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

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2012–13

Melbourne — 8 May 2012

Members

Mr N. Angus
Mr P. Davis
Ms J. Hennessy
Mr D. Morris
Mr D. O'Brien
Mr M. Pakula
Mr R. Scott

Chair: Mr P. Davis
Deputy Chair: Mr M. Pakula

Staff

Executive Officer: Ms V. Cheong

Witnesses

Mr D. Davis, Minister for Health,

Mr L. Wallace, Acting Secretary,

Professor C. Brook, Executive Director, Wellbeing, Integrated Care and Ageing,

Mr P. Fitzgerald, Executive Director, Strategy and Policy, and

Ms F. Diver, Executive Director, Hospital and Health Service Performance, Department of Health.

Necessary corrections to be notified to executive officer of committee

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the 2012–13 budget estimates for the portfolios of health and ageing. On behalf of the committee I welcome the Honourable David Davis, MLC, Minister for Health and Minister for Ageing; and from the Department of Health, Mr Lance Wallace, acting secretary; Professor Chris Brook, executive director, wellbeing, integrated care and ageing; Mr Peter Fitzgerald, executive director, strategy and policy; and Ms Frances Diver, executive director, hospital and health service performance. Members of Parliament, 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 gallery that they cannot participate in any way 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 to provide information to the minister, by leave of myself as chairman. Written communication to witnesses can only be provided via officers of the PAEC secretariat. Members of the media are also requested to observe the guidelines for filming or recording proceedings in the Legislative Council Committee Room, and no more than two TV cameras are allowed at any one time in the allocated spaces. May I remind TV camera operators to remain focused only on the persons speaking and that panning of the public gallery, committee members and witnesses is strictly prohibited. I would add to that, for the benefit of the camera operators, that there was in fact an incident yesterday during an adjournment of proceedings in which I had to intervene. My role as chairman of these proceedings is to maintain order, but it is also to maintain a dignity in the committee hearing room and particularly preserve the dignity of witnesses. I do not find it amusing at all that certain cameramen yesterday chose to film witnesses during an adjournment. Just take that on notice, if you would, for the future. As previously advised to witnesses here today, I am pleased to announce that these hearings are being webcast live on the Parliament's website.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. This committee has determined that there is no need for evidence to be sworn; however, witnesses are reminded that all questions must be answered in full and with accuracy and truthfulness. Any persons found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript to be verified and returned within two working days of this hearing. Unverified transcripts and PowerPoint presentations will be placed on the committee's website immediately following receipt, to be replaced by verified transcripts within five days of receipt.

Following a presentation by the minister, committee members will ask questions relating to the inquiry. 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 10 minutes on the more complex financial and performance information that relates to the budget estimates for the health portfolio.

Mr D. DAVIS — Chair and committee members, I am pleased to make this presentation. If we can just step through that on the screen, that would be helpful.

Overheads shown.

Mr D. DAVIS — I think it is worth outlining the budget focus. Obviously this is a budget shaped by the economic challenges of the present; it is focused on securing the future; as the Treasurer said, it is about driving economic activity, productivity and jobs; and it is about investing in infrastructure, front-line services and meeting the needs of the community.

I do think it is important just to start with a brief context. It is a very tight fiscal environment nationwide, and in many respects Victoria is not the worst off there. Some of my colleagues interstate — in Tasmania, in South Australia and indeed the new minister in Queensland — face real challenges with the financial sustainability of their systems. There is no question in Tasmania, for example, about the significant reduction that occurred in the spending in the health portfolio just a little while ago.

There are a number of historical and context issues — and I do not want to dwell on these — including the black holes that we inherited and the public holiday costs. In a more broad context there is the ongoing steady incremental increase in patient demand and numbers of patients and there is also obviously ageing of the population. Ambulance Victoria has been meeting its financial and operational challenges. It has been a significant task to begin the process of turning around Ambulance Victoria. The EBAs are a significant point of pressure — we see the nursing EBA — and I will say more about those in a moment. There are forthcoming EBAs that will be part of the context. There are commonwealth-state negotiations that occur which have fiscal impacts and costs of implementation. I will say more about these as we proceed forward.

On the enterprise bargaining agreements there is a long list, and the status of those is put out there. The nursing EBA obviously reached in-principle agreement, and we are awaiting the ballot. The allied health, mental health, medical scientists, ambulance paramedics and doctors are ones still to come. Government wages policy, as I think the community understands, is 2.5 per cent plus productivity. On the nurses' EBA — the impact on performance — there were a number of elective surgeries that were cancelled, and that has had an impact across the services that will remain for a little while and take some catch up on that. Agreement was reached within government wages policy. Productivity gains and professional development gains were features of the deal.

If we move to ICT, this is a historical background here but it does affect how we spend and how we move forward now. It was originally scheduled for completion in 2007. The time line has extended to 2009. It was originally budgeted at 323 million. That went up to 471 — 95 million in additional spending required to complete the remaining six health services. The final project costs to complete the project would be well north of 500 million. Health services in an ongoing way — and this affects directly the budget year now — need to find between 700 000 and 2 million a year to keep the clinical application running. Obviously the Ombudsman and the Auditor-General have looked at this, amongst a long series of ICT projects, and there are a series of issues around that. The costing of the project was seen as too ambitious and the department underestimated the size of the task. There is obviously the ongoing challenge with ICT.

On the positive side, going forward into the budget this year there is an innovation, e-health and communications technology fund, and I am happy to say more about that later. There is obviously also some funding to support national obligations under the National E-Health Transition Authority, NEHTA, and I am happy to say more about that. It is probably one of the bright spots on the horizon in terms of authorities in Canberra and national authorities.

The highlights of the state budget include the significant increase across the health portfolio. Within the context I think we have done better than many departments, and the challenge is there to deliver in what is actually still a reasonably constrained fiscal environment. There is an increase in funding for hospitals and a significant 364 million for capital investment with a number of projects, which I will come to in a moment.

In ongoing matters, the comprehensive cancer centre is a $1 billion project that is under way now. As I think the committee will understand, and I referred to this last year at the committee, there is state money, there is commonwealth money and there are non-government sources to support that project. Construction is proceeding, and the committee, if they are minded, may want to go onto the website and see the progress of the construction. There is a refresh every quarter hour. You can see men in hard hats doing their work and building what will be a very important cancer centre for Victoria and the nation.

In Bendigo, there is a $630 million project. Significant work has occurred to get this to the stage it is at. A formal request for tender is imminent, with two consortia short-listed: the Exemplar and the Intecare consortia. The process will move forward strongly from here.

The budget highlights, in terms of statewide infrastructure, 25 million. In hospital performance and patient growth, there is 603 million. That is over four years. The Ballarat hospital additional capacity, ambulatory care and helipad, at $46 million, is a major outcome for the important Ballarat city. There is a medical metropolitan program, an ongoing but very important program that replaces medical equipment in a timely way.

There is a series of capital projects. The Monash Children's continues its forward movement with an additional 7.3 million. The Charlton hospital — I think everyone in the community is pleased to see the progress of the Charlton hospital. It is a town that did it very tough in the floods not this January but the one before. This, I

think, is a major shot in the arm for the town. The government has secured the land, and we are in the process of moving forward with the allocation of money to build the hospital now.

In Castlemaine there is an election commitment of $10 million. For Frankston Hospital there is just shy of $40 million for the emergency department down there, which has been badly needed. It is a piece of infrastructure I think the community understands is well overdue, and we are very proud to be putting the money in the second year in a row into Frankston. A 68-bed expansion last year was funded.

I am moving as fast as I can. In Kilmore, there is $20 million. There is a lot to say, Chair, and I am speaking pretty swiftly.

The eye and ear is at the first step in its process to a full rebuild, and we are proud to see that movement forward. The intensive care unit at Sunshine is also an important project at $15 million. We will finally deliver those intensive care beds at Sunshine and expand maternity services. Those are important steps.

There is cancer funding: new funding for the cancer agency, Seymour chemotherapy beds, south-west treatment and the ongoing commitment to the comprehensive cancer centre.

In preventive health the health and wellbeing plan is an important base for moving forward on preventive health care. Importantly there is the Vision 2020 funding this year — 2.6 million over the next three years — to help prevent avoidable blindness. This is a very important commitment. It helps older Victorians in particular, but it is a very significant commitment. There is the work that is going on with the prevention community model as well.

On commonwealth financial impacts, there is the withdrawal of GST, both for the slowdown in the national economy — I am sure the Treasurer has given you chapter and verse on this, so I will not go over it — but also the share that Victoria gets and the need to backfill a number of key commonwealth programs as best the state can. There are a number of risks from commonwealth action, and I think it is important to get these on the agenda at a committee like this because we are at a point now where we are going forward into a new set of arrangements. There are challenges and risks. There is uncertainty about a number of parts of the implementation, and we need predictability and certainty to run health systems to support networks here.

The private health insurance rebate, the withdrawal of that $2 billion, is a significant impact on the system in Victoria. Ultimately we will see less private activity, and that will see a shift to the public system. I am concerned about the Medicare safety net murmurs that we are hearing about the commonwealth budget tonight. I will say some more about that in a minute. The health deal implementation costs are also important. There are the data duplication and reporting burden issues — I will say something about those in a moment too — and the proliferation of national bodies. And carbon pricing, where there has been no allowance for compensation or adjustment for the state, or the states in general; it is not just Victoria, to be clear. On private health insurance, we see that there will be a significant impact. I am going as quickly as I can here.

I think there are two key issues with the safety net. If the commonwealth seriously winds back the safety net, that will directly affect obstetric services in the private sector in Victoria, potentially causing a significant fallback into our public system, and will likely impact most severely on the chronically ill, and I would be concerned to see that.

Mr PAKULA — Chair, would it be too cynical of me to suggest that the minister might get some Dorothys about these matters and we can move onto questions?

Members interjecting.

The CHAIR — Thank you for your assistance, Deputy, I am sure the minister is just about to conclude his presentation.

Mr D. DAVIS — There are a number of issues around the implementation. The administrator is not yet appointed, legislation is not in place, scope of services issues as to what is in and what is out of things around the national agreement are there, and there are issues around block funding. There is the growth in national bodies and the intrusiveness of some national bodies, and the cost of data. I might get Peter Fitzgerald at a later point to some say something about the data issues.

In terms of the new national bodies that are appearing — the IHPA, the NHPA — all of these national bodies, the lead clinician groups, the Medicare Locals; there is a long list of these bodies. Without referring to the gallery or the audience, Chair, I would warrant that very few people in the audience would know what the NHPA or the IHPA are or what they do, but what you can be quite clear on is that they employ bureaucrats and will largely exist in activities in Canberra. I will come back to those in due course in the interests of brevity.

The carbon pricing issues are significant. The $13 million per annum that we will face as additional costs are very significant costs into the public hospital system, but in areas like air ambulance and construction costs there will be a significant impact. But the carbon costs will also impact into the private system. The government is taking efforts to reduce greenhouse gas emissions, but none of those longer term measures will stop the impact of the carbon tax on the health system in the short term.

The CHAIR — Thank you very much for your comprehensive overview, Minister. The remaining time available in this session, which is until midday, we will dedicate to questions, but I might point out that given that it is such a long period we will take two very short breaks, on the hour, of no more than 5 minutes, so I would intend to resume immediately at the conclusion of the 5-minute break whether members and witnesses have returned to their places.

Minister, given the key growth and efficiency initiatives announced in the budget, can you please outline for the committee the likely impact of the budget on enhancing service delivery, promoting productivity and achieving efficiency gains within your portfolio, and in responding to this question, could you also indicate how you intend to monitor the portfolio's effectiveness in maximising improvements in these areas?

Mr D. DAVIS — On the efficiency and growth issues around the portfolio, you will see there is a recognition of the growth through the output groups — acute health, ambulance services, mental health, aged care, rural services, public health. There is a recognition across the portfolio of the challenges that we face in terms of growth and the issues around growth. It is important that efficiency is a key focus, and one of the key things we have sought to do is to focus on quality and safety as key aspects. This is the important location in the portfolio where better clinical outcomes also drive efficiency and reduced costs. So this is a critical focus.

Over the last few years we have ramped up the measurement of quality and safety in the budget papers, and I think your committee will have noted the addition of new measures this year and new measures last year. They are not things that will impact in a day or a week, they are things that will impact over a longer period, where services and the system as a whole and governments understand the reporting that is required and the focus on key areas of activity.

To just give you the snapshot of some of those new measures, the intensive care unit central line associated with bloodstream infections; the staphylococcus aureus bacteremia infections per 10 000 patient days; unplanned and unexpected readmissions for acute myocardial infarction per 1000 separations; unexplained or unexpected readmission for heart failure per 1000 separations; readmissions for knee replacement per 1000 separations; unplanned and unexpected readmission for hip replacements, for paediatric tonsillectomy and adenoidectomy. These are new measures, and this year there is the addition, for example, of hand hygiene measures and the important focus on quality in that respect. So better clinical outcomes, better safety outcomes, also lead to better financial outcomes. We think this is a very important focus. It fits with the longer term direction of some national initiatives — the national quality and safety group, and I think that is one of the more important national focuses. But Victoria is not prepared to wait on these things. We are moving forward very strongly, delivering better quality outcomes for patients in that way and a focus on better financial outcomes in the same way. We think this is an important point to land.

The CHAIR — Minister, could you inform the committee what you consider will be the likely impact of these initiatives on industry and/or community stakeholders in your portfolio, so rather than within the health department really the outreach to the community stakeholder?

Mr D. DAVIS — I think what will be required here is for health services to focus on these quality initiatives and to work with their clinician groups and their communities. For example, in the case of readmissions, we will need to make sure that strong community support is available when patients are discharged from hospital. The strong support there will reduce the likelihood of readmission. We need to ensure that that community activity and that community support are strong. Equally in terms of the impact on individual patients, I do not think

there is any patient, for example, who wants to be discharged from hospital, have the discharge fail for some reason and then be forced to be readmitted. I give you that example; I think it is an important way of looking at things.

Mr PAKULA — Minister, budget paper 3, page 119, shows that for every output group under your portfolio you overspent in the 2012 year with one exception, the exception being ambulance services where you underspent by just under $1 million. If you look at the same budget paper, page 127, you will see that the performance of the ambulance service continues to deteriorate in terms of the proportion of code 1 incidents responded to within 15 minutes, which is the clinically crucial time frame. That proportion dropped from 77.1 to 74.7, and that is way under the target of 85. My question is: why on earth would you underspend when you have performance deteriorating, and how can ambulance services improve when you have not even spent the funding that was allocated in the last budget?

Mr D. DAVIS — Chair, I am informed that the premise in the member's question is not accurate. It is money that came into the service later in the year, for example, public holiday money and so forth.

Mr PAKULA — Then the budget papers are wrong, Minister. The budget papers show that what was allocated was 588.5 and what is revised is 587.6, and I am sure that you are not suggesting that the budget paper is wrong when it says that the proportion of code 1 incidents responded to within 15 minutes has fallen from 77.1 to 74.7. But my question — —

Mr D. DAVIS — I will make two points.

The CHAIR — Let the Deputy Chair complete his question.

Mr PAKULA — Let me just finish the follow-up question, Minister, and you can respond to both together. It is also interesting to me to note that in regard to category 2 elective surgery patients, when you did not hit your target of 80, your response has been to reduce the target for 2012–13 to 75. In answering the question, I also seek an assurance that you are not going to respond to the fact that you did not hit your target by reducing the target in future.

The CHAIR — Thank you, Deputy Chair. There were a number of threads to that follow-up question.

Mr D. DAVIS — I think that is about nine questions. But let me be quite clear — —

Members interjecting.

The CHAIR — Can everybody pause. This is going to be a long session, and I would like it to be orderly. I would like the minister's responses to be heard, just as the members asking the questions are entitled to have their questions heard.

Mr D. DAVIS — The first point is the money came in later in the year, as I indicated. The second point is that I think this committee is well aware of the difficulties faced by the ambulance service. I think the ambulance service is doing the very best job with the hand that they have been dealt. The government came to power with a challenge in the ambulance service. There has obviously been a serious deficiency over a lengthy period — the auditor pointed to six years of decline under the previous government. There was a forced merger in 2008 under the previous health minister, who has to take direct responsibility for the botched merger. Let me be quite clear here: there is a real challenge to turn around the ambulance service and to get things moving better at our ambulance service.

I think the staff, the paramedics, are doing a magnificent job. The money, as I said, went in later in the year; it was an additional amount of money that went in. That is why the money was not fully spent. But I will be quite clear: the government has, through a series of steps in the recent period, been implementing its election commitments, putting very significant tranches of new money into Ambulance Victoria. The $151 million package over four years for 340 additional ambulance service staff — 310 ambulance paramedics and 30 patient transport officers; the additional funding for 10 MICA single-responder units in 10 Victorian country towns that have never before had MICA; the additional funding for ambulance stations; and the additional support that is going in. If you look at the budget outputs, you will see there is a more than 8 per cent increase in

funding for ambulance this year, and that reflects the second tranche of the government's 151 million package going into Ambulance Victoria and additional support as well.

There are significant lifts in the amount of resource, significant lifts in the numbers of staff going into Ambulance Victoria. Let us be quite clear: it takes a while to train staff, to bring them through, and we are going about that task steadily, carefully and trying to deliver for the Victorian community. But I am not in any way pretending that it is going to be easy to turn around 11 years of mismanagement.

Members interjecting.

The CHAIR — Order! Come on, just settle down. Thank you, Ms Hennessy, thank you, Mr O'Brien, thank you, Deputy. Everyone just calm down.

Mr D. DAVIS — Can I respond to the second question of the member? Essentially this relates to the national targets, the new national targets. These are agreed national targets across Australia. We have had those looked at very carefully by senior clinicians here. These are targets endorsed not just nationally but by senior clinicians in Victoria as well.

Mr MORRIS — Minister, I refer you to budget paper 3, page 138, which refers to small rural services. I am wondering: can you inform the committee of what initiatives the government is taking to support bush nursing hospitals, and in particular do those initiatives enjoy widespread support?

Mr D. DAVIS — I can indicate that our country hospitals are very important, and there is one particular category of country hospital that is particularly vulnerable and worthy of support at this point — that is, our bush nursing hospitals. In opposition the government recognised the need to ensure that bush nursing hospitals in Victoria had strong support, and we allocated a package in last year's budget which will be washing through over the next four years — $2.2 million to provide 0.55 million each year. These are small capital support grants to bush nursing hospitals.

Not everyone may understand what a bush nursing hospital or service is. They are essentially a community-based service, a community-owned service. They are not public hospitals, they are not private hospitals in the sense of a for-profit hospital and they are not hospitals that are denominational, as it were. They are community based, generally funded through a subscription system, with a long and proud history. Indeed I think 1910 was when the first bush nursing hospital was founded in Victoria, and there are a significant number of bush nursing hospitals that are still in existence: Balmoral, the Buchan Bush Nursing Association, Cann Valley, Dargo, Dartmoor and district, Dingee, Elmhurst, Ensay, Gelantipy district, Harrow Bush Nursing Centre, Lake Bolac, Lockington and district, Swifts Creek, Walwa, Woomelang and District Bush Nursing Centre, Ballan district health services, Cobden, Euroa, Heyfield, Nagambie, Neerim South and Yackandandah. That is the list of currently functioning services and hospitals in the state.

The government, aside from the general commitment, has also committed $2 million for Ballan. The hospital there, built in 1966, was very run down. That was a commitment in last year's budget, but allocation in this year's budget is supporting that rebuild. Ballan is an important hospital in a growth area. The commonwealth, to its credit, has provided support for a clinic next door to the hospital, which makes it a very effective entity to provide support for what is a significant growth area. That $2 million grant and the money being funded now — and I am informed that the construction is now well advanced at Ballan — will make a big difference.

One of the issues here is that there has generally been broad support for bush nursing hospitals and a recognition of the importance of them in particular communities. I was very surprised to see the Ballarat East MP attack the government's commitment of $2 million to Ballan as a reckless funding commitment and attack the idea of supporting a bush nursing hospital in his own electorate. I think some people would be surprised to see a member of Parliament attack a funding — —

Mr PAKULA — You wouldn't be verballing the member, would you?

Mr D. DAVIS — No, I am reading what — —

Mr PAKULA — You wouldn't be verballing the member, would you?

Mr D. DAVIS — I am happy — —

The CHAIR — Minister, through the Chair, please.

Mr D. DAVIS — If it would help, I am happy to provide the *Melton Leader* and indicate that I think most people would be surprised to see a local member of Parliament attacking the provision of $2 million to a hospital rebuild in their electorate.

Members interjecting.

The CHAIR — Ms Hennessy, Minister — everyone just take a deep breath, calm down and deal with this quietly, thank you. Minister, will you conclude your response?

Mr D. DAVIS — I do want to conclude by indicating the importance we attach to the bush nursing hospitals.

Mr PAKULA — It is two years old!

Mr D. DAVIS — It is, and he attacked it. It is extraordinary, isn't it? Do you support that, Mr Pakula, or not?

Members interjecting.

Mr D. DAVIS — Do you support it?

Mr PAKULA — You have basically misled the committee.

Mr D. DAVIS — No, I think you clearly support the member.

Members interjecting.

The CHAIR — Thank you. Everybody just calm down. It is very vigorous this morning. Just calm down everyone, and everyone will get their turn.

Mr SCOTT — Minister, I refer you to budget paper 3, page 22. There is an output initiative 'Sustaining hospital performance — organ retrieval and transplantation', with a figure for the 2012–13 year of $5 million. I presume you are familiar with the line item. Is this allocation specifically designed to cover up for the embarrassment of yourself, with the program closing down during the course of last year and your ongoing attempts to close down the upper house inquiry into this matter?

Mr D. DAVIS — I think organ donation is a very important task for the community. The government has made a very significant financial commitment to the process. I have to say that at a national level there is great cooperation between the commonwealth government and the state governments on this matter. Indeed at the health ministers conference recently, I was very prepared to give the federal parliamentary secretary some significant credit for work that she has done in parts of her portfolio.

I indicate that Victoria is doing extremely well in its task of bringing forward additional support for organ donation and additional support for transplantation. We have a number of key services, nationally funded centres, that deliver particular services here in Victoria at the Alfred, the Austin and the Melbourne — very important services. The children's is also doing excellent work. The government is proud to have put in more than $5 million additional funding this year and that through the forward estimates period as well. That is a significant contribution of more than $20 million that will bolster the task of lifting organ donation and activity.

Mr SCOTT — As a follow-up, will this be significant to fix the funding shortfall at the Alfred hospital revealed by Alfred CEO Andrew Way?

Mr D. DAVIS — I understand that at the Alfred and indeed right across the system Victoria will hit new records in terms of transplantation this year. I think the community as a whole can be proud of that. The additional funding recognises the ongoing growth that is required in this area and the ongoing need to continue to make a provision.

Mr PAKULA — What about the shortfall outlined by Mr Way?

The CHAIR — Thank you, Deputy Chair. I remind members that each of them has many opportunities to ask questions, and if they wish to follow up on a response from the minister, they may do so when they are called. Minister, would you like to continue?

Mr D. DAVIS — No, I have finished.

Mr ANGUS — Minister, I refer you to budget paper 3, page 136, under the output heading 'Community health care'. Can you please detail for the committee how the Better Health Channel is performing and how it is improving the health of Victorians through the Better Health Channel apps?

Mr D. DAVIS — I am very pleased to. This is something I think is a remarkable success story over a long period. The Better Health Channel is recognised as Australia's most used and award-winning consumer health and medical website. It is a channel that started in the late 90s, and, to the credit of the previous government, was continued and expanded through their period. We have worked to expand its activity strongly as well. It received approximately 20 million visits over the last 12 months. This is a rise of nearly 50 per cent over the previous year. This is a very significant increase. Importantly, it provides high-quality, reliable and independent online consumer health information and, as I say, is in demand more than ever before.

In addition to the substantial increase in the statistics, the Better Health Channel is now available through mobile platforms, with the release of iPhone and iPad apps, so that you can access this information in a way that gives you the greatest flexibility. You can get to different health conditions, treatments and first aid and find health services, which is a useful locational device, and various other help and advice. The app has been downloaded 65 000 times since last September and was also awarded the most popular free health and medical app in the Apple iTunes app store. Again, it is a very useful site, very useful information for communities and for families to access, and it provides timely and accessible information to allow them to make better decisions.

The features of the next app will include a number of key things: food and nutrition, physical activity, healthy weight, health checks, immunisation and reducing alcohol and tobacco consumption. There will also be further recipes and nutrition on the site and the opportunity to in future integrate the app with a whole series of personal health information as well. The platform, I think, enables Victorians to actively manage their health and wellbeing and improve their health literacy. It supports individuals to identify, set and achieve meaningful health goals and provides opportunities for them to store and share information with their GPs and community networks.

I think it is a very valuable service. I particularly pay tribute to the section of the department that does this work. They have really, I think, excelled themselves over the past 12 months in being able to lift the level of activity on the Better Health Channel. This is a service that is not just valuable to Victorians but is used nationally as well.

Ms HENNESSY — Minister, according to budget paper 3, page 22 and page 119, the increase to the acute health services funding line item to hospitals is 3.8 per cent compared to the revised 2011–12 outcome. Within this allocation, what is the net cost of the nurses enterprise bargaining agreement?

Mr D. DAVIS — Just as a little clarification, you generally compare budget to budget rather than revised budgets. It is just a point.

Ms HENNESSY — Thank you for the patronising advice, Minister, but I am quite confident about my own question. I asked for the revised comparator, and can you explain to me where the nurses EBA has been factored into the net cost?

Mr D. DAVIS — I am getting to that, but I think my point is well made. The second point — —

The CHAIR — Minister, can you just pause for a moment? Ms Hennessy, you have asked a question, and if you allow the minister to complete his answer, you can ask a follow-up question if you need to.

Mr D. DAVIS — If you look at the individual line items in those output groups, you will see they contain the nursing and other EBA conclusions on each occasion. They are embedded within them. As I have said, the nursing EBA is within government policy, 2.5 per cent, and that is included.

Ms HENNESSY — And you were answering the question from the revised figure, I note. Minister, is it not true that despite your metropolitan health plan indicating that services will grow at 3.3 per cent in their own right, your patient demand growth contribution is only 1.6 per cent of the total budget at 145.3 million this year?

Mr D. DAVIS — There is no doubt that there is some strong growth pressure on health services across the state, and we are determined to meet that the very best we can. That involves looking at new ways of achieving efficiencies and productivity. In fact in response to the Chair's question at the start I detailed one very effective way that health services can meet demand by getting better and higher clinical quality outcomes.

Mr O'BRIEN — Minister, I refer to budget paper 4, page 32, and I ask: can the minister explain to the committee how the Royal Children's Hospital is regarded as an infrastructure project within Australia?

Mr D. DAVIS — I can inform the committee — and some upper house people may remember this, but I am obviously quite proud to inform the committee and the community more broadly — that the Royal Children's Hospital was very successful in winning project of the year at the Infrastructure Partnerships Australia awards on 4 April — —

Mr PAKULA — Thank you, Daniel Andrews.

Mr D. DAVIS — Indeed I noticed Bronwyn Pike yesterday claiming credit for the Royal Children's Hospital as the minister who signed off on it. I have always taken the view that this hospital is Victoria's kids hospital and is a little bit above politics, and I am very happy to give credit across three governments and three health ministers — —

Mr PAKULA — You have never done anything above politics in your life!

Mr D. DAVIS — and indeed three Premiers for what is a magnificent achievement for Victorians and the Victorian community. I am particularly pleased to put on record the work that was done by the Department of Health and its predecessor departments. It won the project of the year award, and I was fortunate enough to attend that function. I want to put on record the work done by the Children's Health Partnership Consortium — International Public Partnerships Ltd as equity holders, Lend Lease as builder, Spotless Group as facilities manager, and Billard Leece, Bates Smart and HKS as architects. I want to particularly put on record the work done by the children's hospital itself, the Royal Children's Hospital, and the contribution that it made to a very successful move, which is always disruptive.

At the same time I think it is important to put on record the work done by my department, Tony Lubofsky in particular, who led the project team over that long period. It is a massive project, more than a billion dollars, a project that will be there for Victorian children for many decades to come, and I think Victorians can be very proud of what has been achieved.

Mr PAKULA — Minister, just going back to the health plan to which Ms Hennessy referred in her previous question. As Ms Hennessy indicated, that health plan suggests service demand growth will escalate at 3.3 per cent per year. But on budget paper 3, page 121, you are anticipating the growth in hospital separations — that is, people leaving hospital — is only going to be 5000 in the coming year, which is only a 0.3 increase on the previous year. So is that budget paper performance number correct, or is it wrong like the last one was?

Mr D. DAVIS — Again, I think you need to go year to year, Deputy Chair. I think that you need to understand that it is just a little more than 2 per cent and it varies year to year.

Mr PAKULA — When you say 'year to year', Minister, the expected outcome for 2011–12 is 1561 and the expected outcome or the target for 2012–13 is 1566. There is no point referring to old numbers that have proven to be wrong when you have a better and newer figure. But let me say this: you said in the *Herald Sun* after the budget that you think there will be 21 700 more admissions this year, but only 5000 more separations. That sounds like very bad news for 16 700 people. Are you suggesting that there will be 16 700 people who will be admitted to hospital but not discharged in the upcoming year?

Mr D. DAVIS — I am very careful not to be verballed by the particular member in question — —

Mr PAKULA — Would you like me to hand you — —

The CHAIR — Just let the minister respond.

Mr PAKULA — He is accusing me of verballing him.

The CHAIR — Let the minister respond.

Mr PAKULA — 'Health Minister David Davis said 21 700' — —

The CHAIR — Deputy, you do not have the call; the minister has the call. Thank you.

Mr PAKULA — Why are you shutting me down? 21 700 more patients — —

The CHAIR — Minister, when you are ready, you may respond.

Mr D. DAVIS — I note that the WEIS, the weighted separations, is actually up by a significantly greater amount, and that takes into account the complexity of particular procedures.

Mr PAKULA — Right. It still sounds like bad news for 16 700 patients

Mr D. DAVIS — No, I think you are wrong; you are just quite wrong.

The CHAIR — Minister, I refer to BP 4, page 7, and I ask: can you provide some detail about the Victorian comprehensive cancer centre project and how it will improve cancer services in Victoria and Australia?

Mr D. DAVIS — Thank you, Chair, and again the community will have heard me talk about the comprehensive cancer centre project on several occasions before. It is an important project. It is a billion-dollar project on the old dental hospital site. It has been constructed as a public-private partnership. It is expected to support 5100 full-time equivalents, both on and off-site, over the life of the project. Of these, 560 will be new full-time equivalent jobs. Construction of the VCCC, as I have indicated, has already commenced — it began late last year — and is proceeding steadily forward. It is expected to support 5100 full-time equivalents both on and off site over the life of the project. Of these, 560 will be new full-time equivalent jobs. Construction of the VCCC, as I have indicated, has already commenced — it began late last year — and is proceeding steadily forward. The comprehensive cancer centre is an important keystone in the delivery of services in the longer haul in Victorian cancer services and is both a construction project but also a consortium of health services that will deliver coordinated, systematic and first-rate cancer services across the longer haul.

The project was awarded to Plenary Health, who through that process will have a 29-year concession to design, build, finance and maintain the new comprehensive cancer centre. As I said, it is on the old dental hospital site. The Plenary Group is the sponsor and investor, Grocon and PCL from Canada are joint venture builders and Honeywell will provide the facility management — that is, the facilities support over the 25-year operating term. The architectural design team from Plenary Health is led by DesignInc and Silver Thomas Hanley in partnership with McBride Charles Ryan. Detailed design for the new VCCC facilities with user groups is well commenced and schematic designs are expected very shortly. The excavation has commenced, and they are digging down at this point for the construction of the car park and facilities support that will be in the basements. There is an opportunity for people to see construction through the website; you can see the refresh that occurs about every quarter hour. As I have indicated earlier, there is both commonwealth money and private sector money in the VCCC as well as a very significant state contribution.

We know that the burden of cancer will increase. We know that this will be a centre of excellence in cancer treatment, but it will also bring that linkage between cancer treatment and cancer research, and that is a very important focus that we need to strengthen into the future. As I say, it is a billion-dollar project, it is going forward very strongly and I think Victorians will watch with interest as this project comes forward.

Mr SCOTT — Minister, I would like you to return to budget paper 3, page 119, and the output 'acute health services'. What allocation has been made for the commonwealth contribution to this increase in the funding for acute health services?

Mr D. DAVIS — The commonwealth contribution is included.

Mr SCOTT — What is it in terms of a proportion of that increase?

Mr D. DAVIS — It is just embedded in it, and it is many and disparate parts.

Mr PAKULA — So what, all of it, most of it?

The CHAIR — Deputy — —

Mr PAKULA — If we could get an answer — —

The CHAIR — Deputy, let me be clear about this. When Mr Scott asks a question, he is entitled to have it clarified. He sought clarification, which I have allowed.

Mr PAKULA — And which we did not get.

The CHAIR — Mr Scott can ask a supplementary question if he wishes to.

Mr SCOTT — Can you confirm that the commonwealth contribution to Victorian hospitals is larger than ever before and guarantee that all commonwealth investment allocated for health purposes in Victoria is included within the health budget?

Mr D. DAVIS — I can point to pages 174 and 175 on budget paper 5 and indicate that the commonwealth has made a very significant contribution. As you will note, on a number of occasions as I have gone through presentations I have pointed quite directly to the commonwealth support that has been part of those projects, and the comprehensive cancer centre, for example, is one of those.

Mr MORRIS — Minister, I refer you to budget paper 4, the state capital program, and in particular page 32, which is the existing projects and the line 'Mildura Base Hospital'. Can the minister detail the performance of the Mildura hospital, particularly in relation to similar-size hospitals in the region?

Mr D. DAVIS — Mildura is a very important hospital. It is operated by Ramsay Health, as the committee may well be aware. It services a big area in the north-west of the state. It obviously provides very critical services not just to Victoria but to parts of southern New South Wales and parts of South Australia as well. It is true to say that over the last few years the number of maternity services delivered there has grown, there has been pressure on the emergency department and there has also been a challenge to keep up with the demand overall. We have certainly recognised that.

I can say in terms of the overall performance Mildura compares very favourably with the performance of any of our major regional hospitals, and for the first time data from Mildura is available as part of the normal data releases for Victorian public hospitals and health services. That data is able to be compared. People in Mildura can have confidence that the Mildura hospital has been performing very well in their interests, delivering timely services at least as well as equivalent services in other regional centres. It is important, I think, to put on the record the financial contributions made by the state government of $5 million for emergency department upgrades. Indeed, to pick up an earlier point, federal contribution will be made for further expansion of the hospital as well — 9 or 10 million. I stand to be corrected on the exact number, but I think that is the correct figure, and we have certainly welcomed that. I had conversations with federal officials on those matters, and certainly I think it is important that Mildura has those important upgrades. I can say the government is very committed to providing critical services in Mildura, is prepared to put the information out publicly on the performance of Mildura and is congratulatory of the staff and clinicians at Mildura who have done a magnificent job.

Ms HENNESSY — Minister, according to budget paper 3, page 22, your ongoing funding to support elective surgery demand is 36.1 million this year. In 2010–11, there were 152 451 elective surgery procedures in Victorian hospitals funded in hospital agreements completed under Labor. In 2011–12, that number was reduced by your government to 143 056 elective surgery procedures. How many elective surgery procedures will be funded by the 2012–13 budget?

Mr D. DAVIS — I think, just to correct Ms Hennessy, there are contributions from the 36.1 that she points out, the 145.3 and also the 44 on the same page — and the 44, of course, in part replacing the commonwealth concluding funding, so there are some additional contributions there that I think you need to count in. These are output initiatives on top of the base. It is important, though, Chair, to understand that the government will do the very best that it can. Obviously as a process each year we negotiate with each health service to get the best

outcomes through their SOPs and seek to get the best outcome for particular communities. We will do that again this year, and we will seek to get the very best results.

Ms HENNESSY — Noting that you clearly do not want to be held accountable for the number of elective surgery procedures that you will fund this year, the waiting lists increased by 7564 during your first budget, to 43 795. What do you anticipate waiting lists increasing to in your second budget?

Mr D. DAVIS — Ms Hennessy, I think you well understand the process with health services. Having been on a health service board, you understand that there will be negotiation with each health service at the time of budget allocation and the department will seek to get the very best deal that it can. We will seek to get the highest number of services and the best weightings of services delivered that we possibly can for the community.

Ms HENNESSY — On a point of order, Chair, I simply asked for a figure, not a lecture.

The CHAIR — Thank you for your point of order. It is not really a point of order; it is a commentary about the nature of the minister's response. I am sure the minister will take that into account when he concludes his response.

Mr D. DAVIS — I think the key point here is that there is a negotiation that occurs with each health service, and the negotiations will begin in the next short period. We will seek to conclude the negotiations as swiftly as we can with health services while at the same time driving the very best deals. It is a negotiation, and you obviously do not know the result of the negotiation until you have concluded it.

Members interjecting.

The CHAIR — Thank you, Ms Hennessy, you have had your question.

Mr ANGUS — I refer you to budget paper 3, page 31, in relation to the matter under the heading 'Sunshine Hospital'. Minister, can you please explain to the committee the history of the Sunshine ICU project and why the government has chosen to fund this project in this budget?

Mr D. DAVIS — For those who are not familiar — and I know some people in the upper house will know that I have discussed this in the upper house chamber, and indeed I think Mr Pakula actually did ask me a question on these matters in the upper house — I think it is instructive to understand the history of the Sunshine Hospital. It was a hospital constructed in the Kennett government period with a purpose-built intensive care unit. That intensive care unit was never opened over the 11 years of Labor, although Steve Bracks did do a review in 2001 which concluded that the intensive care unit should be opened. We are aware of the significant growth in demand both at Sunshine and across the western side of the city, the need to have an intensive care unit available at Sunshine proximate to the growth in the size of Sunshine Hospital and the complexity of cases that it now handles. This is why the allocation has been made this year.

The $15.1 million will support the intensive care and maternity initiatives as well. There is clearly significant growth in births through the western side of the city, and Sunshine is carrying a significant part of that load. It is important, I think, to understand also that the Auditor-General pointed to Sunshine Hospital and indicated that there was a need to respond to maternity and related matters at that hospital. The government understands that. Ms Hennessy pointed to the health plan earlier on. We understand the growth that is occurring on the western side of the city, and this is a direct recognition of that.

What I can report to the committee is that under the previous government, instead of commissioning intensive care at the Sunshine Hospital, the old purpose-built ICU unit was turned into a film studio and was rented out for film space — —

Mr PAKULA — What about the hundreds and hundreds of millions of dollars that were ploughed into — —

Members interjecting.

The CHAIR — Deputy! Calm down! Everybody just calm down and take a cold shower. Minister, I am going to give you the call, and I wish you to complete your answer.

Mr PAKULA — I wish the minister to recite facts, not government spin.

Mr D. DAVIS — Some clear facts, Chair, are that Sunshine Hospital was commissioned by the Kennett government.

Members interjecting.

The CHAIR — Can all members just calm down? Thank you, Ms Hennessy, Mr O'Brien, Deputy — everybody calm down.

Mr D. DAVIS — Chair, I understand the touchiness of the Labor members from the west side of the city.

Ms HENNESSY — Oh, for God's sake, Minister! Labor put in $180 million, and you are putting in 15.

Mr D. DAVIS — I understand the touchiness, and I understand that Ms Hennessy might be a bit embarrassed about the fact that she was on the board when they were renting it out as a film studio. It is an extraordinary thing to have done.

Members interjecting.

Mr D. DAVIS — It is true, and there is the evidence for you. That is the Film Victoria website renting out the intensive care unit. No intensive care under Labor!

Members interjecting.

The CHAIR — Order! Minister, Ms Hennessy, this is extremely undignified. Everybody just calm down. Minister, you have been asked a question, and you are giving a response. Inevitably there will be robust interjections, but there is no need for members to yell over the top of each other. Please conclude.

Mr D. DAVIS — I will contain myself, Chair, and I will make the point that it has been a long time for this intensive care unit to come. It has been a Liberal government that has delivered the intensive care unit, a Liberal government introducing the expansion in maternity services at Sunshine, a Liberal-Nationals government, I should say, delivering very important services for the people in Melbourne's west — very important services that will strengthen the capacity of Sunshine Hospital to expand into the future and have the complete suite of services that it does need in the long run.

Mr PAKULA — Minister, budget paper 3, page 23, outlines savings over the forward estimates of 32.3, 33.1, 33.9, 34.8, a cumulative total of about $134 million in the portfolio. That comes on top of $482 million worth of savings that were identified in last year's budget. So that brings the total to $616 million over two budgets. Can you just tell the committee what that $616 million worth of savings will do to hospital operating budgets?

Mr D. DAVIS — I think you had a longer year period there, Mr Pakula, and I am not sure that I necessarily accept all of your figures, but — —

Mr PAKULA — Was 482 not the number in last year's budget?

Mr D. DAVIS — You seem to be speaking about a number of figures there, but let me answer the question.

The CHAIR — Minister, could you pause for a moment? Would you like to clarify, Deputy, your reference?

Mr PAKULA — Well, 482 was identified in last year's budget over the forward estimates, and no-one will dispute that there is another 134 here, and you did not dispute 482 last year because it was in the budget papers. I can go and get BP 3 from last year if you want, but 482 plus 134 is 616, is it not?

Mr D. DAVIS — This is over the forward estimates period, as I understand it, and this year's contribution is listed as 32.3 — —

Mr PAKULA — Yes, I am talking about the forward estimates.

Mr D. DAVIS — That is what I am just pointing to in exactly the table that you have pointed to. Also in the budget, and I am not sure whether I have the page handy, but let me summarise what I recall of the page. It outlines that there will be a number of initiatives taken this year. We will be using Health Purchasing Victoria to do greater buying and more leveraged purchasing as a way of reducing costs. We believe we can strike better deals by adding to the range of services that Health Purchasing Victoria delivers. We have also — in fact it at page 27; Chair, I can direct you there:

> Additional efficiency measures in the health portfolio will be achieved through improved efficiencies and cost containment across health and aged care, including a focus on improved purchasing practices through enhanced contract management by Health Purchasing Victoria, improvements in patient flow, both within hospitals and community health services, benchmarking and reduction of administrative overhead costs.

There has been a recognition of the need to achieve reasonable outcomes, and we are certainly determined to get good value for money and to focus on protecting services.

Mr PAKULA — That is all interesting, Minister. I am interested to hear from you how you are going to find $616 million worth of savings over the forward estimates in consumables and purchasing arrangements and contracting, when, if you look at the health questionnaire that was submitted by your department, over the financial years 11–12 to 12–13, you expect to spend an extra $61 million on purchases of services intra-government, you expect to spend more money on operating supplies and consumables, almost from 2293 to 2312, and you expect to spend more money on maintenance. So in a lot of the areas which you have talked about, your own questionnaire answers say that you are going to spend more.

Where are you going to find $616 million over the forward estimates in efficiencies when you are already spending more, according to your own answers, in a number of the areas you have identified? Surely the impact will be felt in front-line services?

Mr D. DAVIS — We are confident that we can make the savings as outlined. I am confident that Health Purchasing Victoria and other key approaches will actually deliver sensible cost savings. I am also confident that by paying attention to keeping administrative overheads as low as possible we will actually achieve sensible outcomes. I do not think that the community would expect us to do any less than to focus on services rather than administrative overheads, to focus on services with smarter purchasing policies and to focus on service delivery with better purchasing mechanisms that will deliver cost reductions.

Mr O'BRIEN — I refer to budget paper 3, page 24, and I ask: can you indicate how commonwealth funding is affecting state health budgets?

Mr D. DAVIS — I will say more about commonwealth-state interactions perhaps a little later in the proceedings if I get the opportunity, but there are a number of challenges, and about $50 million in the national partnership agreement for improving hospital services, the step-down funding, will cease this year. We have had to replace that. That has been a significant challenge, and there is no question that that is a challenge that has been met as best we can. There is a recognition that in some ways these national partnership arrangements do not provide the ongoing support that is actually required to provide predictability into the future. Do you want to say anything about that, Peter Fitzgerald? No.

Mr SCOTT — Minister, I take you to budget paper 3, page 125, and the output headed, 'Acute training and development' and then the figure for total output cost from expected outcome, 2011–12, and the 2012–13 target, which I note is both lower compared to the expected outcome and the 2011–12 target, which you indicated was your preferred measure of these things — though I do find it strange that a more accurate figure is not the one you would seek to use in general. The AMA has been critical of reduction in funding for training in hospitals. Clearly from those figures there has been a reduction in the training budget for doctors, nurses and other professionals in hospitals in the upcoming budget, and it is shown that the reduction, as I said, is from 328.2 million last year to 313 million this year. Minister, how can you justify this reduction in the number of nursing training places and the lack of additional opportunities for doctors to be trained in the hospital system?

Mr D. DAVIS — I should just say first that I am informed that there is no reduction in nurse training places. The challenge to keep the training effort going is a significant one. We recognise that. There is no question that it is a tight fiscal environment. We are, however, as a government, committed to supporting that as best we can, and certainly Victoria does more than its share on the national level to support training and the placement of

both medical and nursing and indeed allied health staff in the period after they graduate. Would you like to say anything, Professor Brook?

Prof. BROOK — The graduate nurse number has come up again and again publicly and in this forum. Each year we allocate 1305, I think, places for the baseline of graduate nurse training, but in many years public health services and public hospitals ask for additional funds, which are always provided. The reason we stick with the same target is that there is a finite number of possible places within health services, and we cannot target for something that continually rises above possibility. That is the only comment I would wish to make.

Mr D. DAVIS — The other one comment that I would make is that the private sector is increasingly making a contribution to the training effort. The larger size of the private sector is a part of the picture now, and although those places may not be provided by government or government agencies, they are actually part of the picture, and we welcome the initiatives of some of the large private hospitals in particular to support training and indeed, increasingly, research.

Mr SCOTT — It is clear from your answer that you are not denying the actual reduction in the figure, though.

Mr D. DAVIS — We are determined to get the very best result in terms of outcome. I think Professor Brook has made very clear that the number of nurse training places will remain the same.

The CHAIR — Minister, I refer to BP 3, pages 123 to 125. Will you indicate what impact changes to private health insurance and the Medicare safety net will have on Victorians?

Mr D. DAVIS — I am quite concerned about the impact on the private health insurance system and the private health-care system in Victoria of the recent commonwealth changes. I have made comment about this in the Parliament. I think the Premier has also made comment about these matters. What is clear is that the removal of $2 billion from the health system at a commonwealth level and returning that to Treasury is going to have a significant impact. I think it impacts on the fairness of the system — that is, those who are making a private contribution are required by the stick, as it were, to contribute, but there was also previously the carrot, and the strong means testing of that carrot for the additional support will, I think, make people reconsider very closely the level of private health insurance they have. I think many will look at private health insurance and say, 'Can I come down to a lower plan or a plan that has less ancillary cover?' — less extras, as it were. That, I think, will have an impact in Victoria — less people with dental cover and less people with allied health cover. Less people with higher hospital tables can only impact on the public system, and every bit of movement back from the private system to the public system adds to the pressure, adds to the demand and makes it harder. So I think this has been a retrograde step.

There is no indication from the commonwealth government that the overwhelming bulk of that money will be returned to health. I think there are two debates in a sense. One is whether the money is best deployed as a subsidy into private health, and the other is could it be deployed somewhere, in a sense, better than that. The second debate is always a legitimate debate in the health portfolio, as to which priority you put on different things, but in this case the $2 billion has been taken from health and has gone elsewhere. That is my concern. I think there is a significant risk that there will be some fall back into the public system, and that that will put additional pressure on our public system. In a sense those decisions of the commonwealth are likely to have a negative impact on the Victorian system.

Ms HENNESSY — Minister, if I could just take you to budget paper 3, page 28. You inherited a completed Royal Children's Hospital project, and we thought that you — your government — had matched our proposal to redevelop the Monash Children's hospital, and yet you failed to provide any funding to see it completed by 2014, which is what our promise was. I note that you have only allocated 7.3 million in the forward estimates, identified at page 28 of BP 3. My concern is that it kind of tells the community that you are not really serious about the project. What commitment are you prepared to make and what promise are you prepared to make about when families in the south-east will have their children's hospital open?

Mr D. DAVIS — I think, Chair, there are essentially two parts to that question. The first part relates to the Royal Children's, and I might deal with that first.

Mr PAKULA — There was no question about the Royal Children's.

Mr D. DAVIS — Well, let me be quite clear — —

Mr ANGUS — You brought it up.

Ms HENNESSY — When will the children's hospital in the south-east be opened?

The CHAIR — Thank you, Ms Hennessy, you have asked your question. The minister will respond.

Mr D. DAVIS — We did not inherit a completed children's hospital. Significant construction still had to be undertaken. Decisions had to be made about aspects of that construction, which fell to the department and myself, and indeed the hospital is now completed, but it was not completed when we came to government. I note the failure of the previous government to provide ICT support into the hospital — a $24 million black hole, which you did not fund. I think it is very important to get that on the record.

Members interjecting.

The CHAIR — Thank you, Minister. Would you continue?

Mr D. DAVIS — If I can deal with that preliminary point, the essence of Ms Hennessy's question is about the Monash Children's, and that is a hospital to which the government is very, very committed. We are determined to get the best outcome for children in Melbourne's south-eastern suburbs, and indeed in last year's budget an allocation was made for initial planning money and also money that would purchase three blocks of land adjacent to the Monash Medical Centre. Indeed I think I tried to explain this to the committee last year. That money has indeed purchased those three blocks of land. They have been compulsorily acquired. The tenants there — medical practitioners — are on very short-term leases, so we have now taken the very concrete step with the money last year of acquiring land for the building of the children's hospital at Monash.

The money this year, the $7.3 million, is for further progression of the planning to bring it to the stage where the project can go forward. I can make it very clear to the committee that the government is extremely committed to the Monash Children's — the allocation in our first budget of initial planning money and money to purchase that land to secure the land that will build the best configuration; the additional money this year, the 7.3, to progress the planning further, is an important step; and we will be moving as fast as we can through this year on further steps. We intend to stick with our election commitments, and we will deliver for the people of the south-east.

Ms HENNESSY — So, Minister, will the new Monash Children's hospital be open by November 2014?

Mr D. DAVIS — I have got to be very clear on this, Ms Hennessy. I have laid out the sequence for you directly, and we are moving as fast as we can to get — —

Members interjecting.

Mr D. DAVIS — There was a backlog or a failure to plan for this, Ms Hennessy.

Members interjecting.

The CHAIR — Mr O'Brien, Mr Angus, Ms Hennessy! Thank you, Minister; proceed.

Mr D. DAVIS — Chair, when coming to government there was an inability to pick up any solid planning that would have enabled us to move immediately ahead.

Ms HENNESSY — This was your promise, Minister. Will the hospital be open by November 2014?

Mr D. DAVIS — Chair, an important point here — —

The CHAIR — Mr O'Brien, Ms Hennessy, thank you.

Mr D. DAVIS — An important point here is that over 11 years Labor failed to build this hospital. We are moving — —

Members interjecting.

The CHAIR — Mr O'Brien, Ms Hennessy, everybody calm down and you will get the answer from the minister. I am going to give the minister the call to respond to your question, Ms Hennessy, if you will allow him to.

Mr PAKULA — If only he would. He won't.

Mr D. DAVIS — Thank you, Chair. What I will do is be very clear on this. The government will stick with its election commitments. We are moving swiftly to secure land to do the planning and the preparation work to progress this project as fast as possible, and we will meet our election commitments.

Ms HENNESSY — So it will be open by November 2014?

Mr MORRIS — It seems to me, Mr Chairman, that like so many Labor projects, there was no proper planning done in the first place.

Members interjecting.

The CHAIR — Thank you, everyone. Mr Morris, please.

Mr MORRIS — Can I refer the minister to budget paper 3, page 121, 'Acute health services', and indeed the minister referred in part to this matter in his response to the Chair's first question, but could I ask the minister to expand on the way the government monitors quality and safety within the health system?

Mr D. DAVIS — A key point here is the government's preparedness to expand the monitoring on health and safety outcomes, on clinical outcomes, in the budget process. One of the key additions this year has been the addition of hand hygiene monitoring. We want to make sure that compliance is at 70 per cent. I welcome the comments by the college of surgeons the other day supporting stronger regimes for the implementation of hand hygiene in our hospitals. I know there is a good deal of data about the importance of hand hygiene. There is a good deal of information about the need to ensure compliance with hand washing regimes.

This is again one of those areas where by better practice, better clinical outcomes can be achieved — better outcomes in terms of the costs, because infections are avoided. Infections not transmitted in hospitals relate not just to better clinical outcomes, and again I think it is important to just draw the committee's attention to the set of measures that have been successively added over the last two years, on page 122. The intensive care unit central line associated bloodstream infections per 1000 device days is a new measure. The staphylococcus aureus bacteraemias infections per 10 000 days, new measures added; unplanned and unexpected readmissions for hip replacement per 1000 separations; unplanned, unexpected readmissions for acute myocardial infarction per 1000 separations; unplanned, unexpected readmission for heart failure per 1000 separations — again the addition of new measures; the same readmission matrix for knee replacements and for paediatric tonsillectomies and adenoidectomies. These are important additions to the quality measures suite, and the focus I think at health service level has got to increasingly turn to these quality measures.

Better outcomes clinically, cheaper outcomes, because people either do not come back to hospital or infections are avoided, or complications of operations are avoided through those measures. Some of our best hospitals are increasingly using a dashboard approach where they are reporting data of this type daily, in some cases, and certainly weekly, with the recognition that teams of people in theatres and teams of people on wards can take responsibility as a group for improving the clinical results through better focus on quality and safety. This is about the measurement of those quality and safety outcomes and then ultimately the reporting. I think this is a major step forward, and a preparedness to focus on this I think can deliver long-term outcomes for the community.

Mr PAKULA — Going back to your election commitments, Minister, in the last campaign there were a number of commitments by the previous government to rebuild particular hospitals, which the coalition matched, but you also had in your pre-election costing document a very discrete line item, which was for 800 additional hospital beds. Looking at the budget papers now, particularly budget paper 3, it appears that there is no discrete line item for the 800 additional hospital beds. In fact what appears to be the case is that the 800 bed commitment is being absorbed into the redevelopment proposals that were previously exclusive of the 800-bed undertaking. Is that the case? Are the 800 beds now just absorbed into other redevelopment proposals,

or are you going to keep your promise to have 800 extra hospital beds, separate from those particular redevelopment propositions?

Mr D. DAVIS — Chair, I think the deputy is trying to redefine our commitment — —

Mr PAKULA — No, I am not.

Mr D. DAVIS — But it was for 800 beds, and we are working steadily towards the 800 beds. Money was allocated in last year's budget and is in the base in this year's budget to move forward with our bed commitments.

Mr PAKULA — In the base, embedded.

Mr D. DAVIS — Also I make the point that the government is getting on with the task of building capacity through the system, and we are doing that very steadily, whether it be the commitments for two beds at Ballan — that is two public hospital beds that we talked about before — or whether it be the commitment for major rebuilds at Box Hill Hospital or Bendigo or the commitments at Frankston, Maroondah. I can go on; these are all important commitments to deliver capacity into the system. In addition we are certainly very focused on getting the best outcome for the community in terms of additional beds. We recognise the importance of the capacity issues in the system and are working hard to deliver on that.

Mr PAKULA — Well, Minister, your suggestion that I have redefined your commitment I will take as you conceding that the 800 is incorporated in the various redevelopment proposals, unless you want to suggest otherwise, but in last year's — —

Mr D. DAVIS — I am not having it defined by you, but that is — —

Mr PAKULA — Well, you can answer it when I am done. The other thing that you said in last year's budget and in these estimates hearings was that in the current financial year you would implement the first 100 beds of those 800. Could you take the committee through where those 100 beds are?

Mr D. DAVIS — Chair, the commitment was to 30 June, and the coalition is on track to deliver that commitment.

Mr PAKULA — Well, take us through what you have done so far.

Mr D. DAVIS — We are on track to deliver that commitment.

The CHAIR — Deputy, you have concluded your answer. Mr Angus.

Mr PAKULA — Would you take it on notice?

Mr D. DAVIS — We are on track to deliver that commitment.

Mr PAKULA — Tell us where they are. These are phantom beds. Where are these 100 beds?

The CHAIR — Mr Angus.

Mr PAKULA — The Victorian community is entitled to know where the 100 beds are, not — —

The CHAIR — Deputy, you do not have the call.

Members interjecting.

The CHAIR — Mr Angus has the call.

Mr PAKULA — What a joke!

The CHAIR — I will ask Mr Angus — —

Mr PAKULA — Stop covering up for him.

The CHAIR — I will ask Mr Angus to direct his question to the minister.

Mr ANGUS — Minister, I refer to budget paper 3, page 24. Can you please detail patient experience through the health system in Victoria and general impressions patients have?

Mr D. DAVIS — Thank you, member. What I would say is that the government is — —

Mr PAKULA — Point of order, Chair. Can Mr Angus please outline how his question relates to the budget papers?

Mr ANGUS — Mr Chairman, in relation to the hospital performance indicators, as — —

Mr D. DAVIS — Page 121, 'Consumer participation — —

Mr PAKULA — How do you know? Did you write it?

Mr D. DAVIS — No, I just know what is in the budget paper.

Members interjecting.

Mr ANGUS — It is also contained in more detail on that other page.

Mr D. DAVIS — Again, a new measure in the budget papers measuring consumer participation and consumer enthusiasm for the experiences that they have. The government is prepared to measure performance in this area, and I can indicate that the patient satisfaction monitor is an important document that provides a good outcome in the last financial year. The July 2010 to June 2011 patient satisfaction monitor indicates a modest but statistically significant increase, from 79.06 to 79.76, in the overall positive patient satisfaction reported. I am happy to make available to the committee a copy, if that is of value.

Mr PAKULA — You won't tell us where the beds are.

Ms HENNESSY — We would just like to know where the hospital beds are, Minister.

Mr D. DAVIS — This is about outcomes; this is about results for patients — —

Mr SCOTT — Yes, how about a bed outcome?

Mr D. DAVIS — It is an important measurement of the satisfaction of consumers. Across the system the satisfaction has lifted over the recent period, and I think that that is a clear recognition of the good work that staff and health services are doing. It is a clear recognition of the focus that the government has on getting good outcomes for communities.

The CHAIR — Just table that, thank you.

Mr SCOTT — I would like to return to the issue of the 800 beds, which the minister appears to be unwilling to give specific answers to. I refer you to last year's transcript, where you indicated that in 2011–12 $112 million dollars was allocated to acute hospitals that would cover off your bed promise. How has this money been acquitted in that task?

Mr D. DAVIS — As you will understand, the money is put to health services. Health services work to deliver services for the community, and that requires bed-based services. It also requires other services for them to deliver but particularly bed-based services, and as I have said we are well on track —

Mr SCOTT — How about where the beds are?

Mr D. DAVIS — to deliver the 100 beds by the end of 30 June.

Mr PAKULA — Except no-one can find them. No-one will know where they are. No-one can find the beds. How many of them are at your place?

The CHAIR — Deputy, will you allow Mr Scott to ask a follow-up question, if he so desires?

Mr SCOTT — I do so desire. I understand your Treasurer recently said that the 100 beds will be identified in the Australian Institute of Health and Welfare report in June. Is that true?

Mr D. DAVIS — The average available bed days is reported by the institute of health and welfare, and the last financial year's figures — —

Mr SCOTT — Actual beds?

Mr D. DAVIS — No, they are actual beds, Mr Scott. I think you need to understand that this is the most effective measure of bed availability in the state and at a national level, so we have a national body that is reporting on bed numbers, and they indicate that we are on track to reach our targets.

Mr O'BRIEN — Minister, I thank you for the commitments to 56 additional beds in Geelong and 60 in Ballarat in my region as well. I would like to take you to the departmental objectives and outputs in budget paper 3, page 118. I will refer to the financial capacity of health services and the government's objective of improved health service performance, as detailed on page 118 of budget paper 3. I ask you, Minister: could you please detail for the committee the history of collateralised debt obligations as they relate to Victorian health services?

Ms HENNESSY — You ran this out last year, David.

Mr D. DAVIS — As the member — and I think the committee — will understand, this was a matter of discussion last year at this committee, and I can report some updates on where the collateralised debt obligations are. Obviously what occurred is that a number of health services went out and purchased CDOs. I think in retrospect everyone would concede that was unwise for public health services to be purchasing. New guidelines were introduced — indeed under my predecessor at the very end period, but it is also true to say that my predecessor presided over the purchase of some of those collateralised debt obligations. Certainly the — —

Mr PAKULA — We will remember to hold you responsible for everything that every health services does.

Members interjecting.

Mr D. DAVIS — I am trying to be very reasonable here, Chair, and indicate that when health services go out and buy CDOs in the interests of chasing a higher dividend and put $5 million or $10 million or $15 million into a CDO and later, during the GFC, when the CDO drops to being if not worthless very close to worthless, that is a matter of concern I think, for the community, where tens of millions of dollars may be lost through a poor investment process.

I welcome the guidelines, and I have certainly encouraged health services to abide by the new guidelines. I note that in a number of cases these issues have moved forward. I think there was just a moment of hope in the period before things tightened a bit again that some of the CDOs might have, as it were, come good. The auditor in his review did not indicate that they were likely to come good — in a sense he wrote them off — but I think many people may have almost hoped against hope that the CDOs would come good.

In the latter part of last year, people will understand, the financial position internationally tightened, and that became a significant point. That impacted on those who were carrying these CDOs and other exotic financial instruments that might have been purchased at one point. I know that groups like Ballarat Health had some, and others — Western Health was one that had some. I know there was some discussion last year about Western Health. It put working capital reserves with Grange Securities; $6 million placed in December 2006 and 2 million in May 2007.

Ms HENNESSY — Was there a dollar lost?

Mr D. DAVIS — Let me just explain here. Northern Health also had money invested with Grange Securities. Both health services — northern and western — instigated legal proceedings with Grange Securities. Western Health has advised they had reached a commercial-in-confidence settlement with the investor company, and I am not at liberty to provide detail of that, but I know that — —

Ms HENNESSY — And the budget papers would show that there was not a loss, Minister, if you were capable of reading them.

Mr D. DAVIS — I have got to say what this shows is a sorry tale of poor investments and insecure — —

Mr PAKULA — Do you know the detail of the commercial in confidence?

Mr D. DAVIS — No, I do not.

Mr PAKULA — You do not know the detail of the settlement?

Mr D. DAVIS — I do not know the full detail, because it is commercial in confidence.

Mr PAKULA — You, as minister, do not know? Are you having us on?

Members interjecting.

The CHAIR — Thank you, Minister; please proceed.

Mr D. DAVIS — What I can say is I think this sorry tale shows very clearly that the important thing is the investment guidelines. The important thing is to make sure that we do not in future have health services investing. We cannot unwind the past easily, but we can make sure that health services do not make unwise investments in the future.

Mr PAKULA — You are a pea-and-thimble artist.

The CHAIR — Thank you, Deputy. I do not think we need those sorts of pejorative remarks during this proceeding.

Ms HENNESSY — I do not know; I think he has a point.

The CHAIR — Ms Hennessy, you are very keen to ask questions —

Ms HENNESSY — I am!

The CHAIR — and here is an opportunity for you.

Ms HENNESSY — Thank you. I wish the minister was as keen to give us an answer today. Minister, I take you to budget paper 3 at page 51. That includes the DPC output 'refugee support program'. You would be aware of the whole-of-government refugee support strategy that was funded in the 2008–2009 budget. There was 17.7 million over four years as opposed to the paltry 5.2 million in this year's budget. Minister, on Friday the Premier indicated before this committee that he was very confident that resources were being provided to refugee support programs. Could you please outline in the budget papers where we can find the missing 12.5 million to continue those programs?

Mr D. DAVIS — As I understand it, it is a recurrent expenditure incorporated in the base in the budget.

Ms HENNESSY — So did the Premier mislead this committee when he advised us that there was other funding to enable those refugee health nurses component programs to continue?

Mr D. DAVIS — I am sure he did not.

The CHAIR — I am sure.

Ms HENNESSY — Very Bill Shorten of you.

The CHAIR — That is an awkward question for the minister to respond to because he was not here at the hearing, so he does not know exactly what it is you are asserting.

Ms HENNESSY — Well, it is $12.5 million.

The CHAIR — So, would you like to rephrase?

Ms HENNESSY — No, no. I am happy to be assured that somewhere in the budget papers within the health portfolio the missing $12.5 million may be found.

The CHAIR — Thank you, Ms Hennessy. Minister, I refer to BP 3, pages 126 through 128. Will you advise the committee on the government's efforts to improve bypass and hospital early warning system data accessibility?

Mr D. DAVIS — Yes, I can, and I can indicate that one of the government's election commitments was that data would be made available; that this data, particularly HEWS data that had previously been kept secret would be made available. That is now routinely available.

Members interjecting.

Mr D. DAVIS — Well it was. It was kept secret. It was never released. But now indeed you can actually go online and see the status of each of our major emergency departments. You can see whether the Alfred or the Austin or Ballarat Health or Western Health is on bypass in real time. You can actually see now whether the hospital emergency department is on bypass or on HEWS. There has been a significant reduction in the amount of bypass and a reduction in the amount of HEWS. There is a good outcome being achieved for the community. I know in June 2011 the government launched its performance website, and the HEWS and bypass data is on that website. We are certainly meeting the targets in this respect, coming down from higher levels to lower levels of bypass and lower levels of HEWS as well. The outcomes, I think, are very good.

The government has got additional capacity that will help with EDs in the budget this year, the 145.3 million, which will equate to 603.5 million over four years, to expand acute hospital-based services, and that will include the treatment of more ED patients. That will help with the reduction of ED overcrowding, promote patient flow and improve patient service. There is obviously an important need for patients to be able to see whether a hospital is on bypass and whether the time they are likely to wait is great. This is also something that, as I say, we were very committed to in opposition, and we see that as a very good outcome for the community.

Mr PAKULA — Minister, budget paper 3, page 22, has a funding allocation for the Victorian Cancer Agency of $14.9 million per annum over the next four years, but, as was outlined during the hearing with the Premier and not disputed by the Premier, that is actually $19 million less than the previous four-year allocation. When the Premier was asked about that he said the additional money, the $19 million, had been absorbed in the base. Can you confirm that that additional $19 million has been absorbed in the base?

Mr D. DAVIS — What I can say is the government is very committed to — —

Mr PAKULA — No, no, no. You can answer the question.

The CHAIR — The minister is entitled to actually give a response before you interrupt him.

Mr D. DAVIS — I can indicate that the government is very committed to cancer services. If we go back to the initial slide that outlined a number of key initiatives from the VCCC, the cancer agency and a number of other aspects, the action plan is supported. The health priorities framework points to a focus here. We are focused also on prevention efforts and significant steps in the prevention space as well. I am particularly pleased to indicate that the cancer agency will be funded, and the funding will build on things that have occurred in the past. But the cancer agency undertakes very important collaborative translational research — it focuses on major tumour streams — and for the first time this will be built into the ongoing forward estimates. It will be built into the future. It will be indexed in the out years. It will be a long-term commitment rather than the short-term commitments that had been there in the past. Those commitments are long-term commitments, building into the base, into the future.

The development of an integrated cancer research platform that builds on and links Victoria's existing research infrastructure platforms to support cancer research growth is absolutely critical. The cancer agency will build and develop a highly skilled cancer research workforce and attract and retain nationally and internationally renowned clinicians and researchers. It will improve research collaboration and integration across the Victorian cancer system, including driving efficiencies for Victorian cancer centres of excellence, both metropolitan and rural, and their associated partnerships. It will also build closer partnerships with industry and private and charitable sectors to maximise benefits from investment by all parties. The allocation of recurrent funding will provide ongoing certainty and predictability to enable the cancer agency to undertake long-term strategic planning in translational cancer research. It is very significant.

Victoria does well in terms of our competition for national funds through the NHMRC. We do a bit less well when it comes to the ARC, but we do extremely well because we have that strong biomedical research focus in Victoria. I know that is important, and successive Victorian governments have provided funding — indeed since 1997 under the government that you and I were part of, Chair, and, to give credit to the last government, it did fund a number of key cancer projects. I indicate that this is a matter that I think does go beyond party politics. I am particularly proud of the funding now being incorporated into the ongoing stream so that the cancer agency will not be in the position of being forced to, as it were, beg for funds into the future. It will be in a much more secure position. That will enable, as I say, that predictability and long-term planning, which will deliver not just better research outcomes but more cost-effective research outcomes.

I can indicate that there is strong support from the consortium at VCCC, and also a number of the key medical research institutes around the state — whether it is the WEHI or others — are very supportive of the fact that we now have the cancer agency in a more secure, long-term position.

Mr PAKULA — That was a very, very long answer, Minister. You talk about the permanent funding. You funded it for four years, exactly the same as the last funding, which was for four years, the difference being the last funding was $19 million higher than for the four years you funded it for. I think it is also notable that you will not support what the Premier said. The Premier also suggested to the committee that there will be a new cancer action plan funded out of the general health appropriation. Is that right? That will be funded out of the base?

Mr D. DAVIS — Yes. That is right. Further, I think I should just make it very clear to you that it is actually different funding than was provided in the past. It is not a four-year funding cycle with a stop at a certain point and dropping to zero. That is guaranteed funding into the future, and that is very different and a very important distinction to understand, giving the security and long-term predictability for the agency and its planning.

Mr PAKULA — Where does it say that?

Mr D. DAVIS — I am telling you that is the decision.

Mr PAKULA — You are telling us that is what you will do?

Members interjecting.

Mr MORRIS — I will go back to the page we were addressing, page 22 of budget paper 3, but focus on a slightly different subject. I want to refer to organ retrieval and transplantation. You made some comments earlier in response to a question from Mr Scott, but I wonder whether you could indicate to the committee the steps the government is taking to increase the rate of organ donation and transplantation.

Mr D. DAVIS — I thank you for the question and indicate that, as with many of these things, these are now national arrangements that we work on in collaboration with other states and the commonwealth. Victoria carries a particularly significant load because we have a number of national centres here. Those national centres perform work for not just Victoria but Tasmania and South Australia. We are very aware of the need to support those centres. The Alfred, the Austin, the Melbourne and the Children's play critical roles in these areas. I am particularly pleased with the additional contribution of 20.7 million over the next four years in the budget to boost the number of transplants funded in hospital. That is in response to a significant increase in the number of donor organs.

Victoria, as I indicated before, has done particularly well on a national level, and I think that has been recognised by colleagues interstate. There were obviously a series of reforms in 2010, and the donor rate lifted from there and is, I think, lifting further from that. We need to capitalise on the community interest and generosity; there is, I think, a big reservoir of generosity. That is why the coalition is particularly pleased with the 20.7 million in additional funding for organ donation that has been provided in this budget.

Mr SCOTT — I would like to return to the issue of elective surgery and the fact that you waited four months to submit what I think was an implementation plan to acquit the national partnership agreement from December to April. The delay in its submission to the commonwealth caused a delay in the receipt of I think 146.5 million, that funding being contingent on the achievement of various targets. Is that 146.5 million factored into the 2011–12 figures or the 2012–13 figures for the budget?

Mr D. DAVIS — I stand to be corrected on this, but I understand it will be in this year's funding? That is correct. We are not in any way unconfident of finding that money coming through. As I understand it — and Peter Fitzgerald might want to say something on this — there is no particular concern, and we will indeed receive that funding for Victorian patients.

The CHAIR — Minister, is that the 11–12 year? You said 'this year's'.

Mr D. DAVIS — It is.

The CHAIR — The 11–12 year?

Mr D. DAVIS — Yes.

Mr SCOTT — That is where I was seeking clarification. So it is in the 11–12 budget?

Mr D. DAVIS — That is my understanding.

Mr FITZGERALD — The implementation plan was submitted just in the last month or two. There was no deadline for that during the year. The agreement was only signed in August last year. There is a teleconference tomorrow to talk about some of the detail. There is a list of questions that are readily addressable, bar one or two. So we are confident that all or a very high substantial proportion of the number you have mentioned will be flowing during 11–12.

Mr SCOTT — Sorry, just to clarify this so it is simple — people nodded, but just for the transcript — that funding is budgeted for the 2011–12 budget in how it is being treated in this process?

Ms HENNESSY — Not carried over?

Mr SCOTT — It is not carried over? Is that a 'Yes', because you are just nodding?

Mr D. DAVIS — Yes.

The CHAIR — Thank you. The answer is yes.

Mr SCOTT — I just wanted it in Hansard.

Mr ANGUS — Minister, I refer you to budget paper 3, page 23, table 1.7, 'Output initiatives'. Minister, can you please explain how the government is improving health ICT?

Mr D. DAVIS — Chair, I am very pleased to report to the committee a focus on funding for innovation, e-health and communications and also additional funding for the National E-Health Transition Authority. Again this is probably one of the more effective national bodies of this type, that I alluded to earlier. I think it is important to understand the background to this. The HealthSMART program finishes on 30 June 2012. The government, as I say, has announced these two additional funding streams, the 100 million over four years to progress innovation and e-health initiatives. Public health services will be invited to submit proposals. Priority areas of expenditure for this fund need to be identified. There will be specific innovation projects. Particularly the department is interested in — and I am interested in — seeing a greater expansion of telehealth.

It is important to understand the background of the ICT issues in government. I know the committee will be aware of the HealthSMART history going back to 2003, the allocation of funding, the blow-outs in the streams of cost and the Auditor-General's report in the mid-2000s, which pointed to a series of significant problems with the program. The previous government ploughed on with this program, and in fact much of it is still to be delivered. It is many tens of millions of dollars over budget and very much under-delivered. The Ombudsman, as I am sure the committee is also aware, reported late last year, laying out some issues and principles concerning this.

I think it is important to note that there are costs which will be incorporated in the current budget going forward due to HealthSMART. I probably do not need to go back over the details of those, which were in the initial presentation. There is an ongoing cost that will be sheeted home to health services. On the one hand you might argue that this is part of doing business these days and that health services, like other entities, need to undertake

or have in place proper ICT programs, and I think that is a legitimate point. The question is whether this is the best program and whether they have had their hands bound on this. The clinical system is the only HealthSMART program with outstanding tasks. There is no further funding required, but the program, importantly, is incomplete from the initial aims in 2003, despite being many, many millions of dollars over budget.

We are focused on innovation and targeted support to help health services make decisions that will deliver better clinical outcomes but potentially also better cost outcomes as well. I think that is an area where you can make targeted investments, but I do not think there is going to be a sort of whole-of-government, whole-of-department approach into the future.

On the National E-Health Transition Authority, it has done good work on laying down standards and laying down arrangements that will help states and health services, public and private, make decisions about the protocols and standards that are used for health ICT into the future. What we want is interoperability; we do not want, as it were, a rail gauge problem. We want to make sure that we get a good outcome nationally. For the committee's benefit, NEHTA is a company that is owned by the states and, I think, the commonwealth as equal partners. It is an entity that has pushed forward to set those national standards and arrangements and to do that in a way that is to the benefit of all states and the particular health services as well.

Ms HENNESSY — Minister, if I could just take you to budget paper 3, page 141, and the public health outputs, you would know that since 2009 the Victorian government has funded free vaccinations for parents and carers of newborns in an effort to protect newborns from the current whooping cough epidemic. Indeed last year you announced an extension of that vaccine until 30 June 2012. Last week there were 1655 notifications to your department of whooping cough for the year. Can you just confirm for the committee if the public health outputs include the funding of the extension of that program to protect families, in particular newborns, from whooping cough?

Mr D. DAVIS — I will get Professor Brook to perhaps fill in some of the clinical details in a moment, but I can inform the committee that, as you indicated, pertussis, or whooping cough, is a significant condition. We have been very focused on trying to get a good result in terms of levels of vaccination for children, and that has been our primary focus. You are correct that last year we extended the program to fund for the parents of newborns. That was in the absence of commonwealth support; we did that as a state-alone initiative.

I think there have been some developments since that point. Some new evidence has come forward. We did that in the light of the best evidence we had available at that time. I will let Professor Brook step through the clinical matters here, but in short my understanding is that new information is available which does not support ongoing funding for the parental vaccination.

Prof. BROOK — The state decided some three years ago that it would, in consultation with other jurisdictions, initiate what has been called a 'cocoon' strategy. Since children are not born with natural immunity to pertussis and they cannot really be vaccinated until about the third month of life, it is important if there is a pertussis epidemic, or mini epidemic, to try and protect them. The outbreak of the disease can occur because pertussis is not a lifelong vaccination, so it can get into the adult herd and then be transmitted to children. So that can be dangerous — —

Ms HENNESSY — Do you mean parents by 'herd'?

Prof. BROOK — The term 'herd' is an epidemiological one. It implies the population.

Ms HENNESSY — You are talking to humble politicians.

Prof. BROOK — Yes, but parents in this particular instance, or grandparents. The idea was to try and vaccinate the parents and encourage others who may be associated with an infant to obtain vaccination. That was done in good faith based on limited evidence at the time and has been continued in most jurisdictions, I think bar one, to this year.

During the course of the last 12 months, two separate manufacturers have put in fairly complex submissions to the ultimate arbiter of these things, which is the Pharmaceutical Benefits Advisory Committee. So it is not a matter of chief health officers or bureaucrats of any sort, whether professional or not, putting information

forward; this is complex, technical information put forward by manufacturers. On both occasions the Pharmaceutical Benefits Advisory Committee, which is totally independent and very expert, has determined that there is no clinical effectiveness of this strategy, and therefore the commonwealth, having previously declined to contemplate any support for the vaccine, has firmly determined that it will not.

But that changes the dynamic in so far as each of the jurisdictions is concerned, because obviously if we are told something is ineffective, then it becomes a moot point — and still not a moot point, it becomes clear that it is not something that should be supported when indeed there may be better ways to spend the money concerned. So all jurisdictions who have been in this program will be effectively ceasing the cocoon strategy as of the end of June this year. One jurisdiction — and I am sorry, I do not have which one before me — has already done so without ill effect.

I should also point out that the actual rate of disease has declined significantly. It is about half what it was in the 12 month prior period, although there is still some ongoing activity in New South Wales compared with Victoria.

Ms HENNESSY — I mean no disrespect to Professor Brook, but, Minister, given that whooping cough can kill babies, are you not taking a massive gamble?

Mr D. DAVIS — If I can perhaps, Chair, just say to the member and the committee that I make decisions of this type on the basis of the evidence that is put to me by department and clinical experts. There has been a national committee meet to look at this and to make decisions on the basis of the best scientific evidence available. I am not a clinician, and with the greatest respect I think none of us are as members of Parliament. So we can I think best rely on the scientific evidence that is brought forward to the committee and the decisions of the Pharmaceutical Benefits Advisory Committee and the advice from those who have clinical knowledge and research knowledge in the department.

The evidence is that the strategy has not been effective. As I understand it, all jurisdictions have been made aware of the decisions of the Pharmaceutical Benefits Advisory Committee — —

Ms HENNESSY — Not all have cut their whooping cough vaccinations for parents and carers.

Mr D. DAVIS — I think it is on the basis of the evidence that is available — —

The CHAIR — The minister I think is completing his answer, so I will let that proceed.

Mr D. DAVIS — Yes. I am trying to be helpful and direct to assist what is a significant set of decisions, but I think decisions that can only be made on the scientific evidence that is presented to ministers or to government by experienced clinicians and researchers.

Mr O'BRIEN — Minister, I refer you to budget paper 4, page 29, under 'Department of Health — new projects' and the first item there, Ballarat hospital, and I ask: how is the Baillieu government delivering on its health election commitments to the people of Ballarat in this budget, and what steps is the government taking to build the helipad at Ballarat base hospital — I might add, after 11 years of Labor inaction?

Members interjecting

Mr D. DAVIS — Chair, I am very pleased to inform the committee that we have made significant progress on the Ballarat hospital project. There has been an implementation working group chaired by upper house member David Koch with the support of Ambulance Victoria, the support of Ballarat Health and the support of departmental staff and others. The working party looked at options for Ballarat Health with the helipad — sites and locations and where to get the best results for the community in Ballarat.

I have to add this has been a very long-term project, a project that people in Ballarat have been advocating for for many years. Indeed I remember in the chamber in 2004 when Mr Koch, who has been a very long-term advocate for the helipad, moved a motion to support a helipad in Ballarat. Certainly the coalition supported that motion, and that commitment to a helipad in Ballarat has never wavered from that day. That is why it is particularly pleasing to see this being delivered at this point, and being delivered in a way that will get advanced capacity at Ballarat Health.

As I say, the helipad implementation working group did excellent work. I think the Premier might have referred to some of the strong comments made by local activists about the achievement of this funding for the helipad. It is very significant. It is 46.363 million. It will see additional beds, an ambulatory care centre, which I think will make a significant difference for Ballarat Health in the flow of patients and their ability to service the community. Remember that Ballarat is not just about the Ballarat town; it is about the whole district and the support that is brought in from that district. It currently operates 120 medical and surgical beds, 8 short-stay, 12 intensive care, a coronary care unit, the 48 maternity and paediatric beds and also the special care nursery, and this will build on that capacity for Ballarat Health. It will provide safer and faster transfer of patients in and out of the hospital. In general I think patients who experience multiple trauma in the Ballarat area are taken to Ballarat hospital and stabilised. The presence of a helipad will enable the trauma system to operate with transfer to the Melbourne or to the Alfred for trauma services at that point.

I think this is a magnificent outcome. The community can be proud of it. The community input into the helipad implementation group has also been very significant, and I pay tribute to the work of those long-term community activists who kept the candle burning. They have had coalition support all of the way, and now this important commitment is being delivered for Ballarat and region.

Mr PAKULA — Minister, I ask you to turn to page 349 of budget paper 3. These are the performance measures that the department is recommending to this committee be discontinued. Under 'Emergency services' there are three performance measures which you are seeking to discontinue: 'emergency category 2 treated in 10 minutes', for which you actually hit the target for 11–12; 'emergency category 3 treated in 30 minutes', for which your target was 75 and you are expecting to hit 69; and 'non-admitted emergency patients with a length of stay of less than 4 hours', for which your target was 80 and you were only expecting to hit 71. Can I ask why you are discontinuing those measures and, in particular in regard to the first two, why would you remove a measure which gives you a time constraint, which is 'treated in 10 minutes', and replace it with a measure that just says 'emergency department patients treated within time'. Equally on the next one, 'emergency category 3 treated in 30 minutes' is going to be replaced with 'emergency department patients treated within time'?

Mr D. DAVIS — We did actually cover this before. If you remember, you asked the same question.

Mr PAKULA — No.

Mr D. DAVIS — No, you did on the end of another question.

Mr PAKULA — I never dealt with these ones. I did not deal with these ones.

Mr D. DAVIS — I am very happy to go through it again at length.

The CHAIR — Thank you, Minister. We have some time.

Mr D. DAVIS — You can check the transcript, and I think you will agree with me when you have read it.

Mr PAKULA — No, I will not, but go on.

Mr D. DAVIS — Let me be clear here. What has occurred here is there is now a set of national arrangements that have been put in place. These are agreed across all governments, and these new measures directly reflect the national arrangements. We went a little bit further than just accepting the national arrangements. People who know me will know that I am always thoughtful about simply accepting national arrangements, but I do not want to be silly or bloody-minded about these things. I want to see the best outcomes and the best mechanisms put in place, so the department at my request also convened a panel of emergency department experts to look at this and to look at whether there was any material reason why we would maintain those measures into the future in addition to the national measures that we are required to report on.

They concluded that the best thing to do was to maintain the category 1 reporting, because they are the most acute. That is not required, but we are maintaining that as an additional reporting. But we would in the sense report under the national arrangements into the future. We have joined with other jurisdictions and the commonwealth, and a set of arrangements have been put in place. We have checked with our own ED physicians through a panel process to work through what is the best way forward for us. I do not want to burden hardworking doctors and nurses with, as it were, double reporting. I want to make sure that we get fair measures

that are nationally consistent to enable reasonable comparability, but where there is a material point that the ED physicians thought was important, we have retained it. It has been a careful process — mixing with the national arrangements, consulting the very best experts in the area here in Victoria and coming up with an outcome that we think is fair.

If I can perhaps point for the committee to the broader problem that this brings up — that is, the issue of data reporting, which we need to be quite careful about in the sense of building further and perhaps unhelpful layers in some cases that require effort and cost and burden on our health services.

Members interjecting.

Mr D. DAVIS — I am actually trying to be very fair here and indicate that we are required to report under the national system, and we will do so. We need to make sure that our EDs are not unfairly burdened. We have had clinicians look at this, and I think this is a very fair outcome that we have achieved. If I can perhaps say something about this data burden that is a general problem. This is a classic example of where there is reporting of very similar items in a way that may require duplication. Peter, if you want to just say something. We have a data project. New South Wales and Victoria are working with the national health ministers to try to get a sensible rationalisation of data reporting.

Mr FITZGERALD — Just a few comments, Chair. The issue of indicators and the national consolidation of indicators has resulted in a concern that there is duplication between agencies, so that there are separate ED — emergency department — datasets sent to the COAG reform council, separate from the data sent to the AAHW, separate to the reports sent to DOHA as part of our commonwealth filings.

There is a set of new agencies in Canberra — the national health performance agency; the IHPA, the hospital pricing authority; as well as the safety and quality commission — and the prospect is and the concern that has been expressed is that datasets that have been sent that presently amount to tens of millions of lines of data will this year become hundreds of millions of lines of data and could well exceed a billion lines of data within a couple of years, because of the combination of greater frequency of reporting, so moving from annual to quarterly, but also moving from a subset of hospitals to all hospitals.

Also the level of detail that is being required is getting deeper, so for all admitted patients we ask their country of birth and for a set of patients we ask them their proficiency with English. We ask all patients not only their date of birth, on some occasions we then ask, 'Are we sure they were born at that time?' and if we are not sure, 'Are we not sure about their month or their day?'.

The level of detail that is being developed by reporting agencies is quite deep and quite broad. The estimation has been given by an external agency — Ernst and Young — that the Victorian health system should consider that it might cost $20 to $25 million a year additional as a result of the prospect of these additional reporting burdens. As a result of that, health ministers convened a working group to seek to rationalise the data collected and the reporting made, as a result of which you have seen an attempt both for BP purposes — so budget paper purposes — to actually rationalise at the margin the indicators that are reported for budgetary purposes in Victoria to align them with national indicators so that there is not, if you like, an additional layer of burden at the Victorian level.

Mr PAKULA — Minister, just to set your mind at ease, earlier when I asked about this I was actually referring to the measure in budget paper 3, page 123, 'Semi-urgent (category 2) elective surgery patients admitted within 90 days', not the measures on page 349.

Mr D. DAVIS — The ED measures; okay.

Mr PAKULA — In regard to both your evidence and Mr Fitzgerald's I do not think anyone disputes the desire to avoid duplication. My concern, though, is the replacement of an easily explicable performance measure, or an easily understood measure — being treated in 10 minutes, treated in 30 minutes — with a performance measure that just says, 'Treated within time'. My question is: what does 'within time' mean and how is anyone going to know whether you have met that measure or not?

Ms DIVER — For the measure 'Treated in time' for emergency departments, the department in Victoria uses the college of emergency physicians indicators, so category 1, treated immediately; category 2, treated in

10 minutes; category 3, 30 minutes; and on it goes. The 'Treated in time' indicator will measure the cumulative treatment of all of the category 1 to category 5 patients within those specific periods, and there is a target of 70 per cent. We will be able to break down the subset, but the overall performance is measured as all of the patients being treated in time. So it is in time according to the college of — —

Mr PAKULA — Can you explain what you mean by 'cumulative'?

Ms DIVER — It is the aggregate of all of those categories of patients. The category 2 patients will be expected to be treated within 10 minutes and the category 3 patients within half an hour, and then the measure is reported as a single measure.

Mr PAKULA — Not cumulative as in if you save 1 minute on one, you can be 1 minute late — —

Ms DIVER — No.

Mr PAKULA — Right.

Ms DIVER — They are confined to the target for which each category is determined, and that is determined by the college of emergency physicians. We use their measures.

The CHAIR — Thank you very much. Minister, I refer to BP 4, page 29. Can you advise how the government is delivering on its health election commitments to the people in Geelong in this budget?

Mr D. DAVIS — Chair, I am very pleased to do so and indicate that I think the community in Geelong and region and the staff at Barwon Health and the patients of Barwon Health will be very happy with the commitments in this year's budget. It is a very significant commitment building on a more modest commitment last year. Forgive me if I am wrong by a tiny amount, but about 8 million or 8.5 million was committed last year for a series of enabling works for the ongoing projects that are required at Geelong Hospital, Barwon Health's major campus. In doing so, that cleared the way for this larger commitment. I can also say that this matches in with the commonwealth commitment of some money for cancer services as well, but this significant commitment of money will lead to much better services for people in Geelong and the Barwon region.

This will include a wellness centre at the hospital for cancer patients, which will provide them with information, support and coordination as they progress through their treatment journey. The coalition's commitment to cancer support and treatment in the Geelong community includes a third linear accelerator to be installed and commissioned in an existing bunker. There will be a significant increase in the radiotherapy treatment available to Geelong and the broader community in Barwon-south western. The budget funding will also see a significant accommodation for cancer patients who have travelled to Geelong, and there will be a commitment to better models of care.

Again, this builds on the commitment from last year of just over $8 million — money that was strongly advocated prior to the election, and money advocated, I might say, by Andrew Katos, the member for South Barwon, in a very strong commitment to Barwon Health. There will be extra beds and more palliative care capacity for older patients with more complex needs. The additional cancer services, I think, will make a very big contribution to the future of services at Barwon Health. Geelong and the south-west will be very pleased with this strong commitment.

Mr SCOTT — Minister, I refer you to budget paper 3, page 142, and the outputs under 'Health advancement'. You would be aware that significant funding of almost $20 million over the last four years has been provided to Quit Victoria for anti-smoking advertising, and this funding expires as of 30 June this year. Can you please advise the committee whether the health advancement or any other Department of Health output includes funding for antismoking social marketing or advertising?

Mr D. DAVIS — I am informed that there are ongoing commitments to Quit, and we will continue to support Quit.

Mr SCOTT — If it has to be on notice, so be it, but can we have the figures for what that ongoing commitment is? It is a very serious issue.

Mr D. DAVIS — Sure, and we have a very strong commitment to supporting Quit and the anti-cancer message; so, yes.

The CHAIR — Thank you. We will take that on notice.

Mr MORRIS — I will continue the theme of your question, Chair. Minister, budget paper 4, which deals with the state capital program, lists on page 29 new projects to be undertaken by the department. Can I ask you how the government is delivering on its commitments to the people of Kilmore in this budget?

Mr D. DAVIS — Chair, I am very pleased to indicate a strong commitment to the people of Kilmore. Prior to the election the government, or then opposition, committed $10 million to what was a $20 million project at Kilmore hospital, conditional on the commonwealth providing that $10 million to match it. In last year's budget we acknowledged that commitment, and I had communication with the then federal health minister and was very pleased when she made an announcement that Kilmore would receive the $10 million of commonwealth money. Here now is the matching state money to enable that project to go ahead.

It is a significant contribution. It builds on other commitments in that particular area. With the $20 million there will be 30 extra beds, adding to the existing capacity. Kilmore, of course, is a key area for growth around the edge of the city. The redevelopment will also see a dedicated outpatient service that will expand the health services that are available to the community at Kilmore.

Kilmore is, I think, well positioned to provide a broader range of services. This is an important injection of funds. I acknowledge the commonwealth's contribution, and this is an example of a project that is proceeding with both commonwealth and state matching contributions that will deliver a great outcome for the community in Kilmore.

Ms HENNESSY — Minister, if I could just refer you to budget paper 3, page 22, in terms of the item 'improving security and safety' in hospitals there has been a $1.4 million allocation this year. Can you tell us what this expenditure will achieve?

Mr D. DAVIS — This is an important commitment. What I will say is that the government is very aware of the need for greater security and safety in our public health facilities, particularly EDs, but more broadly as well. Hospitals should, in my view, be a zone of safety and security for patients and for staff, and we are very strongly committed to that. Prior to the election we made some statements around that and were also very clear about the need to get better outcomes there.

The Drugs and Crime Prevention Committee met with a reference to look at safety and security in our hospitals and surrounds. They have come back with a set of recommendations. The government accepts many of those recommendations and will formally respond quite soon. I know the work has been largely completed on that formal response. One part of the response is to ensure adequate training and support and a focus particularly in emergency departments. That $1.4 million per year over four years will help deliver that training support and management in emergency departments. It is a part of the response. It is an important part of the response, and I think the community will welcome it.

A further point, I think, that needs to be made in this context is a commitment of the government to clearer and stronger penalties for those who harm or threaten emergency workers. My colleague the Attorney-General has made some announcements about that recently. We see this as an integrated approach taking up the work of the parliamentary committee. I pay tribute to some of the work that has been done in a bipartisan way by that committee. I also note that there is obviously a need for this tranche of money to improve the training and education around the emergency departments and, finally, the package of sending a very clear signal about what the community expects through penalties.

Ms HENNESSY — So you started with a $21 million promise to put PSOs in hospitals. No-one seemed to like that; in fact the parliamentary committee rejected that.

Mr D. DAVIS — And we have accepted that point.

Ms HENNESSY — To finish my question: we start with $21 million to put PSOs in hospitals and we end with $1.4 million in this year's budget. Can you give us some practical insight in terms of how the hospital will be safer and more secure arising out of this $1.4 million allocation? Explain to us what it looks like.

Mr D. DAVIS — As you correctly allude to, the committee did conclude that PSOs were not the right step to take, and the government has accepted that point. Equally the committee came back with a series of other recommendations — more than 40 in fact. We have examined those recommendations very closely and, as I say, we will respond formally quite soon. But some of those recommendations directly go to training and the aspects around that, and we have responded to some of those. This is an initial response; it is not the full response, it is an initial response. It is listening to what the parliamentary committee has said, it is putting in place some important programs and, as I said, my colleague the attorney has also made the point that we need to have a clear signal about what the community expects in terms of safety and security in our hospitals.

Mr ANGUS — I would like to follow up on Mr Morris's previous question, and I refer you to budget paper 4 page 29 under 'New projects'. How is the Baillieu government delivering on its health election commitments to the people of Seymour in this budget?

Mr D. DAVIS — The government is again very pleased to make the announcement of chemotherapy chairs at Seymour hospital. This was an election commitment, an important election commitment that will be delivered through money in this budget.

Seymour, for those who do not know, is a town to the north of the city, and it has a significant population and a growing population around it, as the city, in a sense, moves out in that direction. Seymour hospital will carry a significant load, and this is a recognition that people who need chemotherapy would be better placed to have that chemotherapy provided locally. The $2 million is an important contribution to that process. I know the local member has been very active in advocating strongly, both prior to the election and since, for this money to be allocated. The community in that electorate can pay tribute to her efforts and be very pleased with the additional services that will be provided.

Mr PAKULA — Minister, I just want to go back to my previous question and your response, and particularly Ms Diver's. This is a question about emergency services performance measures. My recollection is that Ms Diver said that the new measure would be a cumulation of the outcomes for categories 2, 3, 4 and 5. But my understanding is that in the health data that was released last week there is in fact no time frame for category 4 and category 5. Will that not skew the overall outcome if there is no designated time frame set for categories 4 and 5 patients?

Ms DIVER — Up to date there has been reporting of the actual time for category 4 and 5 patients, but previously there has not been a target set. However, the college of emergency physicians does have a target for those patients, and so we will be using the college of emergency physicians' targets for category 4 and category 5.

Mr PAKULA — So in the health data that is released in the future, that will be immediately apparent?

Ms DIVER — In the BP 3 measures, it will be combined in the single measure. Previously BP 3 has only had categories 1, 2 and 3, now this gives a measure of all of the patients attending emergency departments.

Mr D. DAVIS — To conclude — and Peter Fitzgerald's points before — there are these new national measures, and we have to work our way through how we get a good outcome for transparency on the one hand, but without duplicative or excessive burden on clinicians.

Mr PAKULA — I suppose the risk is that good results for category 4 and 5 patients might well mask poor results for category 2 and 3 patients when you bundle them all together.

Mr D. DAVIS — We are in a position where we have these national arrangements and we have different sets of arrangements. As Frances Diver points out, the college has a set of arrangements. We consulted closely with them. We have not made these decisions without that clinical consultation.

Mr O'BRIEN — I take you to page 29 of BP 4 under 'New projects'. I ask you: how is the Baillieu-Ryan government delivering on its election commitments to the people of south-west Victoria in this budget?

Mr D. DAVIS — I thank the member for his question, but I indicate that another key election commitment — and I think the member understands it well, representing that area, and the member for South-West Coast representing that area also understands this well — the south-west coast is an important area and Warrnambool is an important health service. The $5 million that is committed is a very important first commitment to this project, and I indicate to the committee that the government has done a good deal of work with a review of cancer services across the south-west, and again, this is one of those services that will draw patients ultimately not just from Victoria but from south-east South Australia as well, and it is important to understand that. There are communications with the commonwealth about further steps on this as well, and we look forward to working with them on these matters, but the 5 million is a very important commitment.

I want to pay tribute too to the work of Vicki Jellie from Peter's Project. For those in the committee who may not know of Vicki Jellie, she is a local woman and an advocate for cancer services in Warrnambool and the south-west. Her husband tragically passed away with cancer, and it became very apparent to her — the need for additional services in the south-west. She has led a significant campaign that has great community support from both South West Healthcare and St John of God Hospital in the town, but also a strong group of community backers and community supporters. As I say, this is an example of where a local group of community activists are not just agitating for government support — commonwealth and state — but are actually putting their money where their mouth is, as it were, and doing the fundraising and local community support. This is a very important initiative. It recognises the work of Vicki Jellie and Peter's Project, as the community group is called, and it recognises also that South West Healthcare, St John of God and Peter's Project have worked together on this occasion to put forward proposals consistent with the service planning that the department has done.

The CHAIR — I would like to thank Ms Diver for her attendance.

Witnesses withdrew.