has been very clear to me that Victoria does have an extremely sophisticated response to homelessness. Indeed

from the point of view of a comparison with other states we are a long, long way ahead. Can I also say that the rough sleeping problem is not as acute in Victoria as in other states. That is generally accepted as being a statement of fact, particularly when you deal with other states.

The $104.8 million is basically split in a number of ways. We have $36.3 million for boosting prevention and early intervention, and that was one of the key outcomes of the white paper. It is really about saying, 'You have to do a lot at the front end to try to support people at risk of falling into homelessness'. Obviously we have a significant amount there — $52.57 million — to improve and expand services to homeless persons, and $15.8 million for what we are categorising as breaking the cycle of homelessness.

The other two really important initiatives here — and I want to talk in some detail about these — are $15.6 million to be allocated to mental health reform and $1.6 million of new funding to be invested in the court integration services. In relation to the mental health one I want to draw the attention of the committee to the really groundbreaking work that we are doing with the Common Ground proposal down in Elizabeth Street. We talked about that, I think, Chair, last time around.

This is essentially the proposition which says that if you not only provide a person with secure, stable accommodation at an affordable price but you also wrap around them services to support their tenancy on site, whether it be drugs and alcohol, mental health, employment and psychiatric services as well, people can and do get better. The experiences of that have been drawn from our learnings from New York where in fact, as I think I talked to the committee about last year, I visited a number of Common Ground facilities there.

It is not just visiting those facilities; the really important thing that we learn from America is from its longitudinal studies. They have done studies of people over a length of time where they have said, 'If you intervene here and you invest at this point in a person's life and you support that person, the cost to the public purse going forward is infinitely less than if you just let them ricochet through the system' — through the mental health system, through the public hospitals, through the casualty wards, the ambulances, the prisons. The cost to the state is infinitely more.

Their classic case study — I cannot remember his name — was Million-Dollar Murray. Million-Dollar Murray lived on the streets of New York, in Times Square. It was costing the state of New York $1 million a year to keep him on the street, because of all his interventions through the public system. Once people intervened with him, got him secure housing, got him the supports around him, he cost the state of New York something in the order of $17 000 a year. It is a self-evident truth, but the key from the point of view of the American example is that they have done these really detailed longitudinal studies.

When you go to Treasury and you have to argue the case, in America they say, 'We do not have to argue about that any more, because people understand that intervention here is going to get you this result over here and save the state enormous amounts of money'. It is just simply a statement of fact, whereas here we still do not have that work done. In America they will argue about how much of a quantum of money you might get through the budget, but no-one is going to argue about that being the right intervention to take.

The Common Ground I think is going to be a terrific example of where we really integrate those services in effect across the whole of DHS. The Department of Human Services is absolutely fundamental to the success of the Common Ground. We will be doing longitudinal research on this as well, so that we will be in a position, if we are here having this conversation in five years time, to track where people are at and the cost of that intervention versus what it would have cost the state to do nothing. In that respect we will not only do Elizabeth Street but we will be looking for other opportunities to do smaller Common Ground-type proposals in other parts of Victoria as well.

The other quick one I just wanted to indicate was a really excellent example of an intervention with young people. We launched just last week a program with one of our housing associations, Yarra Community Housing, and the AFL. Down in Hoddle Street, just near the corner of Hoddle and Victoria streets, we have just opened a development of 21 units, where there was a partnership between Melbourne Citymission, Yarra Community Housing as the housing provider and the AFL.

The AFL is going to play a hands-on mentoring role with homeless young people to get them out of the cycle of homelessness and to really engage them in the most positive elements of what AFL football has got to offer to people, not in terms of people playing sport as such but role models and leaders. The AFL Players

Association, through Mark Bolton in particular, has been absolutely fantastic in putting this proposal together. We very much look forward to it as another intervention with young people as a model towards preventing homelessness.

I think that is a good space for us to be in. It is a substantial amount of money and they are ambitious targets. But I would reiterate that Victoria has got, without a shadow of a doubt, the most progressive and far-reaching strategies around homelessness of any state. I would also indicate that we want to develop a new homelessness strategy going forward. I announced a couple of weeks ago to the homeless sector that we want to refresh our thinking, make sure that we are on the right track, learn from other experiences both within Australia and overseas as to what works and why it works and to really bring the homeless service providers along with us in that. We will be starting on the development of consultation around a new homeless strategy going forward in the next few months. You will see that emerging as well, Mr Noonan.

Dr SYKES — I refer you to budget paper 3, page 120, and the output measure for the number of properties to be acquired during the year, which shows a figure of 3430.

I also draw your attention to the total number of dwellings, which is expected to increase by only 2415, from 74 532 to 76 947. The discrepancy between these two figures is over 1000 properties. It appears that the government intends to dispose of 1000 properties during the year. My question is: does the government have a strategy for acquisitions and disposals, can the minister outline the strategy, and can the committee have a copy of the acquisition and disposal strategy document or any documents that outline strategies in this area?

The CHAIR — The figures show there will be a discrepancy of about 200, not 1000. The minister, to answer.

Mr WYNNE — In relation to the 76 947, Dr Sykes, that excludes crisis and transitional housing as well, so they are not counted in there. In 2008–09 we disposed of about 750 rental housing units. We will dispose of in the order of 900 properties in the 2009–10 year. They are basically properties that are past their economic life or properties that simply cannot be rented because nobody will take up those rentals.

As you know, Dr Sykes, a third of our stock is in regional Victoria. You know very well, as you drive into any of those big country towns — in the lead-up to your good city of Benalla, as you and I know very well — a lot of the public housing is on the fringe of the city. Some of that is quite difficult to rent, not necessarily in Benalla but more broadly in some of the regional cities, and a lot of it is quite downgraded. The beauty of what we got through the maintenance money, the $100 million, is that we have had the opportunity to inject quite a deal of money into upgrading properties to breathe some life into them going forward.

In that respect the near enough to $100 million — the $99.2 million — for urgent maintenance will breathe life into a lot of properties which we might have looked at in the future and said that some of them will have to be disposed of as well. With the investment of $20 000 or $30 000 to upgrade the kitchen and do some carpeting and painting, you can potentially get out of some of those properties in the order of another 10 to 15 years, and I think that is a good thing. But where we clearly have properties that are past their economic life or we simply cannot rent them, obviously we will dispose of them.

Dr SYKES — Can I just get clarification on the strategy, Chair? I understand that reason for disposing of properties, Minister, but there also seems to be a strategy of disposing of strategies in smaller communities, and in my area I refer to places like Longwood, Murchison and Bright. I understand it is on the premise of the inability for tenants in those locations, particularly if they are complex needs tenants, to access the necessary support services, which you have highlighted as being so important in public and social housing.

Mr WYNNE — Absolutely.

Dr SYKES — In selling those I think there is an intention to focus on housing in the larger communities, presumably on the premise that the support services are there.

Mr WYNNE — Yes.

Dr SYKES — That might be contended because there seems to be pressure on the services. So I come back to my question: is there a strategy, particularly factoring in the issue of availability of support services, and is it possible for the committee to have access to documents that relate to that acquisition and disposal strategy?

Mr WYNNE — Clearly the disposal strategy is a matter of sensitivity in terms of the market situation, so I would be reluctant to provide that, but more broadly I am happy to provide the committee with the broader overarching strategy — —

The CHAIR — The rationale, that sort of thing.

Mr WYNNE — Yes, the broader overarching rationale and that sort of thing, but there are market sensitivities around the disposal of properties, obviously.

Dr SYKES — In what you provide I would be particularly interested in this issue of ability to deliver services to these social housing tenants. Often they have complex needs. They are leaving their extended families, they are leaving their social network, they are leaving their support services and they are coming to communities where they do not necessarily have any affinity and they put a heavy demand on support services that are arguably quite severely overloaded. So everyone is a loser as distinct from everyone being a winner.

Mr WYNNE — Indeed you and I have had separately in — —

Dr SYKES — Some discussions on that.

Mr WYNNE — A number of discussions about that. Not surprisingly, the broader policy setting of the government is to ensure that these units are very well located. In that context we do have a number of developments in regional Victoria which are very poorly located and inaccessible to the larger towns where the services are, so we are looking at those fairly critically as well. The broader proposition you put is right and it is one that we will be happy to provide you with the rationale — —

Dr SYKES — I just make the point that just because it is a larger town does not necessarily mean it has the service capability to deliver the services required by clients that often have complex needs.

Mr WYNNE — I understand, indeed, but we are doing developments in Bacchus Marsh and Ballarat; we are doing them all over regional Victoria, as you know. I understand that, but really the key here is that disposals are about where a property's economic life is finished and we cannot get a tenancy taken up. But your broader point I am happy to take — —

Dr SYKES — So you will provide us with some broader information for a start?

Mr WYNNE — We will, absolutely.

The CHAIR — We appreciate that, Minister.

Ms HUPPERT — Minister, I refer you to page 120 of budget paper 3 and to the outcome under 'Quality':

Percentage of neighbourhood renewal projects that have achieved active resident participation in governance structures

which sounds like a very interesting measure. Could you please outline what progress has been made in addressing the needs of disadvantaged communities through the neighbourhood renewal program and what is intended through the budget period?

Mr WYNNE — I have talked about this before. Neighbourhood renewal is a fantastic program that goes from Latrobe and Wendouree and East Reservoir, Delacombe and Doveton. We have 19 existing sites right across metropolitan and regional Victoria. It is truly one of the success stories of the government, because it is an investment in both the social and physical fabric of communities. If you think about that, for communities that often happen have been left behind, this really has lifted those communities up. The interlinking of both physical and social outcomes through the program is, I think, quite a phenomenal success story. Let me give you a couple of examples.

This has been the evaluation of neighbourhood renewal. I will give you a brief snapshot. We have had a 4 per cent reduction in unemployment in our neighbourhood renewal areas, a 12 per cent increase in further education and an increase in community participation. Although there have been some conversations in some neighbourhood renewal areas about the reduction in crime, I think overall the reduction in crime has been quite significant.

The CHAIR — It is 27 per cent in my area.

Mr WYNNE — There you are, Chair. There are some people who debate that, but I can say — —

Ms MUNT — It is greater in my area. Do you want me cite mine?

The CHAIR — Minister, our apologies for the distraction.

Mr WYNNE — It is the sort of program, I must say, Chair, that does elicit very positive responses.

The other element of it is the link of neighbourhood renewal to social enterprises. A large number of social enterprises have developed, which are often linked to community hubs and Men's Sheds. They are really energising communities and giving people for the first time a sense in which there is really a future for them going forward. Whether it is heading back into training leading to employment, there is a sense in which people through a social inclusion agenda feel that they are now back and part of the community and valued by the community. It is really one of the most powerful outcomes of neighbourhood renewal.

Obviously the upgrade of the stock is really important. The opportunity particularly for young people to get employment is fantastic. Things like fencing programs, gardening programs and maintenance are important things, often for young people who have never been employed in some of these areas, and that is a fantastic thing.

When you talk to them you get this incredible sense of pride. They will take you around and say, 'I built that park' and, 'I built those new fences there'. There is a real sense in which they are back again and engaged in their community. I think it is a wonderful example of where relatively modest levels of government investment have created huge outcomes, both in the physical and social fabric of the communities.

I also indicate that we have two new neighbourhood renewal sites that were announced in the budget. We indicated we would have two new sites, and I am pleased to advise the committee that two areas that by any measure have been on any of the social indicators require this level of support will be funded — one in Maryborough and the other one in Flemington, the high-rise area in Flemington. Flemington in particular has a significant conurbation of public housing; it is one of our biggest public housing estates. It has had some significant issues over the years, so I am pleased to provide that information to the committee.

The CHAIR — Thank you very much for taking the opportunity to make announcements during our hearing, Minister.

Mr WYNNE — It's a pleasure.

The CHAIR — I am sure you will provide us with the appropriate press release.

Ms PENNICUIK — Minister, the boost to social housing in the budget is a welcome step. Can you clarify the time frame for delivering the 5000 new houses? Also, given that there is a shortage in public housing properties at both ends of the spectrum — that is, in one-bedroom properties for single occupants, or larger properties for larger families, in particular new refugees with large families — can you let me know what the proposed breakdown of those 5000 is? What percentage would be one-bedroom and what percentage would be larger four or five-bedroom ones?

Mr WYNNE — The acquisition target is 75 per cent of the 5000 by 2010, with the other 25 per cent by the end of 2012, so there is a tailing off of that.

Ms CRAWFORD — June 2012.

Mr WYNNE — June 2012. Thank you, Director of Housing. The stock will largely be acquired on the basis of the waiting list. The waiting list is essentially one and two-person households. That does not mean, though, that we will not be acquiring or building some larger stock as well. It will be skewed essentially so it is reflective of the waiting list.

In relation to the larger families and indeed the larger refugee families that you talk about, I am pleased to say that over the last couple of years, particularly in the western region, we have built a number of five-bedroom properties, obviously with larger lounge rooms and so forth for people to recreate in. Also what we have done,

which I am particularly pleased about, is use the high-rise flats in a much more creative way. We have a number of large families living in the high rises. We have knocked out the adjoining wall between two units to make six-bedroom units, which is absolutely sensational. We have piloted that down at Alfred Street in North Melbourne in a block there. There are some technical issues from a engineering point of view as to how many walls you can punch out.

Dr SYKES — A house of cards — a bit like the budget!

The CHAIR — Without assistance, please!

Mr WYNNE — I cannot remember how many we have now, but I think it is four or five of these five and six-bedroom units. For some of the emerging refugee communities, this has been just a fantastic outcome. Indeed, as the secretary points out, the other option we do have available is movable units as well, so that if you are in public housing and you have an extended family, you can get a movable unit to put at the back. We will have some very innovative movable units in response to the fires, which we are testing at the moment.

One is under construction up in Dr Sykes's area, and we are very much looking forward, subject to assessment of that particular product, being in a position to purchase a further number of those movable units, which will be an excellent outcome in terms of the larger families. But the high-rise stuff is fantastic — really good.

Mr SCOTT — Minister, I refer you to table A.5 on output initiatives at page 315, budget paper 3. Could you please provide the committee with a update on the National Partnership Agreement on Remote Indigenous Housing as it affects Victoria?

Mr WYNNE — Yes. As I indicated earlier, we got about $30 million over 10 years. Victoria does not qualify for remote indigenous housing support, because according to the commonwealth we do not have defined remote indigenous housing. However, we have in the order of 500 commonwealth-administered houses — this is known as CHIP (community housing and infrastructure program) houses, which were previously fully funded by the federal government, and 20 organisations have these houses.

As I indicated earlier, they are all run through cooperatives like Framlingham, Warrnambool, Brambuk, and Rumbalara in Shepparton — the bigger organisations. Some that are quite small have got perhaps only half a dozen houses, and go through to some of the larger ones that might have 30 or 40 houses in their stock.

What we are seeking to do over the next two years — and as I indicated earlier, we do not want to have this stock back in the state system; we want Aboriginal communities to manage their own stock and to grow the stock over a period of time — is to get those cooperatives registered as housing providers, which then gives them accessibility to funds, and also obviously the renovation money will be available for them going forward. We are progressively working in that conversation with the cooperatives to get them registered over the next two years.

That is a good space for them. We are very pleased to have the stock back within a Victorian context, because they really have been removed from the broader housing conversation here in Victoria, because they were directly federally funded.

Mr DALLA-RIVA — Minister, I refer you to budget paper 3, page 120, in relation to long-term housing assistance. I understand that each year the Office of Housing produces a report called 'A summary of housing assistance', which outlines all the services delivered under the performance indicators that are there?

Mr WYNNE — Yes.

Mr DALLA-RIVA — I understand the summary gets released on a yearly basis?

Mr WYNNE — Yes.

Mr DALLA-RIVA — An issue was raised under FOI, and the request was initially refused on 4 May; and then you issued a press release on 12 May, saying it had been publicly released on that day. There are a couple of issues. One is how you actually release this in the forward estimates. I am trying to get clarification in terms of your press release on the day. The third dot point at the end of the press release says:

> The supply of affordable housing stock is also at an all-time high, with more than 78 000 social housing properties across Victoria — up from 77 456 last year.

I am trying to reconcile it with the forward estimates. What the budget paper says does not seem to match with what you have indicated in your press release of 12 May. I am trying to work out whether there is another measure in terms of what is provided in your 'summary of housing assistance' as opposed what is provided in the forward estimates? I am happy to provide you a copy of your press release to you.

Mr WYNNE — I obviously do not have the release with me at the moment, but I am happy to provide Mr Dalla-Riva with the following response. The 'summary of housing assistance', which, I indicated, shows that social housing in Victoria is at an all-time high. We had in the order of just over 78 000 dwellings as at June 2008.

As Mr Dalla-Riva indicated in his question, we did have some delays in producing the report because of the need to address a number of changes. The first was to ensure that we reported accurately the effect of asset conversion; and, secondly, to ensure that the reporting reflected the changes to community housing — that is, the end of old programs and a new standardised approach.

We generally publish the summary in March the following year for the financial year, but sometimes it is as late as May. We want to try to be timely and to accurately reflect the situation. That certainly was our goal: to ensure that it was both a timely and an accurate response.

Mr DALLA-RIVA — The final thing is the link. I understand it is meant to link to the document. It is not connecting at the moment, so maybe you can see what the reason is.

The CHAIR — There may be some reasons such as social housing including housing provided by housing cooperatives, but the minister should be able to clarify that.

Mr DALLA-RIVA — Yes, if you can clarify it, and check the link as well.

Mr WYNNE — Yes, I am happy to provide that.

The CHAIR — Thank you, Minister. I also thank Ms Thorn, Mr Hall, Ms Crawford and Mr Downie for their attendance.

4.3 Community Services Transcript

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2009–10

Melbourne — 19 May 2009

Members

Mr R. Dalla-Riva	Mr G. Rich-Phillips
Ms J. Huppert	Mr R. Scott
Ms J. Munt	Mr B. Stensholt
Mr W. Noonan	Dr W. Sykes
Ms S. Pennicuik	Mr K. Wells

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

Staff

Executive Officer: Ms V. Cheong

Witnesses

Ms L. Neville, Minister for Community Services,

Ms F. Thorn, Secretary,

Mr A. Hall, Executive Director, Financial and Corporate Services,

Mr P. McDonald, Executive Director, Children, Youth and Families,

Mr A. Rogers, Executive Director, Disability Services, Department of Human Services; and

Mr J. MacIsaac, Executive Director, People and Communities, Department of Planning and Community Development.

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the 2009–10 budget estimates for the portfolio of community services. On behalf of the committee I welcome Ms Lisa Neville, Minister for Community Services. I also welcome Ms Fran Thorn, secretary; Mr Alan Hall, executive director, financial and corporate services; Mr Paul McDonald, executive director, children, youth and families; and Mr Arthur Rogers, executive director, disability services, Department of Human Services; and Mr James MacIsaac, executive director, people and communities, Department of Planning and Community Development. Departmental officers, members of the public and the media are also welcome.

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

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. There is no need for evidence to be sworn. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript to be verified and returned within two working days of this hearing. In accordance with past practice, the transcripts and PowerPoint presentations will then be placed on the committee's website.

Following a presentation by the minister, committee members will ask questions relating to the budget estimates. Generally the procedure followed will be that relating to questions in the Legislative Assembly.

I ask that all mobile telephones be turned off. I might add that mobile telephones should not be used — I think there was an occasion yesterday, from what I am advised — to actually take photos. I remind people in the gallery that they should not be using mobile phones to take photos.

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

Overheads shown.

Ms NEVILLE — Thank you, Chair. I want to take the committee through some of the key areas within the community services budget, looking at some of the achievements and some of the reform areas to date and going forward as well. I will focus on some particular areas. It is quite a broad-ranging portfolio, so I will not be able to go through all the areas of the portfolio in detail.

The first area is children, youth and families and out-of-home care. Over the last few years the government has been systematically reforming our child protection system, with a strong focus on prevention and early intervention, which has substantially contributed to the stabilisation of child abuse substantiations in Victoria. This has been backed by massive new investment of $136 million, with substantiations falling by 7.2 per cent in Victoria, compared with a 143 per cent rise across Australia. The reforms, combined with strategic new investment, have resulted in lower growth and substantiated cases of child abuse again in 2007–08.

The rollout of our early intervention family services model, which is known as ChildFIRST, is contributing to the reduction in child abuse substantiations. I am pleased to advise that in February of this year we were able to complete the full rollout of the ChildFIRST sites, which now sees ChildFIRST being offered right across the state one year ahead of schedule. Demand levels and referrals for ChildFIRST are running at predicted levels of about 6000 referrals a year.

Over the last 12 months the government has focused significant attention on our out-of-home care system. The reforms that we have undertaken at the front end — that is, the reforms I have just spoken about — have contributed to reductions in substantiated abuse, but also reductions in the number of first-time entrants into the out-of-home care system. In fact, we are running at an eight-year low.

We have around 5800 children in care, compared with New South Wales which has 13 000. However, there are changes that are impacting on demand in this area. Children are now staying much longer in care, and that is for a number of reasons. There is better targeting, so that we are getting to the right families and the right

children, but also greater complexity of family needs that impacts on issues confronting children in care. This requires new ways of responding, continuing to focus on strategies to support families and kids to keep them out of care where we can, and better being able to respond to the complex needs of kids in care and improve their life outcomes. This is an issue that the government will tackle with the same innovative evidence-based reform that we did in relation to notifications and reports. The 2009 budget outcome is another step in our new approach to this important issue.

The budget invests $160 million over four years. This includes around $125 million to look at the issue of demand and quality in our out-of-home care system. This includes money to strengthen families, through family mentors providing intensive in-house support to families, particularly targeted at the 0–2 and the 13–16-year-old age group. There is $89 million to reshape the care system, including funding to respond to predicted caregiver growth; funding for greater placement diversity, for example, things like recruiting up to 100 practitioners to provide intensive care in the home; and money to improve quality through things like therapeutic treatment services.

The budget also provides money to upgrade residential care facilities to provide more home-like environments; $14 million over four years to expand the capacity of after-hours child protection services, expand coverage of our Streetwork Outreach Service and make improvements in the central after-hours assessment and bail placement service. The budget also provides $10.45 million to expand our sexual assault services, ensuring that we can provide additional counselling for around 1330 children a year.

If I can move on to concessions, this year we have again increased our water and sewerage concession cap to ensure low-income families are able to manage the anticipated water price increases. This is $42 million over four years to increase the cap from $189.70 to $216.60. This year we are also substantially increasing funding for our WaterWise program to assist low-income Victorians to reduce their water consumption with water conservation audits and appliances.

Moving on to disability, this government has continued to invest in and improve disability services in line with the goals of the 10-year state disability plan. Last year, we made the biggest ever single investment by a Victorian government in disability services, with a increase of $233 million over four years.

As a result of this and previous commitments, we are making major progress on a number of fronts. We have seen a significant improvement in the system's capacity to address client need, as shown in the graph up on the slide, which shows the lowest levels of registered need for supported accommodation and community support since 2006.

The disability support register fell by 15 per cent in the period from June to December 2008 and has fallen by over 24 per cent since June 2006. We are providing greater choice and more self-directed supports for clients, and funding for this area has increased by 207 per cent since 1999–2000. And we have seen the closure of Kew Residential Services, seeing 475 clients move to more appropriate community accommodation in the community.

We are also continuing to invest in a viable disability services sector through price increases like those, most recently, in attendant care services, specific assistance to help NGOs to make the transition to more self-directed funding approaches as well as practical assistance around training and service quality.

As a result of these achievements the latest report on government services by the Productivity Commission report shows that Victoria has higher or comparable levels of access to key services such as supported accommodation, in-home support to live in the community and respite services.

This slide shows the priorities over the next 12 months, which I will just skip over, and I will then show how the budget is going to meet some of those priorities.

This budget builds on the commitment we made last year and in previous years to improve disability services. It provides an additional $86.9 million over four years, which is a 9.6 per cent increase in funding for disability services from the 2008–09 period, and includes $9 million in the children and early childhood portfolio for early childhood intervention services. This investment represents an increase in the disability services budget of 125 per cent since 1999–00, including the 207 per cent increase in the individual support budget and the 83 per cent increase in the budget for supported accommodation.

This budget builds new service capacity with an additional almost $30 million over four years to continue to expand access for people with a disability to individual and flexible support in the community. The Transition to Employment program is provided with new funding of $16.7 million over four years to support and enhance a service to assist more young people with a disability who are leaving school to find employment or access further education.

The budget also supports further industry reform, with $12.5 million to assist community service organisations to improve their capacity to undertake strategic and business planning and move to more self-directed approaches. There is also $4 million which was provided in 2008–09 to respond to cost pressures.

The budget also delivers on other major programs, with $10 million in 2008–09 for stage 1 of the My Future My Choice program, and this budget provides an additional $13.8 million to develop 13 purpose-built facilities for 58 young people living in or at risk of entering residential aged care.

The budget also provides an additional $5 million over three years to establish community-based, co-located facilities where disability supports are integrated with other community services.

Further investment in services will also flow from additional funding of $21.6 million under the National Disability Agreement. This will assist in providing additional individual support and respite services, although it is true to say that Victoria still carries the lion's share of disability funding, providing over 80 per cent of our total resources. The combination of last year's money, this year's money and also the National Disability Agreement money will see an additional $77 million in 2009–10 alone.

This year we have also invested to support the implementation of the autism state plan. The state plan was a result of extensive consultation with families of children with autism and a partnership approach with Autism Victoria. The autism state plan will be released very shortly. The budget commences funding for a number of critical areas that families had identified with us as requiring urgent attention. There will be additional money for our mental health services to provide better diagnosis and support among children and adolescents with autism.

There is also money in education to improve the support for preschool children and young people of school age who have autism and to provide staff development opportunities. This, of course, builds on our change in government policy last year which acknowledged that autism spectrum disorder is a neurological impairment under the Disability Act, and $2.75 million was provided at the time to help families and carers to access information, peer support groups and parent and carer support groups and to help them plan and provide case management for their children with autism.

Briefly on bushfire recovery, the government has almost $1 billion committed over the next couple of years in relation to bushfire recovery. In relation to the Department of Human Services it is around $75 million, which is going to critical services like the case management service, community development officers and the ongoing role of community support hubs, which are replacing recovery centres. We are also playing a role in the distribution of the bushfire appeal funds, and just over $60 million has been paid out of that fund to date.

Mr WELLS — But that surely is not in total. That amount would have been updated, surely. If the total amount paid is $60 million — there would be more than that paid out of the bushfire fund, surely?

Ms NEVILLE — About $3 million is paid every day; about 150 grants are paid out each day. The big grants out of the bushfire appeal fund are, firstly, the $50 000 grant, which is for contents and also for rebuilding; and then there is the needs grant. When people apply they get the immediate $15 000 for the contents. They are then required, as required by the bushfire appeal fund, to provide conformation that they have received financial advice before the remaining $35 000, or the needs-based money, is paid out.

The CHAIR — We will take up the issues in questioning. The minister, to finalise her presentation.

Mr RICH-PHILLIPS — Are you suggesting there is still around $290 million — —

The CHAIR — Can we finalise the presentation first and get the details later?

Ms NEVILLE — I will go through it in detail, if you like, during questions.

The CHAIR — That would be great.

Ms NEVILLE — I will not talk about this, Chair — I am just conscious of the time — but in my portfolio there is also youth justice and family violence.

The CHAIR — Both of which are actually quite important issues. Minister, I would like to begin by asking you, as I have asked other ministers, what federal funding in grants, both output and assets, will your portfolio department and various agencies receive in the budget? Can the department provide the committee with a list and description of these grants going forward? What accountability mechanisms, both upwards and downwards, are there in respect of these grants?

Ms NEVILLE — As you know, last year COAG agreed to a number of funding agreements — both national partnership agreements and SPP agreements — across a number of areas in health, schools, disability and affordable housing. I will not go into full detail — I will provide the list — but I will touch on each of the agreements under my portfolio areas.

There are four principal agreements with the commonwealth. In mental health there is the federal funding that is received as part of the national health care agreement, which comes into effect on 1 July. We also receive funding under the national perinatal depression initiative, which is a jointly funded program between the state and the commonwealth. We also receive funding under the COAG national action plan on mental health. The mental health output group also receives funding from the Department of Veterans' Affairs for services provided to DVA clients, and that is on a contractual basis between DHS and DVA.

The drug outputs group receives federal funding under the public health outcome funding agreement and illicit drug diversion initiative. This is particularly targeted at those in the justice system or those being released from the justice system with drug and alcohol problems. Under disability services we receive funding through the new national disability agreement and the associated disability specific purpose payment which came into effect on 1 January this year.

In 2009–10 commonwealth funding to Victoria through the disability SPP will be $208.2 million, which incorporates the previous funding provided under the CSTDA of over $148 million. There are also other bilateral agreements with the commonwealth in the area of disability, disability assistance package respite, targeted support and the young people in nursing homes program. That will see an increase of about $15.5 million for the disability assistance package in this year. Around 16 per cent of the total disability budget is through some sort of commonwealth agreement. There is also an agreement in aged care under the national partnership of aged care assessment services. There are federal grants, and this year it will be about $18.6 million. Under the national partnership for home and community care, federal grants in 2009–10 will be around $282 million, an increase of 6.8 per cent from last year.

The accountability agreements apply across government, as well as some specific reporting measures that exist within each of those agreements. The broader accountability and performance measures are set out in this intergovernmental agreement on federal financial relations. There is also accountability for expenditure of national SPP which will apply to disability services under schedule D of the IGA. That requires us to spend the money within disability services, but does not require us to spend on particular things, although we do need to report against particular outcome measures. Also, each state and territory treasurer provides a report to the Ministerial Council for Federal Financial Relations within six months of every financial year.

The CHAIR — We are also interested in accountability downwards for the federal money as it is distributed to organisations et cetera, so I put that one on notice. Just to follow up on that one, I know there has been a change to the federal grants and a lot of them have been rolled up into a smaller number now. You mentioned quite a few there; have some of these been rolled up in the new process under COAG into a smaller number of programs?

Ms NEVILLE — All of these remain as separate agreements.

The CHAIR — So there is no movement on that to change that in the future through the ministerial council?

Ms NEVILLE — There is some discussion around some at the aged care end, but that is still to be resolved by COAG.

The CHAIR — Thank you, Minister.

Mr WELLS — Minister, I refer you to budget paper 3, page 109, in regard to the pricing review. The government commissioned PricewaterhouseCoopers to review cost drivers and prices for out-of-home disability services, and it reportedly stated that the sector is currently underfunded by more than $50 million. As minister, can you guarantee that disability organisations in this state will not fail financially as a result of withholding and failing to implement your own report into funding of the non-government disability services?

How do you justify presiding over the decline in the disability sector, closure of programs and closure of possible organisations? I am wondering if you could provide the report to the committee and confirm that the report did say there was an underfunding of $50 million.

The CHAIR — The minister, to answer insofar as the question relates to the forward estimates.

Ms NEVILLE — The government acknowledges how important it is to have a sustainable disability services sector. We are moving to a more individual approach, but within that we need a disability services sector to continue to provide the high quality services that it does to so many people in our community and their families. That is why we have put in place a number of key measures to assist in maintaining their sustainability.

Firstly, we have undertaken two major price reviews. In 2008–09 agencies providing in-home disability services were provided with $9 million in funding for a price increase for attendant care services. This funding was provided as a result of the independent consultant's report, which demonstrated that the cost of delivering in-home care was above what we had previously been paying. In 2008–09, as the member of the committee has mentioned, the department engaged PricewaterhouseCoopers to undertake a review of the out-of-home service prices. The report is being considered by the department in conjunction with other information on price issues which has recently been provided by a group of community service organisations. We are continuing to discuss these issues with the sector. However, in this budget there is an additional $4 million to be delivered in 2008–09 specifically to assist agencies in addressing cost pressures, upgrading infrastructure and developing — —

Mr WELLS — Do you mean 2009–10?

Ms NEVILLE — It is yet to be delivered. They will be provided with the money in the 2008–09 period. Secondly, we are putting in place a range of industry assistance with the provision of additional $3 million in this budget, or $12.48 million over four years, to assist day services to transition to more flexible individualised funding models.

They are concerned about the cost of that, and this additional funding will assist them, particularly around some of the information technology development. The funding builds on the money that we provided last year — another $3 million to assist them in moving to those self-directed approaches — and we provided money to assist the sector to upgrade amenities and accommodation standards.

We are also working with the sector on a number of things around industry plans, industry development and training initiatives, and we are also developing a workforce strategy with the sector given that the workforce is a critical component of delivering our disability services. Finally, we are providing annual price indexation to service providers through the department service agreement system. The department will index agency prices at 3.14 per cent over the three years to 2011–12 to assist agencies to meet the cost pressures and continue to deliver quality services. On top of that, $2 million each year will be provided to community service organisations to enhance their service capacity. This indexation has been welcomed across the community sector organisations.

Mr WELLS — So, can you confirm that the report — —

The CHAIR (to Mr Wells) — Can you ask your question through the Chair, please?

Mr WELLS — Through the Chair.

The CHAIR — Mr Wells?

Mr WELLS — Minister, the two parts of the question are: will you release the report to the committee, and can you confirm that the underfunding was $50 million through the PricewaterhouseCoopers report?

Ms NEVILLE — As I indicated in the answer firstly, there is another report and other information that has been provided by disability organisations to the department. It has other information that goes to the question of price, and we are working with the sector both about that information as well as the information from PricewaterhouseCoopers. My discussions with the sector have been focused on the fact that it is their right for us to be talking together about both those reports before we do anything further with that PricewaterhouseCoopers report.

It is information that the community service disability organisations provided. It is their information and they are entitled to work with us on that information first. Secondly, can I just say that there is a range of information in that document and there is no consistent information that would suggest that there is a price that could easily be set for a range of services, and we need to continue to work that through. Some of the cost pressure issues — —

Mr WELLS — You will not deny there is underfunding of $50 million?

The CHAIR — Thank you, Mr Wells. The minister to answer? Are you finished, Minister?

Ms NEVILLE — Yes.

Mr WELLS — But what about denying the $50 million underfunding?

The CHAIR — I think the minister has given an answer to that twice now.

Ms MUNT — Minister, in your opening presentation, you touched on bushfire recovery. On page 284 of budget paper 3, under the heading '2009 Victorian Bushfire Response and Recovery', there is a range of programs and initiatives detailed under the Department of Human Services. Could you just expand on how the government's response has actually been implemented in bushfire-affected areas?

Ms NEVILLE — I think the events of 7 February will remain with us for a very long time. I think the loss of lives, families and communities has touched all Victorians and all Australians and many across the world. I think it is something that we have never before seen or lived through, and unfortunately I think we are reminded regularly of the tragic statistics and all the people who sit behind those tragic statistics.

After the fires the efforts of DHS were focused on how we could support individuals and communities to recover, and help them to rebuild their lives. That has involved immediate direct relief in the short term but also planning and resourcing for the longer term assistance. I have had the opportunity to visit many of the bushfire-affected areas, both immediately after but also since that time. It is hard not to be affected by all that we have seen and all that the survivors have gone through, but I think set against this tragedy has been enormous community spirit. I think that gives us confidence that we can assist people to rebuild their lives.

As I said, the budget provides almost $1 billion over five years for various services in infrastructure as part of the government's response to bushfires. Of this, $106 million has been allocated to the Department of Human Services to focus on emergency relief and services that provide the longer term support that families will need. Money has been allocated for grants to individuals and for housing support, health and wellbeing programs, and coordination of regional response and recovery activities.

Once the immediate threat had passed, we took on the lead role in the recovery process. From the initial emergency response through to developing and implementing new and longer term recovery plans, the Department of Human Services has been working across a broad range of areas, whether it has been providing emergency shelter and accommodation, material aid, financial assistance, public health information, as well as coordinating medical services and psychological assistance — they were the initial priorities of the department in the immediate aftermath of 7 February. This work has been long and demanding, and at its height we had over 600 departmental staff who worked on immediate relief responses, mainly indirect relief and recovery efforts. Approximately 200 staff remain actively involved.

Given the scale of the event, we established for the first time in Victoria a case management service. It is a joint initiative with the commonwealth government. It became operational within a week of the fires and is

providing one-on-one support for families. It has been a massive task. We have 72 agencies which are involved. We have nearly 400 case managers assisting just over 4000 families and individuals, and the budget has allocated $70 million over the next two years to continue to offer that support.

The needs of registered families vary from simple requests to very long-term and complex issues, and case managers are responding to those. In further recognition of the long-term recovery efforts that we need to be involved in, we have moved from recovery centres into what are now called community hubs in the 10 most affected communities. The hubs will continue to provide services that the communities need. They will vary according to the individual community needs, but will for example have Centrelink, other financial advice, DHS, the Victorian Bushfire Reconstruction and Recovery Authority, and advice on rebuilding and building permit processes.

We have employed dedicated community service hub captains who will be playing advocate in local communities to ensure that we can resolve issues and problems, not only for individuals but for communities as a whole. Of course, as we would always do after a disaster of this sort, we have employed community development officers across communities. We have also been involved in the direct financial support through the emergency grants. You can see the amount we have paid out in emergency grants — $12.9 million. We were also involved in the psychosocial response, immediately with funding for counsellors and specialist mental health teams were involved. Back in March we released *Renew — A Psychosocial Response to Bushfires*, which is providing additional support to communities and individuals who are struggling with trauma in the aftermath of the events of 7 February.

It is very important that we continue these efforts. This will be a long-term effort for the Department of Human Services, but also for the government as a whole. As people physically rebuild, our role is to assist them in that process by helping them to emotionally rebuild their lives.

Dr SYKES — Minister, I would like to follow up on the bushfire recovery program. The $353 million — we are talking the Red Cross-managed appeal?

Ms NEVILLE — Yes.

Dr SYKES — How much of that money has actually been announced as having been allocated — $250 million, or something like that?

Ms NEVILLE — Yes, over $200 million has been committed, and pretty much each week the appeal fund is announcing new grants. The Winter Needs Grant was announced last week.

Dr SYKES — You have got $353 million in total donations received, over $200 million announced as committed and $60 million delivered. I think you would be aware that, certainly to me as a local member, there are lots of expressions of frustration and angst about the gap between announcement and delivery. One of the causes of frustration is that people have to provide their personal details repeatedly for different assistance. I am wondering whether you have got some strategy in place to address this lag phase, in particular a simple concept like one central database through which data can be accessed for all grant applications.

Secondly, as you are aware, there has been a major concern about certain groups falling through the cracks in terms of available assistance measures. In particular in relation to the Red Cross-type public appeal money there has been a problem with making that money available to people whose property is owned in a business entity, particularly farmers. If you had one central database, would you be proactive and use your data to identify clients' needs to develop modified assistance measures? Keeping in mind this is public donation, at an arm's length from government. Would you then be contacting clients who had a need and saying, 'We have now addressed your need, and we encourage you to apply for such and such a grant'? In other words, there is a lag phase, there is angst and frustration. What are you doing about fast tracking that and helping those people who, as you know, are still very, very stressed?

The CHAIR — A rather long question over there!

Dr SYKES — It is a matter of providing the background.

Ms NEVILLE — I think I have got it down.

The CHAIR — You've got that?

Ms NEVILLE — I think I have got it. I just want to be clear that the Department of Human Services does not set the criteria for the grants. We administer the grants according to the criteria and the eligibility established by the Appeal Fund. That is where our role comes in. To explain the process for the large grants, as I have said before, people might be entitled to the rebuilding grant, which is $50 000, and some might be entitled to the additional needs-based grant — for disability or whatever it might be.

If we take the $50 000 grant, which is broken into two figures; one is for contents and one is for rebuilding. When people apply, one of the criteria set by the fund is that people are required to get financial advice. It is a large amount of money and advice is needed on how to manage that money. The banks, National Australia Bank for example, are offering free advice. The advice has been established, but that was one of the criteria.

What we have been doing with the bushfire appeal fund is that for the first $15 000 people applied and that was paid out straightaway. Basically people are assessed and the money is committed. We then have to wait until that financial advice information comes through. We do not see the financial advice; we just need proof that financial advice has been sought. Once that comes in it is paid out. There is a lag time in there, but that is one of the criteria we are required to follow. As I said, it varies a bit but we pay out $3 million to $5 million a day as those grants come in — —

Dr SYKES — Is that increasing exponentially, or is it a constant line?

Ms NEVILLE — Yes, it is absolutely going up.

The CHAIR — There is a graph for you.

Ms NEVILLE — See you can see it there.

Dr SYKES — That is quite exponential.

Ms NEVILLE — It is going up quite substantially. Basically people put in an application with all the details, the financial advice and all of that, and the grants are paid at the most within three days. It is turned around very quickly.

On the issue of how we make it as easy as possible, because this is certainly one of the issues that people confront, having to fill in forms. Firstly, there is the case manager's role in trying to assist people in doing that. Secondly, if we get application forms that do not contain all the information, we will do everything we can before we have to ring that person to try to get the information. We might look back through the database, we might look at a form for another grant application, we might ring the case manager — whatever we can do to minimise the need to ring a person and say, 'You have left a gap on your application form'.

Our first step is to do that. Secondly, if in the processing of that grant we notice that somebody has not applied for another grant, we will pay that grant as well. So they have this application form and clearly they are eligible for another grant, we will notify them to say, 'We are also paying this grant'. Case managers also have the ability to check on their individual client on the database and say, 'Okay, you have applied for X, Y and Z. This is what's being paid for you. You haven't applied for this, so we're going to put in an application for that'.

We are trying to make it as simple as possible. In the emergency relief stage, people were paid without IDs, they were paid without information. It was critical we got that money out to people as quickly as possible, and they were paid on the spot. Obviously the bigger the grant, we need to just make sure they are going to the right people and we are trying to make that as simple as possible whilst ensuring that the money is going to the right people.

Dr SYKES — Just a couple of clarifications.

The CHAIR — Very quickly. You can always ask another question later.

Dr SYKES — Chair, we have had it put to us on a number of occasions that this is a very significant event in the history of Victoria.

The CHAIR — I understand that.

Dr SYKES — The recovery phase is extremely significant. I have a lot of people contacting me, raising their concerns. I would like to get it very clear in my head so that I can give them clear feedback, and I have opportunity to get that from the minister.

Minister, in relation to these larger grants, the turnaround time from submission to payment is in the order of three days?

Ms NEVILLE — If all the documentation is there.

Dr SYKES — And in terms of the data management, are people still being required to fill out different grant forms or do you have the central database that you can look at, doing a lot of the form completion for them and they have to fill in only two or three blanks?

Ms NEVILLE — Case managers will work with people to fill in forms. As I said, if somebody has a plight, so we have somebody's information and we realise they have not applied for everything they can, we do not require them to fill out forms. We will pay that money. If we have their information, we will just pay out that money — notify them, but pay out the money.

Dr SYKES — One last clarification. Survivors are given a one-on-one case management service, but one case manager can look after up to 7 or 10?

Ms NEVILLE — That is right. It is based on a disaster model. The way that we try and do it is we have what are known as inactive cases, where people say 'We don't need a case manager any more', but they are still allocated to a case manager and they get rung regularly. Then people will have around 10 active cases.

Dr SYKES — Are you about to rotate off the case managers? Is the group that has been employed finishing up and is another group about to be employed or are you rolling over the contracts or what?

Ms NEVILLE — We are rolling over the contracts. So the only changes will be that Centrelink staff came in for a period of six months and we are working to replace those, but the intention is to try and have consistent ongoing case managers.

Dr SYKES — That was a concern out there that it looked like one group finishing and 'Oh, my God, we're going to have to go through this with another person'.

Ms NEVILLE — No.

Dr SYKES — Thank you.

Mr NOONAN — Minister, I refer to budget paper 3, pages 38 and 39 under 'Supporting people with a disability'. One of the line items in this budget under the enhanced facilities is $14 million for 13 new purpose-built houses to enable the relocation of young people with high-care needs from residential aged-care services to more age-appropriate facilities. I wonder whether you can advise on the progress of this initiative and any further details that relate to the forward estimates period?

Ms NEVILLE — As I said earlier, this is a COAG bilateral agreement that we have with the commonwealth, known here in Victoria as My Future My Choice, and stage 1 commenced on 1 July 2006. The aim of the initiative is reduce the number of young people living in a residential aged-care facility by either assisting some to move out or preventing others actually having to enter an aged-care facility in the first place.

Over 215 people aged less than 50 living in residential aged care participated in individual planning and assessment that identified what their preference was: was it to move out of the residential aged-care facility into an alternative living arrangement, remain in the residential aged-care facility with enhanced disability support? About 70 per cent of participants indicated that they wanted to move out of the residential aged care.

In addition we have been working with young people and their families and assisting them through individual support packages and other accommodation options other than that provided under My Future My Choice. The figures are encouraging, so in July of 2006 we had about 221 younger people living a residential aged-care facility; in April of this year that had reduced to 187. That will continue to reduce. This is both those who are currently there as well as preventing new people coming in.

Today I will also announce that land has been secured to build three facilities. There is a $1.5 million house in Altona for six young people, which will be managed by Yooralla; a $1.3 million house in Frankston, again for six people, and again that is state and commonwealth money; and a $1.2 million house in Geelong for five young people, to be managed by Scope. I will also be announcing the providers who will deliver 10 new services as part of stage 2. I will be announcing that today.

These innovative new purpose-built accommodation services are being established to provide more suitable options for those who seek alternative living arrangements. In 2007–08 the Victorian government allocated $10 million in capital funding to assist in the establishment of these facilities, and that enabled the commencement of stage 1, which is going to provide places for 46 young people.

The first of those services opened in Balwyn in February 2008 — I think the Chair was there — allowing six people with an acquired brain injury to move out of residential aged care. I think you would agree, Chair, that the young people and their families were pretty excited about the move, and it certainly is making a real difference in their quality of life.

In this budget we have announced a further $13.8 million to facilitate stage 2 of the service development which will deliver supported accommodation options for 58 people, and a number of these services will be in rural and regional Victoria. So in total 104 new accommodation places are scheduled to be completed, including those I have mentioned. There are the 6 places in Balwyn and 18 new places during 2009–10, and I have mentioned a couple of those.

There is construction about to commence also in Alphington and Glen Waverley; there is also a new house in design work in Grovedale. There will also be another 70 new places in 2010–11 which will be in Noble Park, Geelong, Horsham, McKinnon, Altona and Frankston — which I mentioned — Ballarat, Shepparton and Bayswater. The new houses are either in the planning or design phases. We are currently in the process of sourcing land in the western suburbs, northern suburbs, Wodonga, Bendigo, Berwick, Bairnsdale and Moe.

On top of this a total of 19 younger people have been assisted to exit residential aged care. They have either returned home with additional supports through the individual support packages or exited to supported accommodation options. To date 44 younger people have been diverted from entering aged care through the provision of the individual support packages.

Over 100 younger people who remain in aged care, either by choice or because they are waiting for an appropriate option to become available, are receiving support packages, aids and equipment to enhance their quality of life. The support packages, for example, are used to ensure they can access the local community. It might be that community buses are used, they can go home on weekends or they are assisted in maintaining family and social relationships. It might be particular equipment in their rooms that make them able to live more independently in their aged-care facility, or it might be new wheelchairs.

All of those sorts of things are improving the lives of those young people who remain in residential aged care. I think this is one of the really critical initiatives that we have at the moment with the commonwealth government. It is already making a real difference to young people who are required to be in some form of supported accommodation. I think over the next two years we will see significant shifts in the numbers of young people in residential aged care.

Mr RICH-PHILLIPS — Minister, I would like to ask you about indexation and community services. Before you put those slides up on bushfires, can you just confirm that the 393 case managers is the number going forward and that that level will be maintained?

Ms NEVILLE — We are trying to do some planning on that at the moment, because it is a bit hard to predict. Not everybody will require a case manager for the whole two-year period. At the moment we are looking at the issues coming through and the needs of families, and trying to make an assessment based on that. We have committed to continuing to provide over the two years case managers for those families who need it.

Mr RICH-PHILLIPS — You said in your presentation that you have agreed to indexation of 3.14 per cent and that that was welcomed by the sector. I know that in the lead-up to the announcement in the budget the National Disability Services, which at that time was expecting 3.34 per cent, issued a statement. NDS asserts that:

> … the disability sector is unable to continue to survive on price indexation of 3.34 per cent in the context of a history of underfunding, inadequate price indexation and productivity cuts.

Over recent years disability organisations have absorbed countless new regulatory requirements. It went on to say that NDS has voiced strong concern about the approach of the government which did not allow for adequate consultation with the sector. NDS also referred to the Allen Consulting Group's report, which forecast a requirement of 4.2 per cent indexation to maintain service levels. Given that you have come in lower at 3.14, and as NDS said, a lot of organisations have additional regulatory requirements upon them, how do you expect service providers to maintain service levels with an inadequate level of indexation?

Ms NEVILLE — I will just review the process for the NGO pricing indexation process. Firstly, it was this government that established the three-year funding agreements. It was something that the community sector always wanted — to have certainty going forward around their funding and to have price indexation certainty.

Mr RICH-PHILLIPS — Going from the inquiry to this committee; it happened in 2001.

Ms NEVILLE — We did that back in 2003. We have been in the process of negotiations. There has been a price index working group which has contained or involved all of the key people of organisations — VCOSS, National Disability Services, the Centre for Excellence in Child and Family Welfare, VICSERV and Jesuit Social Services. They have all been involved, working in partnership with us to resolve the issue of price indexation.

Can I say that the Victorian Council of Social Service publicly stated how pleased it was with the outcome in relation to price indexation. In fact, overwhelmingly, all members of that working group were very pleased about the outcome in the context of the downturn in the economic cycle.

If you look at how indexation is set, it is a mix of both wages and also CPI. There is a formula that we use and that we have used in all of our funding agreements with the community services organisations. Based on the economic conditions and projections going forward, the indexation is one that community services organisations recognise will provide a really critical role in ensuring their sustainability going forward. And 3.14 per cent is an improvement on the last indexation and is well and truly able to meet the expected CPI costs and wages costs going forward.

Mr RICH-PHILLIPS — What about the increased regulatory burden for disability agencies?

Ms NEVILLE — As I have said already in my presentation, this year we have provided — which we did last year as well — another $3 million to assist disability organisations to move towards more self-directed approaches. Certainly our focus rightly — absolutely rightly — in the area of disability is on ensuring that our system is focused on the needs of the individual and their families, not on the organisations. But in that context we need to make sure our organisations are also sustainable. So we are providing additional money for them to assist them with information technology and to assist them with regulatory burdens. We have got $4 million to assist with cost pressures around transport issues — all of those things. That is about making the sector sustainable whilst ensuring that our primary driver in all of this is delivering the services that families and carers — families and people with a disability — want and choose.

That is what individual support packages are about. That is what direct payments are all about. It is a challenge, and that is why we are working with the sector, providing them with the resources, working with them to actually shift the way that they operate in order to meet the needs of people with a disability.

Mr RICH-PHILLIPS — Given the government's own wage forecast came in at 3.75 per cent of the budget, why have you agreed on indexation of 3.14 per cent — substantially below the government's own wage forecast?

Ms NEVILLE — The government wages policy is 3.25.

Mr RICH-PHILLIPS — The wages forecast is 3.75.

Ms NEVILLE — The wages policy going forward is actually 2.5, but obviously what the budget figures show is the play-out of EBAs that have been agreed to prior to the new wages policy.

Mr RICH-PHILLIPS — The Treasury estimate for the Victorian economy is 3.75 per cent for wages growth, but you are saying your indexation is only going to be 3.14?

Ms NEVILLE — Except the indexation is not a formula that says 'wages policy'. It has proportions that take account of wage increases and it has a proportion that takes account of CPI, so it is 85 per cent of wages and the rest is on CPI — —

Mr RICH-PHILLIPS — It would be heavily weighted on wages, though, wouldn't it?

Ms NEVILLE — So based on that formula, and if you look at wages policy and if you look at CPI, the figure of 3.14 going forward is a good outcome, and the community service organisations have agreed it is a good outcome. They sat at the table with us. It is a partnership arrangement of reaching a sustainable price indexation to support the sector going forward in the delivery of the services that they provides.

Ms HUPPERT — Minister, I want to refer you to page 40 of budget paper 3, which refers to the new funding which is being provided for additional services for children who have been removed from the care of their parents due to abuse or neglect and placed in out-of-home care. Could you please outline for the committee some details of this funding and what the new services will provide in the forward estimates period?

Ms NEVILLE — As I spoke about in my presentation, we have been undertaking substantial reform and investment in our child protection and family services areas. We have had new legislation and new initiatives; we have really targeted the front end of our system. The results of that have been substantial, with the reduction in substantiated abuse. But in addition to that, the results of that investment have also seen us as being at an eight-year low for the number of children who are entering our care system for the first time. However, there are demand pressures, and that is what this budget is all about — demand and quality pressures.

The budget allocates all up $160 million in this area, and of this $134 million is focused on our out-of-home care system, or what I would call the back end of the system. Our focus is on supporting families through intensive support, to try to drive down demand, to try to ensure that those children who can live at home safely with the extra support are provided with that, and that is particularly targeted at the 0 to 2 and the 13 to 16-year-olds. Our focus is also on how we improve the quality of care for those children who cannot live safely at home. It is not just about new funding but is signalling a new direction in out-of-home care, which we have developed with our partners in the community service organisations.

The priority actions, just to go over those again: $19 million, which is about piloting the family mentor system, which is intensive in-home support for those families who might be at risk of a child entering our out-of-home care service; we have $23 million to recruit up to 100 practitioners over the next four years to provide specialist care to kids with particular challenging behaviours who might benefit from that; we have $47 million over four years to redesign our care system to deliver greater placement options and particularly to meet the diverse needs of adolescents; we have $18.9 million over four years to secure more foster and kinship care placements for children removed from their families; $13.9 million will be provided over the next four years to improve the funding to community service organisations who provide general residential care; we have $10 million to upgrade residential care units, for which we want to draw on new building designs to deliver more homelike environments in our residential care services; $1.3 million over three years for therapeutic treatment services to help children recover from trauma and past experiences, and that builds on our unique service which is called Take Two, which is providing therapeutic and mental health support services targeted particularly at children in the out-of-home care system; and $1.2 million to organise better access to positive activities and community support for young people in residential care. We want to ensure that young people in residential care are linked in to sporting groups — are able to participate in other forms of activity outside residential care. There is also support to ensure Aboriginal children receive culturally appropriate care services.

Additional funding on top of this for sexual assault counselling services for children and a boost to the capacity of our after-hours child protection emergency crisis response telephone service will also help address the needs of very vulnerable young people in care who are involved in risky behaviours such as street-based sex and drug exploitation.

These reform directions build on a number of key initiatives that we have already put in place to strengthen our care system: more support for carers through our statewide foster care training; increased reimbursements to carers to assist with meeting the costs of caring for children; the implementation of a new service model to

support kinship carers; enhanced flexibility and capability of our care placements; the expansion of one-on-one placements; as I mentioned before, our Take Two service; and the development of the new model of therapeutic residential care, which is known as Hurstbridge Farm.

We also have a new leaving care support service for children who leave care at 18 years, to help them transition either into employment, further education or into other housing options, and also funding which has been provided through the Centre for Excellence in Child and Family Welfare to work on a recruitment campaign to attract more foster carers to the system.

This is very much delivering not just new investment but also looking at ways of doing this differently, and we will be doing that in conjunction with the community sector, who are very much partners with us in the delivery of child protection and family services here in Victoria.

Ms PENNICUIK — Just a quick follow-up from Mr Noonan's question about how many young people are still in aged-care facilities and the plan to alleviate this. My question is more a global-type question. Given the economic outlook and the expected increase in the incidence of financial and social stress in the community — and you mentioned the provision of financial counselling in your bushfire presentation — is there any plan to look at providing financial counselling services for people who are coming under stress, to prevent them from getting right into the problems of housing, mental health and other community service provision that they may wish to undertake?

Ms NEVILLE — Chair, financial counselling does not actually fall under my area of responsibility. I think it sits with the Minister for Consumer Affairs in the Department of Justice. I am just not able to answer the question on behalf of the minister. The sort of services that sit within my portfolio, including concessions and mental health support, all of those services absolutely go to assisting particularly vulnerable and low-income families and individuals in our community.

Ms PENNICUIK — Can you answer the first question?

Ms NEVILLE — Of how many? Yes. At the moment we have 186, I think, if my memory is right — it is 187 at the moment.

The CHAIR — Close.

Ms NEVILLE — It is 187, and as I said we have 104 new places coming on board. Of those 187 who remain in residential aged care not all those people wanted to move out. We spoke to 215 out of 221 — not everyone spoke to us, but we got pretty close. Of those, 70 per cent said they wanted to move out of residential aged-care facilities. At the same time as you are managing that you are also trying to prevent people from coming in, and the other part of the program has been about doing better work earlier on with families and young people to ensure they do not actually end up in residential aged care in the first place.

Ms PENNICUIK — What is the target time for achieving 100 per cent of that 70 per cent?

Ms NEVILLE — I think the 104 is up to the end of 2012.

Mr SCOTT — Minister, I refer you to budget paper 3, page 286 and Table A.1, which has the 'Enhancing Disability Services and Outcomes' heading. Can you tell us what investment in the 2009–10 budget will be delivered for people with a disability? Previously, Mr Wells asked about what organisations are receiving. I am interested in what will be delivered for people with a disability, in terms of the budget.

Ms NEVILLE — As I mentioned earlier, last year we had the biggest ever single investment in disability services, which equated to $233 million over four years. This budget builds on that, with an additional $86.9 million over four years, which includes $9 million which sits in the department of education and it is targeted at early childhood intervention services for children with a disability. The disability services budget is increasing in 2009–10 by $112 million, or a 9.6 per cent increase all up.

Combined with last year's increase, the disability services budget has increased by more than 20 per cent in two years. The combined effect of these budgets has been to increase the funding available for disability services by over $77 million, and that includes $21.5 million that sits under the National Disability Agreement.

This gives Victoria a total disability services budget of almost $1.3 billion, an increase since 1999 of 125 per cent.

For people with a disability, the 2009–10 budget will deliver almost $30 million to expand our individual support, making more individual support packages available and delivering about another 179 of those with this year's budget over the next four years. These individual support packages are really critical. They provide flexible support. They are about identifying individual needs around respite and around other supports that they might need in order to be able to live more independently in the community.

There is $16.7 million over four years for the Transition to Employment program. This assists young people, particularly school leavers who have a disability, to be able either to access employment or to access further education. This is a really critical component. We want to make sure that if we get our planning right and we get the supports right young people have the best opportunities for full participation in our community.

We also have capital funding which I have just been speaking about, which is the $13.8 million over four years to deliver the 58 new accommodation places, to build the purpose-built community accommodation options for those who are living in residential aged care. There is also capital funding of $5 million over three years to establish community-based co-located facilities where disability supports are integrated with other community services. This again all goes to the issue of trying to ensure that people with a disability have equal opportunities and rights to participate in our community.

The development is focused on three different service models: co-location with existing providers, establishment of support and resource sites for people with a disability within key activity centres in local communities, and also developing local community infrastructure to encourage the participation of people with a disability in community activities. In addition, through the Office for Disability in DPCD, funding of $7.2 million is provided for the ongoing work in raising community awareness and helping to change community attitudes.

Rolling out this year we continue our disability action plans which are focused on ensuring that within the public sector but also in community organisations that our buildings and our workplaces are as accessible as possible. We will see an additional 150 nominated public and community organisations go through the process of disability action plans.

These budget investments continue to ensure that our goals around a self-directed approach for people with a disability can continue to be met. We are determined that any new investments are about providing flexible services and supports and ensuring that people can have a real choice about living as independently as possible in our community, and changing community attitudes about people with a disability and their ability to participate in community activities.

Mr DALLA-RIVA — In respect of budget paper 3, pages 110 and 111, which relate to residential accommodation support, in terms of the forward estimates there is a moderate increase in the total output costs and I note the figures. I just want some explanation about the additional commonwealth funding and how that is reflected in the increases that are there, and in particular about some of the concerns that have been put forward about what appears to be a two-tiered system where the non-government sector appears to be funded out of this total output cost. Can you clarify for us whether there is a continuation of this two-tiered system?

It appears the non-government disability sector is underfunded. It is expected to deliver the same type and quality of service as the DHS services but to do so with less funding. I just want to get more of an analysis about the $584 million and how that is broken down into the non-government disability sector in relation to residential accommodation services and the DHS services, and if there is a disparity between the two, why is that?

The CHAIR — There are a number of strands there, Minister, if you can try to deal with them.

Mr DALLA-RIVA — It relates to the same figure.

Ms NEVILLE — It is the dollar figures that you are — —

Mr DALLA-RIVA — The dollar figure and you have quantity over there on page 110 — clients in shared supported accommodation. That would not be totally DHS, would it?

Ms NEVILLE — No.

Mr DALLA-RIVA — So I just want a bit more of an analysis in terms of — —

Ms NEVILLE — What I can give you is a bit of a breakdown of who provides how many facilities. I can do that.

Mr DALLA-RIVA — You can take it on notice, if you want.

Ms NEVILLE — I will have to take on notice the actual breakdown of the costs, so how much in dollars goes to CSOs to deliver supported accommodation. But I can give you a breakdown of the type of accommodation.

There are about 1060 facilities in out-of-home accommodation support services. Of that, 905 are long-term group homes, 82 facilities providing respite, 23 facilities providing congregate care, 14 accommodation units providing independent living and 14 units providing outreach accommodation. A total of 280 of these supported accommodations are owned and operated by non-government organisations but the majority are owned by the Department of Human Services, either through the secretary of the department or the Office of Housing.

A number of the department-owned properties are managed by community service organisations under funding and service agreements with the department. At the moment there are around 4980 places in the group home component. All the new facilities that we are currently building are being done in partnership with the non-government organisations.

Mr DALLA-RIVA — Through you, Chair — —

The CHAIR — The federal funding you asked about as well. You can take it on notice.

Mr DALLA-RIVA — You can take it on notice about the federal funding.

Ms NEVILLE — It is not allocated separately; it does not go commonwealth to the non-government sector. It is in the pool. In the disability services budget output, the total figure of commonwealth contribution in 2009–10 is $208 million, and we put in $1079 million. As I said earlier, over 80 per cent of the disability output is funded by the state.

Mr DALLA-RIVA — Also on notice, the cost per place of the NGO versus the DHS. I do not expect you to have it on here but just on notice.

The CHAIR — All right. Thank you very much for that. Minister, I would like to welcome your statement before about autism and the fact that it is now seen as a neurological disorder and disability, which I am sure the autism sector welcomes. Could you tell us, in budget paper 3, page 41, just where we going on the autism state plan? Can you give us a bit more detail on that, particularly going into the future?

Ms NEVILLE — Thanks, Chair. This month is actually autism awareness month.

The CHAIR — That is correct.

Ms NEVILLE — And we will be launching the state plan some time this month as part of the autism state plan. As I said earlier, this plan is probably a unique plan in that it was a real partnership between government and Autism Victoria as well as very extensive consultation with people with autism, families, carers and people who are involved in working with people with autism. The plan will provide a platform for building new and improved approaches right across government to better meet the needs of families and children with autism spectrum disorder.

As I touched on earlier, as part of the autism state plan and some of the priorities that have been identified by families, the budget provides $8.2 million over four years to commence implementation of that plan, and they are really in the critical areas that families identified with us as some of the key priorities. Just over $4 million will be provided by the Department of Education and Early Childhood Development. This will see the development of things like autism spectrum disorder plans, education and workforce development — really skilling up our early childhood workers, our teachers to be able to better support and respond to often challenging behaviours that might result from autism.

There will be coordinated positions to support regional autism consultation and training networks, and also specialist secondary consultation to support the early childhood workforce in working with children with highly complex ASD. There is $4.16 million to DHS to enhance the capacity within our child and adolescent mental health services and to build our ASD expertise in the mental health workforce. There will be increases in staffing to our CAMHS services, which will include the appointment of 14 dedicated coordinators to manage the process of diagnostic assessment of children and young people with complex presentations of ASD. Operational guidelines will be developed and ASD training to the specialist mental health workforce will also be rolled out.

The plan will build on the government's announcement, as you mentioned, Chair, last year to include all people with ASD under the Disability Act. In the development of that act and for a very long time, people have argued that ASD is a neurological disorder and should be acknowledged under the Disability Act. That change back in December enabled that to happen. We provided some additional support at the time to improve the information and support for families and individuals with ASD, to assist them in doing planning and case management.

There was also funding allocated to Autism Victoria, who are working in partnership with the Association for Children with a Disability, to improve the information referral processes as well as providing additional peer and parent support groups. There has also been money allocated to fund ASD case consultant practitioners, who will be established in each region. They will provide secondary consultation for case managers working with families and individuals with ASD and provide some regional leadership. It is one of the really critical areas in autism. It is still a very poorly understood issue, which means that diagnosis, treatment, care, access to information — all of that — is very misunderstood in a whole range of services. That is really one of the key focuses of the commitments we have made in this budget, to try to address some of those particular issues.

We are also working with the Australian government to help families maximise the benefits of the commonwealth initiative, which provides families access to funding for some early intervention support. Being able to clear some of the waiting lists in our CAMHS services for diagnosis will actually assist families to get earlier access to some of the commonwealth money. Absolutely, families having access to early intervention services makes a difference to life outcomes for children with ASD.

Just in the consultation on the autism state plan, over 1000 Victorians participated. I think the plan combined with these initiatives will really go a long way to improving the lives of families who have children with autism and people who live with autism spectrum disorder.

Mr WELLS — Minister, I refer you to budget paper 3, page 112, child protection. According to the 2007–08 DHS annual report, there were 1556 child protection staff employed by the department. Of these, how many actually have contact with children, and what will be the figure over the forward estimates, please?

Ms NEVILLE — That figure, as I understand, will not be full-time effective. That will be — —

Mr WELLS — Okay, it is 1556, and full-time effective is 1421, so we will work on 1421.

Ms NEVILLE — And the question was, 'How many have contact?'.

Mr WELLS — Of the 1421, how many have contact with children?

Ms NEVILLE — They all front-line staff, so they are all working with children in the front line.

Mr WELLS — So of the total amount, every single person in the child protection unit has contact with children?

Ms NEVILLE — They would be working as teams, so you might have a supervisor —

Mr WELLS — No, no. How many actually have contact with children?

The CHAIR — The minister to answer.

Ms NEVILLE — The overwhelming majority of them would have contact. They are front-line staff; they are doing — —

Mr WELLS — How many?

Ms NEVILLE — I do not know. I would have to give you a breakdown of supervisors.

Mr WELLS — There is a roomful of hardworking public servants. Someone would have the number.

Ms NEVILLE — The way that child protection works, people do not work in isolation; people rightly work in teams There is a process, absolutely, of ensuring quality, of ensuring supervision. It is a very difficult area to work in. Of course out of that group of people would be some people who provide supervision work — —

Mr WELLS — Yes, I understand all that.

Ms NEVILLE — — people who oversee cases, who review case files, who might do a number of those case files to ensure that we are delivering quality services across the board. The vast majority of that workforce are front-line staff who would be meeting with families, working with families, working with children, going to the Children's Court, ensuring access between children and their families — the overwhelming majority. I would be guessing, but it would be certainly in the 90 per cent that would be front-line.

Mr WELLS — Would you take it on notice, then?

The CHAIR — The question has been asked. I have already suggested it be taken on notice and also, Minister, to estimate that going forward, too.

Mr WELLS — The actual number.

Ms NEVILLE — Yes.

Ms MUNT — Minister, I notice incidentally from the constituents who come through my door that low-income families are under growing pressure with their household budgets, particularly in relation to essential utilities like water. I was interested to see in your presentation and also at page 316 of budget paper 3 that additional funding has been provided for concessions in this budget. Could you detail that additional funding and how it would work?

Ms NEVILLE — You are right in saying that families are under additional pressure as a result of the global financial crisis but also the increasing costs as a result of drought and climate change, so the cost of basic utilities has continued to increase. We have a strong commitment to ensuring that low-income households in Victoria are able to afford access to these essential services. This includes ensuring that our hardship programs continue to be effective in reaching those most in need. We currently assist directly around 725 000 households through the provision of more than $1 billion worth of concessions, rebates, allowances. They provide assistance across gas, electricity, water, schools, kindergartens, public and private transport, and ambulance, dental and other health services.

We have new challenges with the financial crisis but also with the changing climate that we are experiencing, which has seen the increase in prices for essential services. In response, we have a number of measures which are about trying to ensure that these essential services remain affordable for our low-income households.

In particular, in this budget we introduced a further increase in our water and sewerage concession, to assist the most vulnerable members of our community to gain affordable access to this essential service. This year's budget provides an increase to the water and sewerage concession cap, rising from $189.70 to $216.60, which represents around about a 14.18 per cent increase in that concession cap. Overall this is around about $42 million over four years.

On top of that, we have also increased what is known as our Water Wise program. We are providing $2.3 million to assist in water demand reduction programs, so not just assisting people with affordability around bills but in the long term ensuring in a sustainable way that they are able to reduce their water use and also bring down the cost of their overall bills.

We have already had a Water Wise program that commenced in January this year out of money from the 2008–09 budget, which is targeted at assisting around 1000 households in hardship to reduce their water consumption through things like free water audits and retro fits, valued up to about $500 per household. The new Water Wise program will be extended and will see perhaps around about another 4000 households assisted

and we will be working with the water companies to really target this additional money to ensure it reaches those low-income households that have the biggest water use in their areas.

These are really important measures to assist in keeping water and sewerage affordable for low-income families. Of course our range of other concessions — electricity and gas concessions, which are uncapped — will continue to play a really critical role in ensuring access to essential services.

The CHAIR — Before I call on Mr Rich-Phillips, I note on your budget estimates questionnaire you have a breakdown in terms of staff, but under allied health, child protection, disability executives et cetera.

Ms NEVILLE — I do not know if it —

The CHAIR — It is not a complete picture, because some of VPS are involved in that. Could you provide for the committee a breakdown of the VPS staff, in the normal fashion that that is done?

Ms NEVILLE — Yes.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the Community Offenders Advice and Treatment Service that operates through juvenile justice. There have been reports that a number of organisations that provide forensic services as part of COATS have received cuts in funding as what I understand are administrative changes within DHS. Can you outline the basis of that and why that has occurred, what funding has been provided for the COATS service for the last couple of years and for the budget year, and what organisations receive funding under COATS and how much?

Ms NEVILLE — It is actually under the drug output. COATS does not deliver to youth justice. It is a federally funded program which, as I mentioned earlier, comes via the state and it is targeted at people in the DOJ under the prison system, not at youth justice. We have our own drug support programs in youth justice.

Mr RICH-PHILLIPS — So who is responsible for administering it?

Ms NEVILLE — It does sit with me, but it is under the mental health area. I am happy to have a look and provide that information — I just do not have it here in front of me — when we get onto mental health very shortly.

Mr RICH-PHILLIPS — You will in 10 minutes?

Ms NEVILLE — Yes, I am happy to do that.

Mr RICH-PHILLIPS — All right. Thank you.

Mr NOONAN — Minister, I am looking at budget paper 3, page 40, under 'Assisting vulnerable children', and I want to ask a question about emergency child protection. I note that there is $14.6 million over four years to enhance the capacity to respond to children in crisis outside of office hours. I wonder whether you can provide details of this funding and the extra services that it will provide?

Ms NEVILLE — As I mentioned earlier, there is $14.65 million over four years in this budget to address the rising demand for after-hours emergency and crisis response services for children in need of protection or at risk of exploitation or remand. The After Hours Child Protection Emergency Service is a crisis service that responds to urgent calls after hours from both professionals and the community in relation to child protection concerns. It is run by a very dedicated staff group, and we recently celebrated its 20th anniversary.

The service performs a vital community service for very vulnerable children and young people, particularly those who might need an urgent response. On a typical day its workload includes responding to reports from hospital medical professionals about new cases of serious abuse and neglect; responding to calls from Victoria Police about children that may have been abused, abandoned or orphaned; responding to reports from family members about the care or safety of a child or young person; receiving reports about children that may be missing from their home or placement; and outreaching to young people who may be engaging in high-risk behaviours, such as illicit drug use or self-harming behaviours in the CBD or St Kilda.

Often these calls may be received late in the day and some in the middle of the night. Often the caller is distressed and deeply concerned, and the response needs to be calm, compassionate and alert to all the potential

risk and safety issues. In 2008 the service handled nearly 40 000 incoming calls. The new funding announced in the state budget is targeted at ensuring that after-hours calls about child protection emergencies are answered in a timely way; enhancing the capacity to provide an outreach response for those children who require immediate action after hours as a result of those calls; addressing the significant increase in demand for after-hours assessment of the suitability of a young person for bail, to ensure appropriate conversion from remand; and ensuring, as I said, consistent coverage with extended hours across the CBD and St Kilda areas.

The funding will extend the capacity of after hours, the bail service and also the street work outreach program. Funding of $14.65 million with $3.52 million this year will be provided to ensure that we are able to meet the benchmark that we have set for this service, which is 80 per cent of calls being answered within 90 seconds, and to increase the service's capacity to provide the outreach to actually be able to go out to families and children who are at risk. It will ensure that the service's call-taking capacity is brought in line with other emergency services' responses and also community expectations. These are really critical services. They operate at times of often very high crisis in families' and children's lives. These additional resources will ensure that we are able to provide the most timely and best quality responses to these very vulnerable children.

The CHAIR — I thank you, Minister, and Mr McDonald, Mr Rogers and Mr McIsaac for their attendance.

4.4 Mental Health Transcript

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2009–10

Melbourne — 19 May 2009

Members

Mr R. Dalla-Riva	Mr G. Rich-Phillips
Ms J. Huppert	Mr R. Scott
Ms J. Munt	Mr B. Stensholt
Mr W. Noonan	Dr W. Sykes
Ms S. Pennicuik	Mr K. Wells

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

Staff

Executive Officer: Ms V. Cheong

Witnesses

Ms L. Neville, Minister for Mental Health,

Ms F. Thorn, Secretary,

Ms A. Hall, Executive Director, Financial and Corporate Services, and

Ms G. Callister, Executive Director, Mental Health and Drugs, Department of Human Services.

The CHAIR — I welcome the Minister for Mental Health. I also welcome Ms Fran Thorn, secretary; Mr Alan Hall, executive director, financial and corporate services; and Ms Gill Callister, executive director, mental health and drugs, all from the Department of Human Services. I invite the minister to proceed with her presentation. She has no more than 5 minutes.

Overheads shown.

Ms NEVILLE — Thank you, Chair. People will remember that last year I spoke about the green paper, which outlined possible areas of reform in mental health. That was backed up by some funding to seed reform, $128 million. Since that time we have done extensive consultation with stakeholders, carers and consumers. In fact, we received over 200 submissions and 1200 people were involved in developing the strategy.

In March this year I released the mental health reform strategy, which will significantly shift the way in which we respond and deliver mental health support and services in our community. It is the first time we have had a whole-of-government approach and a whole-of-life approach to mental health in Victoria. This year's budget of $182 million in this area will see us being able to make significant new investment in our key priority reform areas.

The graph shows that we are spending almost double the amount on mental health since we were elected. In 2009–10, the mental health budget, which excludes capital, will be $945 million, which is a 108 per cent increase over the last 10 years. We have also continued to invest in capital, so last year we put $34 million into capital funding, and more than $74 million will be provided in this budget.

Beyond these reforms, the other things that we have been doing this year include the review of the Mental Health Act — a major review of that — the psycho-social response to bushfires. We have opened new acute beds at Maroondah and started the works at the Northern Hospital. We have appointed Australia's first chief child psychiatrist, who is Dr Sandra Radovini.

Turning to the year ahead, the priorities on this slide reflect the key reform areas of the mental health strategy, and the budget initiatives, which I will go through in a moment, really support each of those priorities and will start to achieve reform in each of those areas. This will give the committee a bit of a sense of where the $182 million investment will go: $21 million will go to improving our early-in-life responses.

We know, for example, the incidence and the development of mental illness are disproportionate for those people under 21. This is about ensuring that our mental health system has a better capacity to meet the needs of children and young people through things like expanding the CAMHS in schools program to identify and intervene with primary school aged children who have emerging and existing behavioural disturbances; strengthening youth early intervention teams; and we have also been doing considerable work within our school system to ensure early identification and support.

There will be enhancement of the pathways to care, which will see further investment in enhanced mental health triage services, which will expand on the funding we provided last year to centralise in six metropolitan and regional area mental health services a 24-hours a day, seven days a week, specialist mental health triage response. This will occur over the next two years, freeing up capacity in our CAT teams.

We also have a strong focus on providing additional support for those at the forensic end, those people who are engaged or involved at some level around our justice system, for example. This will provide some funding for what we are calling expert portfolio-holders to assist these particular people to gain better access to expert advice and support.

There is also a strong focus on recovery and building foundations for recovery. We have allocated $37.7 million, which, again, builds on what we provided last year. We will see new dedicated care coordinators providing support for up to 300 consumers with comprehensive care plans and tailored support packages to support them in accessing the correct health, community and social security services that they need. There are also an additional 50 support packages linked to stable housing, and we will also be piloting a new mental health list in the Melbourne Magistrates Court.

There is also a strong focus on our workforce capacity, with an allocation of $6.6 million, which will enable us to establish a new institute of mental health and workforce development focused on training, education and

recruitment, and there will be some particular time-limited positions to help us drive governance changes in local communities and ensure that we are able to implement our reform processes.

As I said, there is also investment in health service capacity and also in beds. There is $66 million to complete the Dandenong Hospital redevelopment, $8 million for two youth PARC facilities — which will be the first of their kind — and also some money to build some capacity at the Geelong Swanston Centre, with eight new beds.

Among the other areas in this portfolio, alcohol perhaps remains one of the biggest challenges facing government and the community, given the levels of harmful drinking in our community, particularly among young people, the health impacts and of course the link to violence.

Last year we released our alcohol action plan and allocated $37 million in this area. As a result of that we have seen the introduction of new services, for example, 175 young people and their families benefiting from therapeutic intervention programs. We have also had some new intervention programs, for example, the 'Will you handle your alcohol? Or will alcohol handle you?' campaign which was launched in January, encouraging people to think about their alcohol use and the risks around violence.

Also this year we launched the blueprint for alcohol and other drug treatment services. This maps out a client-centred and service-focused reform agenda for Victoria's alcohol and drug sector. As in mental health, a key focus is on prevention and early intervention, and some funding has been provided to VAADA, the peak body, to assist in kick-starting the implementation.

Also this year we have released the amphetamine-type stimulant strategy, which will guide work to continue to prevent and reduce the supply, use of and demand for amphetamine-type stimulants.

We are also providing $127.5 million in ongoing funding for prevention and treatment programs, including funding for 802 beds, and, combined, these continue our strong efforts in preventing the uptake of drugs, alcohol misuse as well as providing the necessary support and treatment services required for those who need additional assistance.

I am conscious of the time, Chair, so I will quickly go to the next slide. I wanted to mention one thing, which is the Overdale alcohol and drug service. This was a service that was unfortunately destroyed in the bushfires at Kilmore. We had a successful evacuation, so there were no issues on the day, but this has meant our bed capacity at the moment has been reduced by 16 beds, and we are working with the Salvation Army to get an interim service in place by the end of June and also to plan for a new permanent service.

The CHAIR — Thanks, Minister. Going back to your mental health reform strategy, which over four years is $182.1 million, where you have got seven headings; and I am also conscious that in appendix A of budget paper 3, page 286, you have got another listing there; also the DHS initiatives. Can you give us a table with your seven headings and then the subheadings over the four years in terms of the expenditure under the various programs that you have got here in the budget so we can have a better understanding of how it all fits in?

Ms NEVILLE — Yes.

Ms PENNICUIK — Minister, many people in the community, including refugees and those who have lived here for a long time and do not speak English or who have English as a second language, encounter barriers in accessing mental health services. For example, a visit to a GP is required to get a referral to a specialist, and often there are no interpreter services available to assist in that process or in other processes in the mental health system. Is there any funding in the budget for interpreter services in the mental health system to assist people from non-English-speaking backgrounds access mental health services?

Ms NEVILLE — There is no additional funding, but we have an ongoing program that provides access to interpreting services for people who are accessing our mental health services.

Ms PENNICUIK — Certainly we are being approached by people who are saying that they are having trouble accessing it. Have you got any idea of the unmet need in that area? Was the department keeping an eye on that?

Ms CALLISTER — I think all clients who are accessing the public mental health system and need an interpreter service are able to access the interpreter service. It is not a barrier to receiving treatment or care, that people cannot receive an interpreter service. That is available through the public mental health program, as the minister said.

Ms PENNICUIK — Obviously we are getting feedback from people about their not being able to access — —

Ms NEVILLE — There may be a difference between those who are going to a GP, for example. GPs obviously provide primary care as delivered by the commonwealth. It is a bit hard to give you the full details of how the strategy works, but there is a focus in the strategy about how to ensure particular access and improvements to services for particular groups in our community who are more disadvantaged and less able to access those services.

Obviously CALD communities are one. We also have some specialist services around for survivors of torture. That is going to be an increasing need given the areas where we have refugees coming from, and obviously also indigenous communities as well. Sitting underneath in the strategy are new ways of working, new supports, how do we provide better access to critical mental health services for those particular groups?

Ms HUPPERT — Minister, as the Chair mentioned, page 286 in budget paper 3 outlines a number of initiatives in the mental health reform strategy. I draw attention to one of line items 'Early in life: improving mental health outcomes for children, young people and their families'. I know you touched on this briefly in your presentation. I wonder if you could provide the committee with some more information about the action taken to improve the responsiveness of mental health services for children and young people during the forward estimates period?

Ms NEVILLE — This is — not wanting to say the others are not critical — a very critical area in terms of how we want to reform our system. We know, for example, that about 14 per cent of children and young people aged 4 to 17 are affected by mental illness at some point. This goes up to 26 per cent between the ages of 16 and 24. We also know that 75 per cent of severe mental health issues occur before somebody is 25. It has a significant impact on children and young people.

Yet probably across the world the focus on children's and young people's mental health has been a bit unrecognised. What the strategy talks about is that if we are able to invest early and earlier in life, we can provide much better outcomes for children and young people; we can prevent and we can also minimise the impact of mental illness on children and young people.

The budget provides $21.3 million specifically targeted at achieving better mental health outcomes for children and young people. Of this, $13.8 million over four years has been provided to the Child and Youth Mental Health Service Redesign initiative. This is about ensuring that we are able to provide a strengthened response for young people up to the age of 25. At the moment we really see young people transition from the youth mental health service system from about the age of 18. That is often a really critical transition period. As you have seen from all those figures — given the incidence between 16 and 24 — this is about ensuring that there are age-appropriate targeted services up to the age of 25.

A further $8 million is being provided to develop two youth PARC services — that is, prevention and recovery care services. We have quite a number of those across the state now, but these are the first time that we will have specific services targeted at young people. These operate as a step-up, step-down facility. Hopefully for young people particularly it is a step-up to prevent the need for an acute hospital inpatient admission so that people can spend some time and get the support they need as quickly as possible in the development of their illness to prevent the need to spend time in an acute hospital ward.

There is also $3 million for a new youth justice mental health initiative, which will provide clinical treatment and care coordination support for young people involved in our youth justice services. One of the key priorities of the strategy is to redesign and connect services and programs to get better mental health outcomes across the board, particularly in our schools.

In collaboration with the education department we will better use student support service officers and make sure that they are plugged into the wider mental health service, particularly providing secondary consultation

with our CAMHS services to ensure that we are able to identify kids at risk of mental illness very early on and ensure that they are getting the support, services and treatment that they need.

As I mentioned in my presentation, we are also extending our CASEA or CAMHS in Schools Early Action program. It will be extended to more metropolitan and rural regions. This is really about identification of primary school children who are at risk of things like conduct disorder, and intervening earlier. Certainly so far that program has been extremely successful in shifting behaviours and in longer term outcomes for young children. We also continue our support of FaPMI, which is for families where a parent has a mental illness. All of these services are contributing to improvements in our response to children and young people and building on some of the demonstration projects that we funded in last year's budget.

Dr SYKES — Minister, before I ask my question in relation to crisis assessment and treatment services, can I on behalf of the people of drought-affected north-east Victoria thank you for organising continuation of funding of Ivan Lister, an outreach worker who has done an outstanding job in relation to not just drought but other matters, including bushfires. I also understand that you are actually working on a continuation of funding for Kyabram community services that provide a similar service.

You are giving me a nod that that is all happening?

Ms NEVILLE — Certainly Ivan, yes.

Dr SYKES — In relation to the crisis assessment and treatment services, known as CATS, you put up a slide there before indicating $11.2 million. Is that to go to supporting the CAT services? The reason I ask is that the Boston Consulting Group put out a report in July 2006 which indicated that the CAT services were seriously underresourced. In the last few weeks I actually had a meeting involving Ivan Lister and the local police addressing this issue of dealing with people with either mental health problems or stress and the difficulty of the local police accessing CAT or professional backup services to help them handle situations, with the potential consequence of some very bad outcomes. Is that $11.2 million to strengthen the CAT service?

The CHAIR — You will find it on the first slide about the health reform strategy.

Ms NEVILLE — There are a number of services that really go to this issue around pathways to care. What we know is that generally the community is very unclear about how to access mental health services wherever they might sit, whether in primary health from GPs or right through. People are very unclear. We are trying to improve that whole pathways to care response as well as our emergency response as part of that. In the last budget we committed to a 24/7 line which is for the whole community, and that will be up and running later this year.

That will provide a one-stop shop core in case you are worried about yourself or someone else and are not sure where to go. That is about ensuring that people are getting access quickly to the right care. It might be that they need to see a GP, they might actually need the specialist end of the service or they may need a CAT team to respond. That service will play some of that role. It will not replace the specialist mental health services, but it will be able to identify people who may require more of an emergency response.

In addition to that we are rolling out the 24/7 mental health triage service. At the moment we have 21 area mental health services that have CAT clinicians and they all operate relatively differently. Some have a triage service you can ring, and that function plays a role in doing an assessment of need, what sorts of supports and services that person might need and how urgent it is. Some do it that way. Some do a bit of triage, and some other clinicians respond to an incident. Some places work well, and some do not work very well.

What we want to do is have a more consistent model and some models that actually deliver better responses. The mental health triage service, some of which we are rolling out now and which will be rolled out with some additional money, will provide a one-point entry into your area mental health service where people will know who you are. The people who are in our specialist system in particular generally know who those people are and what sort of response is needed, and they can make assessments about CAT teams, police attending and whatever the issues might be, and about whether the response is access through the emergency department, where we have some specialist CAT team services as well.

In addition to that there have been some really good models which we will look at. For example, Southern Health, Victoria Police and the ambulance services have been working together to provide a better joined-up

response between a CAT clinician and the police in responding to and supporting people who are in crisis with a mental health service. So, yes and no; that money is about ensuring that we are able to have a consistent model across the state for access to the specialist mental health service and for people who are in crisis. It will also enable us to do some reform of CAT teams.

People have often complained about them becoming only an emergency response. The crisis assessment part of the title is a bit unfortunate, but they really do a little assessment and they do a little treatment, and we want to refocus them a bit more to be able to do some more short-term responses. We think the combination along that pathway of care and range of services will enable us to improve access, support and treatment right across the board.

Dr SYKES — Just focusing on the crisis response component, as a result of the investment will there be a strengthening of the crisis response component; and if so, what measures do you have in place to measure the improvement in performance?

Ms NEVILLE — What it does is basically free up CAT teams to do what they should be doing.

Dr SYKES — So there will be a strengthening of CAT response?

Ms NEVILLE — At the moment CAT teams are doing both of these things. We are going to have additional resources in triage, which will be separate, and the CAT teams can respond better. We are giving them more capacity to do that.

Dr SYKES — And do you have a performance indicator to indicate that what you are hoping will be achieved — a better response — has been achieved? How you are going to measure whether that is achieved? You can take on notice, if you like, what performance indicators you have.

Ms NEVILLE — There are a number in the strategy outline. We already have a series of KPIs, but obviously part of the strategy and moving forward will also be about what other new outcome measures we want to achieve if we put in place new services. A lot of the early life services, for example, are very new; we have no KPIs, so we need to continue to enhance that. But certainly what goes to the issue of performance will be about admission rates, waits in emergency departments — all of those KPIs will help us assess outcomes. Each service obviously provides us daily with information about their response times and who they have responded to, so we have that detail, but we need to continue to ensure that our performance measures match the direction we want to go in terms of the reform of the mental health system.

Dr SYKES — I think the first measure is whether they able to respond or not to the request, and then the second is the response time, so if you could have a look at that, because right now there is an issue of not being able to respond.

The CHAIR — There is a performance indicator there, but any extra information you can provide would be good.

Mr SCOTT — Minister, I refer you to budget paper 3, pages 320 and 321, where there is a table A.6 headed 'Asset initiatives — human services'. Can you inform the committee about mental health capital works programs?

Ms NEVILLE — Again, one of the key priorities that sits under the reform strategy is continuing to ensure that we can respond to demand pressure by building our capacity in the mental health system. This requires us to continue to invest in infrastructure but also in new services so that we are providing both more capacity in what we do now and also new services that better respond in a better way to the incidence of mental illness. In the 2009–10 budget we continue to build on the mental health capital developments that we have announced in recent years. Funding of $74 million was announced, which will see us being able to deliver our commitment in Dandenong to the redevelopment of the Dandenong Hospital. This will increase inpatient beds from 77 to 120, comprising additional adult acute beds and aged and secure extended care beds, and it will provide 30 additional residential beds in the Dandenong area mental health service.

Last year we provided $3 million for detailed planning, and this will meet the $69 million funding commitment that the government made in 2006 to upgrade and expand the services in this important growth area.

The CHAIR — Can you clarify, maybe on notice, just what the figures are, because you have mentioned $74 million and $69 million, and in the budget paper there is $66 million.

Ms NEVILLE — Yes, $66 million. I was just saying last year we provided $3 million for the planning of it in the 2008–09 budget, which gives you the $69 million.

The CHAIR — Thank you.

Ms NEVILLE — In addition to the development of the new acute facilities at Barwon Health we have also allocated funding to increase the capacity of the mental health beds at the Swanston Centre in Geelong, which will see an additional eight acute mental health beds. This will enable us in the medium term to meet the increasing pressures on beds in the Barwon region whilst we continue to do the planning for the long-term redevelopment of the Geelong Hospital. These are on top of some of our more recent capital developments. There was capital funding in 2005–06 of $25 million for the development of two new 25-bed adult acute units at the Maroondah Hospital, which will increase the beds from 30 to 50. The first stage of that project opened in 2008, and the second stage is about to be completed and will open in July of this year.

In the 2007–08 capital budget for mental health $26.6 million was provided, including $15.5 million for the Northern Hospital redevelopment project, which will expand inpatient beds from 25 to 50, and works on that project have commenced and will be completed by about July of next year. There was also $20 million in the 2007–08 and 2008–09 budgets to meet the government's commitment to the expansion of the PARC services.

The first 20 of these beds at Deer Park are due to be completed this month, and the remaining 50 in purpose-built facilities at Ringwood, Preston, Broadmeadows, Clayton and Frankston will be completed next year. As I mentioned before, we have provided the additional PARC beds — the youth PARC beds — in this particular budget. There has also been the funding of money to redevelop veterans mental health, which will be the centre for trauma-related mental health, and $17 million was provided between 2007 and 2009 for that. There is also money for the Ballarat hospital to improve its mental health adult acute unit, with $5.5 million provided last year.

Capital investments over the last few years, combined with these capital investments in this budget, are really building our core capacity, but also as I said building new services and PARC services to provide access for people to more appropriate care and treatment.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the ice strategy. In early 2007 then Premier Bracks made a substantial announcement that the government would undertake the development of a strategy for a pre-emptive strike in the war on ice. Since then and up until now, with the release of the strategy, we have seen nothing. I understand the strategy was basically released on the DHS website at the end of April, with no fanfare and no announcement by you or any other comment from government. The war on ice has basically turned into a quiet release of a document somewhere down the bottom of the DHS website. So my question is: what funding has been provided explicitly in the 2009–10 budget for the implementation of that strategy, and what time frames are in place for the implementation of the programs under that strategy document?

Ms NEVILLE — We have had a very strong focus on the issue of ice, but amphetamines more broadly. Our aim in this area is to ensure that we continue to see a consistent and declining use of ice, and in Victoria we have seen that over the last few years. We have not seen a spike or growth in the use of ice, unlike some areas across the world and across Australia. We have been investing very significantly in prevention but also in terms of our ongoing treatment programs to ensure that people who have an issue with the use of amphetamines can get the treatment that they need.

Part of the package that was announced by the Premier back in 2007 was to develop an amphetamine-type strategy, which was released in a meeting with stakeholders, who have been very much party to this. The strategy has been very much a partnership with ourselves and the non-government sector and experts in this area in developing the way forward in terms of what our focus should be in tackling and preventing the use of amphetamines in Victoria, particularly amongst our young people.

Some of the priority areas that sit under that strategy include things like prevention and early intervention, like targeted awareness campaigns — you might have seen the 'ice: it's a dirty drug' campaign; the strengthening of prevention and early intervention strategies; the provision of sterile injecting equipment,

particularly outside standard hours; in the treatment area, looking at how we strengthen our psychological interventions, how we ensure that we are picking up on other issues, like mental health issues, how we ensure that there is a focus on families, on parents.

Drug users are often parents as well, and we need to focus around protecting and supporting children and families as a whole. We have a focus in treatment around ensuring specialist addiction medicine access as well. That is a new area of work, and we are investing significantly in that and in understanding addiction. Specialist addiction medicine units will play a vital role in that.

There is also a strong focus on workforce — how do we increase the capacity of GPs, how do we increase the capacity of the alcohol and drug sector? And through clinical guidelines and training, how do we increase brief interventions and other referrals, and what are the sort of training and workforce development issues to ensure that we are able to respond to people who use amphetamines?

There are also things that sit outside my area, obviously in justice and law enforcement, about supply issues and ensuring targeted awareness campaigns on drug users who drive cars. So there has been a very strong focus on that, as well as implementing some of the restrictions around precursor chemicals.

The task force that developed this strategy, as I said, had leading experts from drugs, from the health sector, CALD communities — so it is a very broad-ranging task force — and it is really I suppose their efforts that saw the result of that. It is their views and their experience that are reflected in the strategy.

In terms of some of the things that we have been doing to address the issues since February 2007, as I said we had the media prevention campaign, 'ice: it's a dirty drug'; we strengthened legislation regarding pill presses; we developed clinical guidelines; we have got new prevention and community education and funding for drug hot spots and treatment services to assist people.

One of the good things about our drug treatment services is its capacity to be able to respond and shift to meet changing drug patterns in our community. There has been funding for information to parents, which was distributed through schools, helping them understand the risk signs of their children using ice, and what they can and should be able to do about it; further training for alcohol and drug workers; as I said, new clinical guidelines for methamphetamine addiction; money to train staff and volunteers at the family drug helpline so that people could seek information following both our campaign and also the distribution of information to parents; the funding of primary health services and local drug strategies across five drug hot spots in Melbourne also occurred.

As I said, there are a number of other things that we do that sit within the justice portfolio in relation to methamphetamine use and driving, drug driving; changes in legislation around ice pipes; access to precursor chemicals that go to making amphetamines. So it has been across DHS and DOJ by way of response to this issue. It is making a difference in terms of keeping down the use of amphetamines in our community, particularly amongst young people, and we will continue to focus on it.

Mr RICH-PHILLIPS — The question, Minister, related to the strategy that was released in April — whether there is any explicit funding provided in this budget to address the initiatives in that strategy, or are you basically saying what is in the strategy is simply what you have already been doing?

Ms NEVILLE — As I said when I did the presentation on the alcohol and drug area, we continue to have our drug and alcohol output, which funds our treatment services, it funds our prevention services — —

Mr RICH-PHILLIPS — But does that address specific initiatives out of the amphetamine strategy?

Ms NEVILLE — Yes. The drug and alcohol blueprint, combined with the amphetamine task force, and the money that we have given to VAADA is about how we implement that. Some of it is about what sort of services we need to provide, and some of it is about the structure of our drug and alcohol treatment services, and we will be working with VAADA to implement the amphetamine-type strategy and also the drug blueprint.

The CHAIR — I thank the Minister for Mental Health, Mr Hall, Ms Callister and Ms Thorn for their attendance.