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

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Budget Estimates 2016–17

Melbourne — 11 May 2016

Members

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Mr David Morris — Deputy Chair
Dr Rachel Carling-Jenkins
Mr Steve Dimopoulos
Mr Danny O'Brien
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Ms Kym Peake, Secretary,

Mr Lance Wallace, Deputy Secretary, Corporate Services

Ms Frances Diver, Deputy Secretary, Health Services, Policy and Programs, and

Ms Amanda Cattermole, Deputy Secretary, Regulation, Health Protection and Emergency Management, Department of Health and Human Services.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2016–17 budget estimates. All mobile telephones should now be turned to silent.

I would like to welcome the Minister for Health, the Honourable Jill Hennessy, MP; Ms Kym Peake, Secretary of the Department of Health and Human Services; Mr Lance Wallace, Deputy Secretary, Corporate Services; Ms Frances Diver, Deputy Secretary, Health Services, Policy and Programs; and Ms Amanda Cattermole, Deputy Secretary, Regulation, Health Protection and Emergency Management.

All evidence is taken by the committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Comments made outside the hearing, including on social media, are not afforded such privilege. Witnesses will not be sworn but are requested to answer all questions succinctly, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

Questions from the committee will be asked on a group basis, meaning that specific time has been allocated to members of the government, opposition and crossbench to ask a series of questions in a set amount of time before moving onto the next group. I will advise witnesses who will be asking questions at each segment.

All evidence given today is being recorded by Hansard. You will be provided with proof versions of the transcript for verification as soon as available. Verified transcripts, presentations and handouts will be placed on the committee's website as soon as possible.

All written communication to witnesses can only be provided by officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way. Members of media must remain focused only on the person speaking. Any filming and recording must cease immediately at the completion of the hearing.

I now invite the witness to make a very brief opening statement of no more than 10 minutes, and this will be followed by questions from the committee.

Ms HENNESSY — Thank you very much, Chair, and good morning to all PAEC committee members that are here with us this morning. I will give a very brief overview about some of the highlights in the health budget before an extensive period of time for questions.

Visual presentation.

Ms HENNESSY — If we could just go to the overview here, the health budget in 2016 has delivered a total of more than 2.3 billion in additional funding for health. That includes $1.5 billion for hospitals and health programs and another investment of which we are very proud of around 800 million for capital projects to support health services.

On the next slide you can see the historical growth in the acute health output from 2011 to 2016–17. You can see that we have had an average over four years to 2014–15 of about 5.2 per cent. In this year's budget — in the 2016–17 budget — we go to an 8.3 per cent growth in funding.

The next page is the acute health asset initiatives, so that is our TEI in effect, and again you can see the historical investment in capital. Now our capital investment is material, because pipelines are important when it comes to investing in health capital and ensuring that we are continuing to invest not just on one-offs but over longer periods of time, and you can see the significant increase in health capital expenditure from last year's budget of 561.3 million to this year's expenditure of $816.8 million, a really significant growth. I think the only other time, members of the committee might be aware, that there has been a larger investment in health capital was the year that the Victorian Comprehensive Cancer Centre was funded.

The next slide takes us through some of our election commitments that we have discharged in this budget. Of course our first budget was focused on delivering on our election commitments. These are some residual investments that have been made in the 16–17 budget. So we have the $135 million for the Victorian heart hospital, we have $10 million for our investment to build the Maroondah Breast Cancer Centre and we have $21.2 million in health funding to support the government's medicinal access scheme. It is a larger investment all-up in terms of medicinal access, but this is the health component, the other component sitting in Minister Pulford's portfolio.

Some other budget highlights in the 2016–17 budget include more than $1.3 billion over four years, which also includes the largest ever one-off investment to tackle elective surgery waiting lists in 2016–17. There is a $16.8 million package to strengthen hospital quality and safety. I trust we might talk more about those issues, but a very important issue that has not been given, in my view, full attention in the past, and we have certainly got a strong reform agenda when it comes to improving quality and safety, so we are really pleased to be able to make that investment. There is an initial $5 million investment for the planning and development of an electronic medical record system at the Royal Melbourne and at Peter Mac, and $10 million for Better Care Victoria for their innovation fund, which follows on from the commitments that we made before the election to establish Better Care Victoria, the Travis review and the Better Care Victoria board that is now established, so this is $10 million worth of seed fund to drive innovation essentially within our health system.

Some other budget highlights include a focus on prevention. Members of the committee would no doubt be aware that an important priority for our government has been responding to the recommendations of the Royal Commission on Family Violence, so I will not go to many of those issues because they are included in a whole-of-government response. But certainly there are some other very important investments in prevention. Real-time prescription monitoring system rollout of $29.5 million. Members may recall there was a $300 000 investment in last year's budget to do the planning for this very important program. There is $6.6 million to support the development of a reproductive health strategy for Victorian women and some services associated with that. There is a $5.5 million investment as part of the whole-of-government ice package. Some of those investments sit in other parts of the Department of Health and Human Services, but this $5.5 million goes to ongoing training for healthcare workers when it comes to dealing with patients that are affected by ice, and most pertinently to be able to deliver front-line training to our health workforce.

We have also got a $19.8 million investment as well, and part of that investment goes to our medical research agenda. It goes to the issue of accelerating clinical trials. It goes to the issue of getting a better model for the commercialisation of important medical research discoveries that are being made as well.

Again another strong focus on cancer. There is $16.6 million to support more research and more clinical trials. We have made a $500 000 grant to the Leukaemia Foundation to help support them complete a home away from home for families that have a member of their family being treated for leukaemia in Melbourne. We have a $50 million investment to further support the establishment of a National Centre for Proton Beam Therapy. I am happy to talk more about that in the course of the meeting, but again a very, very significant investment in not just the fight against cancer but better treatments for cancer. There is a $1 million contribution to the Wimmera cancer centre as well.

Some of our asset initiatives, or capital as normal people might think of it, include an $816.8 million investment in new hospitals, new equipment, in infrastructure and ambulance branch upgrades. This includes a $200 million Regional Health Infrastructure Fund, our $168.5 million investment for the Shepparton hospital redevelopment, $61.3 million to support infrastructure works at Western Health's Footscray and Sunshine campuses, and some investment to plan for the future of Footscray Hospital. There is also another important investment for Northern Health, and that is a $17.3 million investment to build a surgery centre in Broadmeadows.

Chair, I am conscious of the time and I think I have about 30 seconds to go, so I might wind it up there — —

The CHAIR — You have actually got 3 minutes if you would like to — —

Ms HENNESSY — Wonderful. Well, rather than me wax lyrical about it we might do it in the more interesting and engaging mechanism of questions and answers.

The CHAIR — Thank you, Minister. We have government questions now to 9.23 a.m. I will hand to Mr Dimopoulos.

Ms PENNICUIK — Point of order, Chair. Could the information that the minister was reading from be tabled? I know it is probably from the budget papers but it is just very helpful to have that all together the way the minister has been reading it.

Ms HENNESSY — I am more than happy — —

Ms PENNICUIK — There was more detail than was in the presentation because I was writing notes.

Ms HENNESSY — I was not using notes in the course of talking to that presentation.

Ms PENNICUIK — Well done, Minister.

Ms HENNESSY — Thank you.

The CHAIR — Perhaps the best way to expedite this, Ms Pennicuik, would be if the minister at the conclusion of today's hearings would like to provide any additional information on notice —

Ms HENNESSY — Sure, absolutely happy to, Chair.

The CHAIR — to the committee in relation to her presentation. That might be the best way forward.

Mr DIMOPOULOS — Good morning, Minister and officers. I just want to start with BP3, page 89, specifically in relation to the Goulburn Valley Health redevelopment. It is at the top end of the table. I just want to get a sense from you, Minister, of what the project will deliver and how it will address the current challenges faced in that hospital. I have a couple of other follow-up questions in relation to regional health after this one.

Ms HENNESSY — I am sorry — —

Mr DIMOPOULOS — I have a couple of other follow-up questions in relation to regional health after this one, but this one is about specifically Goulburn Valley Health and the challenges faced and how this redevelopment will assist in meeting those challenges.

Ms HENNESSY — Yes, absolutely. Thank you very much, Mr Dimopoulos. I will just come to my notes, but it is a very important investment. In last year's budget we allocated some funding to do some proper planning work around the Shepparton hospital. Excuse me while I grab my notes so I can give you those details.

It is an important investment. In Shepparton there is obviously growth. There is great diversity in Shepparton. It is now a secondary migration point for many families as well. There is a significant Indigenous community in Shepparton and, like many other hospitals across the state, their infrastructure was not really fit for purpose and so we made a budget allocation last year for the purposes of getting some planning work done on a redevelopment of Goulburn Valley. As you would be aware, it was not an election commitment and $168.5 million is a very significant capital investment.

But in terms of the new and expanded services and the types of services, there will be a new four-storey tower; there will be an additional 34 inpatient beds; there will be three extra operating theatres; there will be two extra ICU beds. There will be an expanded emergency department, and that is very significant. They are very constrained at the Shepparton hospital in terms of their emergency department. It is also important to acknowledge that the work that has been done at the Shepparton hospital on their emergency department has also been part-funded by local community fundraising efforts. It is a really terrific community and so I want to acknowledge the contribution that they have made. But this redevelopment will bring an additional 18 emergency cubicles to the emergency department and it will double its size. Shepparton, by virtue of its location, obviously also gets its fair share of trauma cases given the traffic on highways et cetera.

The other issue why emergency is so important at Shepparton is the nature of the agricultural industry up there being overrepresented in farming accidents and those sorts of things. So a very, very good ED is absolutely critical.

Mr DIMOPOULOS — Minister, the issues you have raised have been around for a while, obviously —

Ms HENNESSY — They have.

Mr DIMOPOULOS — so in terms of the constraints of the hospital, it has been a secondary migration point for years. Given we have known about this for some time, what are the most recent investment strategies in relation to that?

Ms HENNESSY — Look, this is the big first investment that Shepparton hospital has had in a significant period of time and it is one that will make a difference for this community. It will also go to being able to recruit

specialists and additional workforce expertise, because if you are working in very cramped conditions, it is very difficult to attract specialists into some regional and rural areas. But having a really terrific model of care and a suite of services gives those sorts of health services a competitive advantage.

There will also be an expansion of the dialysis service, and I want to acknowledge that there is a really significant prevalence of type 2 diabetes in that community. They are running a 24/7 dialysis service at the moment. They are doing dialysis for people in their homes. The demand is quite incredible and so doubling the size of that dialysis service is going to be very, very important. I am really proud that we have been able to make such a significant investment, one that was not an election commitment but one that is really desperately needed. It is all credit to the community, and I want to acknowledge Suzanna Sheed and Jaclyn Symes, who have been such terrific advocates for that project.

Ms SHING — Minister, I will keep you on the same page of the budget papers, if I may — BP3, page 89 — in relation to the Regional Health Infrastructure Fund, which commits $200 million over the total forward estimates period. That project, that fund, is pretty broad in its scope, and there are a number of explanations in the budget papers, but how will the eligibility criteria for access to this particular fund operate?

Ms HENNESSY — Thank you very much, Ms Shing, and I know that you have a very strong interest in investment in rural and regional health. First things first: a $200 million investment in a regional infrastructure health fund is a record. We have never had a fund this large available for rural and regional health. I want to make very clear that it is not just health services that will be eligible to make application for use of those funds. It will also include public sector, residential, aged care, and other forms of health services across the state, including rural and regional community health services as well. It will assist those rural and regional health services that have very strong needs in terms of upgrades.

We have allocated a small amount from that fund. The $1 million for the Wimmera cancer centre comes from that fund. We have allocated, I think it is, $2.4 million for Moyne Health Services for the development of an urgent care centre. Again, for those people who by virtue of location do not have access to an emergency department, to try and make the sorts of investments that mean that they can access urgent care and help overcome some of the tyrannies of distances for those that live in the rural and remote parts of our state. We are really delighted to make that investment as well.

And most pleasingly to you, I imagine, Ms Shing, there is a million dollars allocated from that fund for the next step in doing the planning for the redevelopment of Warragul hospital. I know that that is a big issue for the people of West Gippsland, but also for those that work and rely upon Warragul hospital in and of itself, so there is a million dollars to start the planning for that work.

Ms SHING — But it includes not just reactive but proactive, preventative measures?

Ms HENNESSY — It does. We have not put a cap on eligibility. Essentially the test will be what it does to improve the model of care and to improve the reach of health care in those communities.

Ms SHING — Thanks, Minister. The description for that particular initiative refers to a number of specific projects. What are the specific investments associated with those projects in terms of how they will realise medium to long-term benefit for regional and rural communities as part of those ongoing commitments to improving health across the board?

Ms HENNESSY — I spoke a little bit about the impact of the Moyne urgent care centre, and the very real need for people in that community is to be able to provide access to very, very urgent care. Those people that ordinarily would have to travel to an emergency department will be able to rely upon that. On the Wimmera cancer centre, again this is a really terrific project. It is one whereby the community has predominantly done the larger amount of fundraising. The federal government has made a commitment, and we have made a commitment of a million dollars, and that gets us home and enables us to have the Wimmera cancer centre now built.

The great need, of course, for those people is having to travel to either Ararat or to Ballarat for the purposes of having chemotherapy. It is a long drive along that highway, and often those people are just requiring access to a day bed for chemotherapy — the tyranny of distance, the fact that people are often very unwell when they are having chemotherapy. That will enable us to ensure that those communities are able to access a better model of

cancer care, with better integration both with Ballarat regional health services and also with the work that is done in Ararat, and provide cancer and oncology services closer to home. I do not need to tell you about the needs in West Gippsland and about the Warragul hospital. That million dollars is targeted at getting on with the planning for the future of Warragul hospital.

Ms SHING — In relation to planning and in relation to that output for bricks and mortar, there is a significant investment based on what you have just indicated. What about the Hospital Beds Rescue Fund and the way in which that is going to, by all intents and purposes, provide better access for individual treatment?

Ms HENNESSY — I am very pleased that I think about 40 per cent of the Hospital Beds Rescue Fund went into rural and regional health services. Again I think it shows the power of how, with a relatively small investment, hospitals can change their model of care and increase and expand their services. Bass Coast expanded their subacute hospital; Castlemaine Health were able to expand their elective surgery, at Goulburn Valley we did some work around their acute inpatient beds; at Creswick we expanded the capacity for end-of-life care there. For small amounts of money we were able to assist those hospitals that applied to essentially increase not just the number of patients that they can treat but to also help develop a model of care where they may have needed some capital or some support to open up some beds. I am really delighted with that $200 million investment — that is an ongoing one over last year and the forthcoming three years. Those services are fully funded, and they are making a very real difference for those communities.

Ms SHING — Thanks Minister. I will take you to page 217 of BP3 now, and the department's total output cost as it relates to the small rural services funding. That seems to indicate that funding will in fact decline by about 3.7 per cent in the 16–17 period compared with 2015–16. Can you give us an explanation for that decline?

Ms HENNESSY — Thank you. There has traditionally, for a long period of time, been a problem with the measure around the small rural budget output and the funding formula for small rural services. We currently have a small rural health services funding model review. Long story short in the time available, small rural services that are defined as services that provide care for a population of less than 7000 are funded predominantly on block funding. That has given them the flexibility to be able to meet local community needs. They often do things like provide aged care or do services in the home. But that is a funding model that has let them down. We are working to provide them with a new funding model that will be essentially a combination of block funding to support what they do, but also funding that will better measure activity. I am happy to talk more about that. I am conscious of how much time we have got.

Ms SHING — So anything that you can provide on notice in relation to the way in which that option and those funding models will operate across the board would be greatly appreciated. Thanks, Minister.

Ms HENNESSY — Absolutely.

Mr D. O'BRIEN — Good morning, Minister. While you are just talking about the Regional Health Infrastructure Fund, I might put in a bid for the South Gippsland Hospital at Foster. We only need 2.1 million.

Ms HENNESSY — I am happy to take their application, Mr O'Brien.

Mr D. O'BRIEN — Well, by the end of the day if you could sign it off, that would be great. But seriously, I want to move to budget paper 3, where pages 89 and 93 look at what will be the heart hospital. I want to talk about the facility being located at Monash University. As you are probably aware, the top cardiac hospital in the UK is the standalone Papworth Hospital, but it has announced that they are moving to Cambridge to be co-located with Adenbrooke's Hospital, and the main reasons they have stated is having access to services for patients with other diseases or conditions in addition to their heart issues — a new service response so linked to a full service hospital. The question I am asking is: with a world-class facility like that moving to co-locate, why is it that we are going to a standalone facility rather than co-locating at Monash, for example?

Ms HENNESSY — Thank you very much for your question, Mr O'Brien. We are very excited about the Victorian heart hospital. The top cardiac hospital in the world, with the greatest of respect to the health service that you referred to, and also Barts, that you would be aware of presumably, which has opened in the UK very close to the university, is in fact the Texas cardiac hospital. So there is very strong international evidence that co-location with a university is indeed a very, very effective model of care.

Of course the Victorian heart hospital would be the first university hospital that we would have in our state. It would also ensure that we are not just building a heart hospital, but that we are leveraging off the very important clinical education opportunities, close to the synchrotron, and close to the very important Monash University medical engineering, which is where all of the work is done around medical devices. Medical regenerative medicine is in fact a very important and emerging part of cardiac care.

We simply do not have the facilities in this state for what our top cardiologists need. Now I know that our top cardiologists — people like Ian Meredith, who is a person that is really behind the vision of what is the Victorian heart hospital — currently have to go to Germany and the United States, to Texas heart, to do the sort of practice operations that they are required to do for the sort of heart and cardiac work that they are doing. The co-location there is in fact a critical part of the model.

And before, in the development of that model, we have done a cardiac services plan, and of course that cardiac services plan was led by experts. So you and I might have views about these things, but I will be guided by the 100-plus cardiac experts that have guided the model in our cardiac services plan.

Mr D. O'BRIEN — Can I just jump into that? I just wanted to ask a question about that plan.

Ms HENNESSY — Sure.

Mr D. O'BRIEN — So from a practical perspective I understand the plan sets out how the heart hospital will integrate and how it will work. What happens, though, when a patient who has gone to the heart hospital for heart surgery or whatever develops a blockage of their vessels or something and needs vascular surgery, for example? Do they then get transferred back to Monash Medical Centre? Will those additional services — —

Ms HENNESSY — Mr O'Brien, I am absolutely confident in the model of care. If you are familiar with the cardiac services plan, you will see that safety is at the centre of that cardiac services plan. It is indeed a specialist heart hospital, and the model that is stepped out in the cardiac services plan is to ensure that we anchor certain specialties there. Patient safety is absolutely critical. There is a proposed ED and ICU. The days of vascular surgery and cardiac surgery being completely divided are long gone.

Mr D. O'BRIEN — That is what I am asking, though. Will there be vascular surgeons there at the heart hospital, for example?

Ms HENNESSY — I absolutely have every confidence that the model of care that we will have at the Victorian heart hospital will include the very important patient safety issues, and vascular and cardiac are often not divided anymore. So the concept that there would not be the capacity to address vascular issues at the Victorian heart hospital is not one that I would entertain, and it is for that reason that you will see right throughout the cardiac service plan that patient safety is at the centre of it, specialisation is at the centre of it, but acknowledging that we are still required to have other specialists and acute points of care for people right across the state.

So at the Alfred, for example, who are the experts in transplantation, that is where transplantation will continue to occur. The Victorian heart hospital will be an acute centre, but it is more than just the provision of emergency acute services. We are way behind the world when it comes to the facilities that we have when it comes to things like congenital heart disease. We have significant research and advancement occurring around the medical devices, which is why we build in with the Monash University as well.

Mr D. O'BRIEN — Can I just interrupt there?

Ms HENNESSY — Sure.

Mr D. O'BRIEN — Sorry, we have a little bit of time and there is a lot to get through. The cardiac plan seems to indicate that there is not an emergency department at the heart hospital, as I understand it. Again, if there is an emergency with an existing patient, are they going to be transferred, or are there going to be emergency facilities there at the heart hospital?

Ms HENNESSY — There will be in the design the best response for the cohort of patients that they are treating. So the concept that patients will not be cared for in that environment is simply just not correct.

Mr D. O'BRIEN — Right, okay. Would there be likely to be a need, if there is not an emergency department, and as you know — —

Ms HENNESSY — Sorry, there is an emergency department planned to be at the Victorian heart hospital, so I just want to make that clear.

Mr D. O'BRIEN — There will be?

Ms HENNESSY — Yes.

Mr D. O'BRIEN — Okay, so there will be an emergency department.

Ms HENNESSY — Sorry, I was assuming that that was mutually understood.

Mr D. O'BRIEN — I do not know. That was actually part of the question. So, okay, there will be an emergency department at the heart hospital?

Ms HENNESSY — Yes.

Mr D. O'BRIEN — Okay. You mentioned the Alfred. The cardiac plan talks about some of the work being transferred from the Alfred to the heart hospital. What proportion of the Alfred's work will go to the heart hospital?

Ms HENNESSY — Mr O'Brien, we are a long way from home on getting what will be a world-class facility established, and so to ask me to engage in projectionism around what will be gone from what hospital where — the cardiac services plan makes it very, very clear that transplantation will remain at the Alfred Hospital.

Mr D. O'BRIEN — Okay.

Ms HENNESSY — They are the experts in this matter, and, you know, that will remain so.

Mr D. O'BRIEN — So an answer to the question on the proportionality would be a couple of years away at least?

Ms HENNESSY — Sorry, what was your question?

Mr D. O'BRIEN — Sorry. Well, the question was: how much of the Alfred's heart work will go to the heart hospital? When will we know how much the proportion will be? Is that going to be next year, four years time when it is completed?

Ms HENNESSY — I am not quite sure. I think we are talking at cross-purposes. I might ask Frances from the department to see if she can provide you with some greater insight to what might be at the nub of your question.

Mr D. O'BRIEN — Well, I will try to be clear. I understand the cardiac plan says that some of the Alfred's work will be taken to the heart hospital. I appreciate your answer that you cannot tell us how much it would be now, but when will we know?

Ms DIVER — So perhaps if I can help explain. The commitment to the heart hospital and the planning for what the volume is and the model of care and how the heart hospital will work within the entire system — to think about how we might plan for that, we undertook a piece of work with a cardiac services plan. It has been recently released. There was a committee of cardiologists and cardiac surgeons and experts, and that really laid out the plan for cardiac services across the whole state. Included in that plan are references to greater collaboration between services so that we can get a more effective role delineation — so, where the most appropriate services should work. The reference that I think you are making in the plan is really about making sure that we have got collaborations south of the Yarra, essentially. So Alfred and Monash will work on what the most appropriate mix of services is. For example, the minister has mentioned transplant services will remain at the Alfred. There will be huge growth in cardiac services obviously at the new heart hospital. What is the role of peninsula? What is the role of Cabrini? And so the plan really outlines that all of those services need to get together in the context.

Mr D. O'BRIEN — That clarifies it a little bit for me. Thank you.

Minister, if I just move on to budget paper 4, page 53. It says the heart hospital has an estimated completion date of the fourth quarter 2019–20. Is that the date that you are committing to?

Ms HENNESSY — We are still completing the final business case, Mr O'Brien, so until that business case is complete I am unable to give you a definitive date.

Mr D. O'BRIEN — Because before the election you said 2018, and I am again a bit confused because earlier on page 50 it does say an estimated completion date is TBC, so which is it and when will we know?

Ms HENNESSY — We will know when the business case is complete.

Mr D. O'BRIEN — And that will be?

Ms HENNESSY — This financial year.

Mr D. O'BRIEN — So, in the next two months?

Ms DIVER — Sorry, I mean 16–17.

Mr D. O'BRIEN — Sorry, can I hear that again? I did not — —

Ms HENNESSY — 2016–17 financial year.

Dr CARLING-JENKINS — Thank you, Chair, and welcome, Minister. I want to congratulate you on the budget. We have heard a lot from ministers to date about our healthy economy, so it is great to see such investment going into the health of Victorians.

I wanted to also ask a question about the Victorian Heart Hospital — so budget paper 3, page 93. It is quite different from the questions from Mr O'Brien but complementary, I think. The Victorian Heart Hospital, it says, is receiving an allocation of $135 million towards its construction and establishment, which is a great commitment. Obviously further funds will be required, and the budget papers indicate the government will be seeking investment from other sources. So my question is around how much additional funding does the project require, and what risks are present should sufficient co-investment not be found?

Ms HENNESSY — Thank you very much for your question. It is correct that our partners are Monash University and Monash Health, who will also be making a contribution. I am at a little bit of a disadvantage by virtue of the business case not being complete to be able to identify the other cost, but we are very open about the fact that we will require other project partners to complete something that will be not just an Australian first but a first in the entire South-East Asian region. The great benefit and opportunity here also lies in embedding not just the medical research and the translational research opportunity, but medical engineering is where the great, not just health but economic, opportunity lies. Clinical training and clinical placement are also important. We are already being approached by countries overseas asking us if we can train their cardio clinicians in this facility.

There are terrific economic opportunities that will be embedded, but we need to finish the business case, and then we will be identifying other potential project partners. That might be the private sector. We, as always, would love money from the federal government. It is a project of national significance, and we have certainly got some strong philanthropic interest as well. We will be pursuing those opportunities as the project partners, but until we have the business case complete I can only put those propositions on the table for you absent of granular detail.

Dr CARLING-JENKINS — Sure. Fair enough. So, just as a follow-up to that, when the budget papers say fundraising will be required and you are acknowledging that private partners might need to be approached, do you anticipate any controversy here? I know we have heard in the upper house a lot of about the controversy around Peter Mac, where investment from private sources was not seen as a viable option.

Ms HENNESSY — We are actively planning for the provision of a private hospital in the Victorian heart hospital. It is on a large greenfields site. Its purpose is much larger. It is fundamentally different from the VCCC

in the following ways: the VCCC is on a very site-constrained site; the VCCC was never planned to have private hospital beds on a top floor. When you plan for a private hospital, you build a proper private hospital, not 40 beds that are disconnected from an intensive care unit, that do not have a lift to them in a way that is very unsafe. The focus on the VCCC is absolutely the combination of good clinical care and medical research.

The benefit of us being located at Monash University is about embedding not just the clinical training opportunities with Monash University and the use of the medical research opportunities around the synchrotron, it is that we have the space and the opportunity to design and to build that in from the get-go. That was not the case with the VCCC.

Dr CARLING-JENKINS — Okay. Thank you, Minister. I appreciate that clarification. We look forward to reading the business case.

I would like to move on now to your commitment to elective surgery, which is budget paper 3, pages 78 and 81. I note, and you pointed out in your presentation as well, the one-off investment to tackle elective surgery waiting lists. This I commend you for, and I think we could both acknowledge that this is a very reactive strategy. We have been told by ministers that have been coming in to date how our population is increasing, so we understand that probably elective surgery waiting lists are going to continue to increase in line with that. Could you outline what your department will be doing proactively in this space to prevent a crisis in these waiting lists from occurring again? I note, for example, that your funding includes minor capital grants to increase elective service capacity, so perhaps if you could talk to that issue a little bit more.

Ms HENNESSY — Yes. Thank you very much, Dr Carling-Jenkins, for your question. It is a very important question, and there is really no silver bullet around dealing with the incredible demand around elective surgery. You may or may not be aware that under the previous government elective surgery waiting lists ballooned to 50 000 people waiting on the lists. There are a number of really important things around reducing elective surgery waiting lists.

First and foremost, it is funding. Funding is really important — making sure that those health services that require a little bit of capital investment or additional money in order to enhance their capacity to perform more elective surgery. That is why we did a bring forward earlier this year of $20 million to enable many of those health services to prepare themselves for this very, very significant investment. There is also what I call some of the people that have to suffer very, very silently on our elective surgery waiting list, and those are what are called the long waiters — people who might have very, very complex surgery that is not classified as urgent. Many of those people have not been given the priority that they have deserved in recent times, so we have also set a target for our health services to say 10 per cent of their elective surgery activity must be those long waiters as well.

I think the other critical issue, another important part of elective surgery, is addressing the very many problems that have beset outpatients clinics and specialist clinics as well, because the two are very much interrelated. For the first time ever, I have published the data around outpatients clinics. I am giving health services some funding to enable them to get their data in a way that is fit for purpose, but we have great administrative and healthcare reform challenges to make sure that we are having more efficient use of specialist clinics, which then means that people are able to ensure that they start bringing down their elective surgery waiting lists dramatically. But demand is a great challenge, both on our elective surgery waiting lists and with our emergency departments. It is population growth/age, but the big one in health is always utilisation.

Mr DIMOPOULOS — Minister, can I bring your attention to BP3, page 78, just in relation to quality and safety in the health system, specifically 'Strengthening oversight, of quality and safety across Victorian health services' budget allocation, table 1.18. I just want to get a sense from you and a bit more detail about what exactly this is and how it is intended to be rolled out across the Victorian health system.

Ms HENNESSY — Thank you very much, Mr Dimopoulos. One of the great challenges, I think, for our health system is to keep a commitment to ongoing improvement around quality and safety. There is a lot of data in the health system, but it is my personal view we need to better use that data for clinical improvement and practice. I think you will find the Auditor-General in quite direct terms has said that quality and safety has been something that there just has not been adequate focus on in the health system, and I am very committed to addressing that.

To go directly to your question, this is a specific investment that will help support some work that I have engaged Professor Stephen Duckett to do in reviewing where and how we need to reform our system and what role the centre, being the department, plays. As part of that package, a specialised training program relating to emergency management and maternity care which is being led and developed by the Royal Women's Hospital is going to be rolled out to all small rural health services right across this state. What that will do is it will ensure that small rural health services have access to very high-quality training for obstetric emergencies and are aware of what best practice is, how it is that they meet current quality and clinical safety guidelines. The funding will also support training to strengthen board oversight of quality and safety at smaller rural health services. Statewide incident reporting and response management systems will also be strengthened as part of that funding parcel.

But there is also another body of work being done that I have commissioned to look at what are the other things that need to be done to strengthen quality and safety in the health service, and some of that funding will go to the recommendations I anticipate coming from the Duckett review.

Mr DIMOPOULOS — Minister, some of those obviously would relate back to the VAGO report?

Ms HENNESSY — Yes.

Mr DIMOPOULOS — Can you expand a bit more on the support for boards around quality and safety? Is it just regional boards or Victorian health boards?

Ms HENNESSY — Sure. We are doing work across all boards but particularly for regional boards. The difference between regional boards and metropolitan boards, other than the big regional boards our smaller rural and regional boards are volunteer board members. It is my view that every board must have someone with clinical expertise on it, so in some rural environments you are working through, 'Is that the local doctor?', 'To what extent has the local doctor got a conflict of interest with the board?'. We have to more broadly train board members because all board members are accountable for quality and safety performance, not just the clinical person on the board.

But we also need to look at what other support can our big regionals give our small regionals and rurals. That might be a specialist clinician from a regional board also participating on a rural and regional board, so training for everyone, better support in the oversight role and better support for the training of the staff that are having to make decisions as to whether or not this is a patient that they can treat locally or one that needs to be transferred to a specialist hospital.

Mr DIMOPOULOS — Thank you, Minister. Can I just move on to page 217 of BP3, and specifically the last line item under table 2.11, 'Empowering individuals and communities'. There is a significant budget allocation in that output stream. Is that something to do with health complaints?

Ms HENNESSY — Yes.

Mr DIMOPOULOS — Can you just explain a bit more about — —

Ms HENNESSY — I will just crosscheck your reference.

Mr DIMOPOULOS — Sure. It is BP3, page 217, and the last line item, 'Empowering individuals and communities'.

Ms HENNESSY — Yes. There has been reform in the role of the health complaints commissioner; that bill takes effect on 1 February 2017. The new health complaints commissioner will replace the health services commissioner. They will play an enhanced role in health system quality improvement. They will have new powers to deal with unscrupulous and incompetent — what I call rogue — providers in a sense, and there are many; I am the recipient of information about these people on most days. What we have done is essentially expand the scope of who can complain to the commissioner. We want to raise public awareness about their role, but also people are often unaware that local health services also have a patient advocate and a local complaints resolution service as well, so we are very keen to ensure that there is greater awareness and confidence, I suppose, in the local resolution as well.

Understanding the needs of whether you want to call them a patient or a consumer is core business as far as I am concerned, whether that is at a health service level, at a department level or around the roles and activities of the health service commissioner's office. One of the important changes we have made is that a family member could not complain previously, so if a patient did not want to complain, a family member could not complain. So there have been some important changes. They will take effect on 1 February next year.

Mr DIMOPOULOS — I think that is a very good change, particularly coming from a family where I have become the chief complainer for my parents. Just a couple more quick questions on the health complaints system, and you may have to take this on notice or maybe the department can answer. We are talking about chiros — not all chiros but the dodgy providers of some of these health services. Has any work been done by the department in terms of what cohorts are more likely to be — I do not want to use the word 'taken in' — using these services? Are they regional? Are they metro? Are there gender differences? Age differences? Ethnic backgrounds? Any work?

Ms HENNESSY — I will have to take that specifically on notice. I am hesitant to not make a fact-based assertion. I get a lot of angry emails as it is, and so I am hesitant to further burden my inbox for making an injudicious observation.

Mr DIMOPOULOS — Thanks, Minister. I suppose my point is that we appropriately target shonky providers across a range of disciplines but it also may be worthwhile looking at the customer-consumer base that is more attracted to those than others. Just in relation to the Australian Health Practitioners Regulation Agency, I know it is a national role and not just a state-based role, but that has come in for a bit of criticism of late — —

Ms HENNESSY — Yes, from me.

Mr DIMOPOULOS — I just wanted to get a sense in relation to, again, the same budget paper reference — page 217 of BP3 — of what, if anything, the government is doing in relation to that criticism of that agency.

Ms HENNESSY — I have been critical particularly in the Djerriwarrh context but some others around the role of AHPRA. In the context of chiropractors, chiropractors are a regulated health practitioner and so they are regulated nationally by both the Chiropractors Board of Australia and AHPRA, who then oversights that. Just to provide clarity to the committee, the health complaints commissioner deals with unregistered practitioners, so we have had issues in dental with people purporting to be dentists, people purporting to be unregistered midwives and doulas — people that are not actually qualified to do the work that they do. Because they are not regulated nationally, they sit in the state scheme.

AHPRA is aware of the criticisms I have made in the context of Djerriwarrh and some other issues that have been raised with me. Two things, I suppose, have happened in response to that. AHPRA have initiated a review in respect of the criticisms around the Djerriwarrh environment, but I have also taken to the national health ministers council a request for review and reform of AHPRA. Specifically the issues that I have asked the national health ministers council and what is called AHMAC, which is the advisory body that does the work for the health ministers' COAG — essentially the sorts of issues that have been canvassed in the tragedy of the Djerriwarrh case are things like that medical practitioners who have done settlements around medical negligence complaints maybe should have reported those to AHPRA.

What are the positive disclosure requirements? How do you deal with the fact that we have large numbers of visiting medical officers that work in different healthcare services? What degree of transparency ought be required about reporting on the prior history of a practitioner? And, whilst I am very committed to pursuing those, I should also make clear that to get change in the national AHPRA law will require the agreement of all other states and territories and the commonwealth. But I am very, very committed to ensuring that we continue to look at reform of AHPRA, and it is critical that it acts in the interests of patients and does not, or is not perceived to, act in the interests of clinicians at the expense of patients.

Mr T. SMITH — Good morning, Minister. I refer to budget paper 4, page 51, 'Bendigo Hospital – redevelopment'. I am just wondering if there will be any dedicated space or wards for private patients at this new hospital.

Ms HENNESSY — No.

Mr T. SMITH — Moving on to the Box Hill Hospital redevelopment, why is the private hospital group Epworth renting a number of wards at the new public Box Hill Hospital to provide private inpatient clinical care at Epworth at Box Hill.

Ms HENNESSY — I can refer to Frances to provide greater detail of those arrangements. Essentially, it occurred because of the significant flooding that occurred at Epworth, and Epworth had to close their wards and their theatres. The great problem is they then land in our public wards and public theatres for people who do not get access to that health care. But we have a very stringent set of financial arrangements around that, and I will hand over to Frances, who will talk you through those.

Ms DIVER — Sure. So the Box Hill Hospital redevelopment, when it was completed, had obviously built for the future, so it had additional capacity that was not required at present. That vacant capacity was then used opportunistically by Epworth to help them in a crisis, really. Their Freemasons Hospital had a significant flood, and they made an arrangement to lease some ward capacity and theatre capacity off Box Hill. That arrangement has worked quite satisfactorily for both parties. It is not providing any financial burden to Box Hill Hospital. Once the capital works for Epworth were completed, Epworth has continued to use the facilities; they have extended that for a short period of time, whilst they are undertaking some capital works at Epworth Eastern, just across the road. So it is not having any financial impact on Box Hill Hospital. It is providing some cooperation between the public and private sector, and importantly it means that patients are not now flowing into the public sector that would have otherwise come to the public sector should Epworth have not been able to have that capacity open.

Mr T. SMITH — How long do you envisage this arrangement will continue for?

Ms DIVER — I will need to get back to about the end date, but there is an end date for the leasing of those facilities. I just cannot think of it off the top of my head.

Mr T. SMITH — If you could provide that that would be greatly appreciated.

Ms DIVER — Sure, happy to.

Mr T. SMITH — Given that private spaces already exist at the Women's, with Frances Perry, at Monash Medical Centre, and you will allow private patients at the new heart hospital, what is different about the VCCC to not justify an empty space being filled with Peter Mac Private?

Ms HENNESSY — Essentially it was not built to enable a private hospital there, and the plan to put 40 private beds there, which again we have discussed up hill and down dale, was not connected to any form of intensive care unit, and the 13th floor will be used for the power and possibility of medical research. I am happy to hand over to my secretary as well to elaborate on these issues, given that we speak about them regularly.

Ms PEAKE — Further to the minister's comments, the space that had been designated for research purposes is intended to be used for research purposes. There were some really quite significant issues about using that space for clinical purposes. The minister has flagged that there was not a ready access to the intensive care unit. The lift well that would have needed to have been used is really there for goods and services rather than transportation of patients, and they were really the two reasons that there has been further work done now on what might be the alternative uses of that floor space for research purposes.

Mr T. SMITH — With regard to, as you are saying, the VCCC — and if I could continue asking these questions to the secretary — when will it be opened, and what is the date that patients can be transferred?

Ms PEAKE — The construction of the new facilities is now largely complete, and commissioning is well underway. The project is on track for delivery by the date of commercial acceptance, which is 14 June 2016. The $1 billion south facility achieved technical completion, I can inform the committee, on 15 March, and service delivery from the south facility will commence following relocation in June, which was as originally planned, of the Peter MacCallum Cancer Centre from East Melbourne to Parkville. The north facility works on the Royal Melbourne Hospital, construction of the new build on levels five through eight is complete, and has been handed over to Melbourne Health, and the new 32-bed haematology IPU was commissioned on 19 April and is now fully operational, with patients in. The relocation of the existing Royal Melbourne Hospital intensive

care unit will occur on 4 May 2016, and will be fully operational as required prior to the Peter Mac relocation in late June

Mr T. SMITH — So the minister has said that VCCC is not suitable for having a private ward, yet why did the board of both VCCC and Peter Mac both agree to that previously if it was not suitable?

Ms HENNESSY — Mr Smith, the previous government could have approved this — —

Mr T. SMITH — No, it is not about the previous government.

The CHAIR — Order, Mr Smith! The minister is answering the question.

Ms HENNESSY — They did not. As the government, the government made a decision that it was not fit for purpose, that clinical safety was an issue and that the space was to be used to advance medical research opportunities in Victoria.

Mr T. SMITH — But that is not what I asked. I asked: why is the board saying one thing and you are now saying another? I do not understand why — —

Ms WARD — There are a lot of things you do not understand.

The CHAIR — Order, Ms Ward!

Mr T. SMITH — Yes, thanks for turning up!

Mr MORRIS — Chair, could I just intervene? I will just ask a slightly different question. I am just wondering who determined it was not fit for purpose. Was it the government or was it done on other advice?

Ms HENNESSY — Both. I mean, the government ultimately is the decision-maker, Mr Morris, and the government made that decision. It is a decision that was not made by the previous government, even though it was open to the previous government to make a decision.

Mr MORRIS — Would you care to elaborate on that last comment?

Ms HENNESSY — I mean, it went to the previous government — —

Mr MORRIS — The previous government supported it.

Ms HENNESSY — Yes. Well, they did not approve it, Mr Morris, is my point.

The CHAIR — Mr Smith, to continue.

Mr T. SMITH — If I could continue, to the secretary. How many of the 195 beds, which is full capacity, are funded and will be staffed in the weeks after it is opened?

The CHAIR — Sorry, just for clarification, Mr Smith; are we still talking about the VCCC?

Mr T. SMITH — The VCCC, yes.

Ms PEAKE — I am just going to ask Ms Diver to respond to that.

Ms DIVER — When Peter MacCallum relocates, in late June, they will be relocating at their existing capacity, and then we are working with Peter Mac on the expansion of services to open additional beds, and that is something that we are currently working through in the context of the budget outcome. As I mentioned before, we build hospitals for the future. We build them with additional capacity. We do not expect that additional capacity to be open on day one; it will be opened gradually over a number of years in response to demand. We expect there will be additional capacity, in 16–17, opened, but in the first instance the priority is to relocate the patients and the services at their current level, and then we will be working on expanding their services over time.

With the budget output growth that we just received, the process now will be to negotiate with each health service their growth allocations, and that will then determine the additional capacity. As part of putting the

budget bid together and working out how much additional funding we need, obviously we put into the calculation for that growth funding the requirements for additional capacity, and so we expect Peter MacCallum to require additional capacity.

Mr T. SMITH — Is there any extra funding in the budget for that?

Ms DIVER — Yes. As part of the growth in the budget there is additional funding to open extra services.

Mr T. SMITH — Where is that itemised?

Ms DIVER — It is part of the acute output group, and it is part of the growth for additional services.

Mr T. SMITH — And how much?

Ms DIVER — It is a billion dollar — I will just get the exact figure.

Ms HENNESSY — Do you want to just explain the funding policy guidelines and the statement of priorities?

Mr D. O'BRIEN — I think Mr Smith means specifically for the VCCC.

Mr T. SMITH — Yes.

Ms DIVER — It is not detailed. What we have in the budget papers is the overall growth for additional services, so the growth funding. That comes as a large bucket, and then there is a process that is starting pretty much the day the budget comes down until we release the policy and funding guidelines and each individual board chair signs up with the minister a statement of priorities. So we are now going through the process of allocating the budgets and negotiating the additional capacity that each of them needs and then setting their access targets in terms of what is the extra performance that each of the health services will deliver as a result of that additional funding. So it is when the statement of priorities is released and the policy and funding guidelines are released. That is when the information about how much additional capacity is going to each of the individual health services.

Mr T. SMITH — Okay, thank you. Have you had any applicants for the expression of interest process run by CBRE, and do any of these applicants propose to provide actual patient care?

The CHAIR — Sorry, Mr Smith, are we again talking about the VCCC?

Mr T. SMITH — The VCCC. It is a floor of VCCC.

The CHAIR — What is CB?

Mr T. SMITH — CBRE is the real estate firm that they are using to rent off floor 13.

Ms HENNESSY — I am not involved in the expression of interest process, Mr Smith — —

Mr T. SMITH — This is for the secretary, Minister.

Ms HENNESSY — so I will ask the secretary.

Ms PEAKE — And given that that is an open process at the moment, I am sure you would understand that it is not a process that we can discuss today.

Ms PENNICUIK — Good morning, Minister, Ms Peake and the other members of the department.

Ms HENNESSY — Good morning.

Ms PENNICUIK — Thank you very much for coming today and spending time with us, basically quite a few hours. I note the significant investment in capital works in the health system, particularly the acute health system, but if I could just turn to a couple of specific issues. One of them is the $61.3 million that is allocated to Western Health for urgent infrastructure works at Footscray and Sunshine. In the budget papers, in terms of the capital program, BP4, page 50, it received the $61.3 million there, but only around 11.5 is allocated this year.

But if you look at the 'Service Delivery' budget paper, on page 89, you can see the tranches going out to 2019–20. What I am really trying to find out is: what is the actual total of that allocation that is going to the Footscray site, and when will the urgent works that are needed at the Footscray site — and I think it is pretty well known about the urgency of the works there — actually be completed, because that is not very clear from the budget papers?

Ms HENNESSY — Okay. Thank you very much for your question, Ms Pennicuik. If I can, I will take you through what is in that $61.3 million and then directly address the questions that you have asked. There is $17 million for Footscray, and I will hand over to Frances at the conclusion of answering the other components of your question to talk to the timing of those urgent works, about which we are all in furious agreement. Also, as part of that $17 million, there is a component of that that is for the planning of a future Footscray Hospital as well. The other component of the $44.3 million goes to — —

As we build the new women's and children's hospital at Sunshine there is an opportunity for us, when the decanting from part of Sunshine occurs, to do capital work around, I am pretty sure it is, subacute as well as acute beds, and to leverage off that process to build essentially more and new wards. So I am happy to hand over to Frances, who may be able to provide you with some more granular detail about that. But that is essentially why it is forecast to those out years — because part of those works will require some of those patients who will move into the new women's and children's hospital.

Ms PENNICUIK — From the Footscray site?

Ms HENNESSY — No, from the Sunshine site.

Ms DIVER — In terms of the Sunshine site you will see that the time line has extended, because of the work that is required to refurbish; some of the areas that are being transferred over to the women's and children's hospital will require refurbishment once the women's and children's hospital is built. So the women's and children's hospital needs to be built first, move the patients over and then there is the renovation and refurbishment back in Sunshine. So that is the Sunshine Hospital.

In terms of Footscray, the feasibility study was completed in 2015, and so we are now ready to engage capital consultants to do the initial urgent infrastructure works reasonably immediately. I will need to get back to you and take it on notice the completion date for those works.

Ms PENNICUIK — Thank you. We know that three wards have been closed, and some 70-odd beds have been closed, so what is going to be the situation with the hospital? When will the $17 million that has been allocated to Footscray actually be spent on Footscray? When will that be acquitted?

Ms HENNESSY — On the issue of the beds, I do not necessarily accept those numbers. There were some patients that were moved to Sunshine not because of infrastructure but because a new critical care unit was opened at Sunshine as well. I do not run away from the significant infrastructure issues. There just has not been enough money spent on health capital in this state for a period of time, and I am committed to addressing that. In terms of the timing of when that money will be acquitted, I will just have to defer to Frances's advice.

Ms DIVER — Sure. So that is the $17 million for urgent infrastructure works?

Ms PENNICUIK — Yes.

Ms DIVER — We are ready to go to tender on those now. I do not have a time line for when they will be completed, but they will be completed. That is a reasonably immediate task, but I will get back to you with the exact completion date. But they are for immediate works as well as some planning money for the future development of Footscray Hospital, and that is when we will consider the volume of additional capacity or refurbished capacity that is required at Footscray.

There has been a significant amount of work that has gone on between Footscray and Sunshine to work out what is the appropriate configuration of services. So in particular with the opening of the intensive care unit at Sunshine, that has enabled a bunch of capacity to be moved from Footscray over to Sunshine. So the empty wards at Footscray is partly about a reconfiguration issue for a more appropriate model of care, and that was really about reducing a large number of transfers that were occurring from Sunshine back to Footscray. So in

fact what it means is that patients that turn up at Sunshine can be treated at Sunshine Hospital, because there was a large number of transports occurring between the health services.

Ms PENNICUIK — Thank you. I would appreciate the further information as well. Minister, if I could just turn to budget paper 3, page 4, there is a $1 billion contingency fund, if I can call it that, for urgent works:

> $1 billion to enable health services to respond to growing patient demand in all areas of patient care —

et cetera. The question I want to link that to is the issue of the Williamstown Hospital emergency department and the Sandringham emergency department. Obviously there is a bit of a dispute going on there, and I will not take up all my time describing that, as I am sure the minister is aware of it, but the issue is keeping those emergency departments open for the local communities. Will they be able to be kept open and would funding maybe come from that particular funding item in budget paper 3?

The CHAIR — One minute.

Ms HENNESSY — Thank you very much, Chair. I am happy to speak about this more when we get the opportunity, in light of the 1 minute of time left. The federal government has clawed back $78 million of money that has already been spent. The boards of both Western Health and the Alfred identified what they would need to do in order to be able to pay that money back. We have filed an application in the High Court for the purposes of arguing about the legality of those issues. We will continue to invest at record levels, as we have in this budget. We are dedicated to both Williamstown and Sandringham, but we are not going to let the federal government off the hook. When the tables were turned under the previous government, which had an issue with the then federal government, the then health minister closed beds.

Ms PENNICUIK — So will they stay open?

Ms HENNESSY — We will be working to invest in those, and we welcome your support with the federal government.

The CHAIR — Order! Ms Ward until 10.23 a.m.

Ms WARD — My apologies for not being here earlier. I was promoting Walk Safely to School Day at Sherbourne Primary School. I also apologise to everyone if I am asking questions or covering areas that have already been addressed. Again, apologies for coming in so late.

What I do want to start off with is around budget paper 3, page 78, and funding around meeting hospital demand. In budget paper 3, on page 78, 'Improving access to elective surgery' is the second line item. Can you go over with me, if you have not already, and talk to me about the $160 million that has been provided, and what that means in real terms?

I also want to talk about the minor capital grants on page 80 of budget paper 3, and how that is helping to reduce waiting times, if that is what is happening, and what that money will also be invested in.

Ms HENNESSY — Thank you very much. I have largely addressed the issue of how the capital that we brought forward will help enable that. Ms Shing had an interest in that matter, so I have largely addressed that issue.

In terms of the elective surgery, this is a really important boost to elective surgery — the $335 million and the $20 million to which your second question applies was about enabling some health services to do both capital and a bit of redesign work to get them ready to be able to take on more elective surgery. Elective surgery is one of those issues. It depends upon what surgery. The cost of doing a tonsillectomy, for example, is relatively minor compared to the cost of doing a major coronary operation. So if you work in averages or if you pick out a particular medical cohort, you could characterise that, I suppose, by saying that what that money would buy is about 6764 hip replacements, 6805 knee replacements, 22 284 sinus or ear operations — and I suppose they are the easier ones to do; that is kids getting grommets and adenoidectomies and tonsils taken out — and 34 169 additional eye operations. We will, depending upon which cohort you build your average at, have an average of around 200 000 additional patients. That is very significant, given we know the demand that is on our elective surgery waiting list. It is one thing for me to come and talk about a record investment, but it is another experience if you are a category 3 with a degenerative hip condition, waiting and waiting and waiting

for when you are going to get your surgery. So I am really conscious of that, and that is why we have put a 10 per cent requirement on our health services, to identify people with more complex surgeries that have been waiting for a longer period of time.

Ms SHING — They are the long listers, are they, that you referred to earlier?

Ms HENNESSY — Yes, the long waiters.

Ms WARD — You also referred in your presentation to the elective surgery waiting list. Can you tell us what the current waiting list is?

Ms HENNESSY — The current waiting list at the last quarter was 41 557. We are happy that we have managed to get the trend going in the right direction around our elective surgery waiting list. That is not to say people still are not waiting too long. We are dedicated to turning that around. Under the previous government that was at about 50 000 people on the elective surgery waiting list. In that last quarter we treated an additional 1296 patients. So all up in the last quarter there were 42 173 patients done; there were 24 676 more patients admitted to hospital, compared to last year. So this is the scale of figures that we are talking about, and they are large. The challenge around — —

Ms WARD — So can I just confirm: 24 000 extra patients were treated last year?

Ms HENNESSY — Twenty-four thousand six hundred and seventy-six were admitted to hospital, compared to last year. The great challenge and the issue about which we are saying — on many of our performance indicators, quarter on quarter, on average our performance is better than that under the previous government, and we are a year and a half in. We have got a lot of work to do, but our trends are largely going in the right direction. These significant investments will help.

Ms WARD — Thank you. On budget paper 3, page 22, it talks about emergency performance targets. What is the government doing to help improve that; is that being improved?

Ms HENNESSY — Look, we have a very strong continuing commitment to invest in our hospitals. The reality is that we have a challenging job to turn our health services around after a billion dollars was taken out. With emergency, there are a couple of critical things to understand. The demand on our emergency departments continues to grow at really significant rates. The other thing that we have picked up in the last quarter of performance data is that the complexity and the acuity of those patients is growing rapidly as well. But last year we put in $2.1 billion and an extra 2.45 into health funding.

We have done things like removing hospital bypass, of which I am very proud. People said, 'No-one will ever be able to do that without the sky falling in'. We worked very, very hard both with our paramedics and all of our health services to abolish hospital bypass. We have done lots and lots of work to get better patient flow working through our hospitals, but we have got a lot more work to do. In our last quarter our hospitals reported the highest ever number of emergency presentations, and that was 151 000 people in the last quarter arrived in our EDs. There has been a 35 per cent increase in emergency admission in the last three years, but despite that we have reduced the number of patients stuck in emergency for more than 24 hours just down to 30. That figure under the previous government was 1154, so we are seeing significant change and significant improvement. Comparing quarters with quarters, average quarter performance, on every performance measure we are doing better but we have a significant amount of work to do.

Ms WARD — That is one thing that I do want to talk to you about, the work that needs to be done, and in particular the people who are actually working in health care. If I could ask you, please, to have a look at budget paper 3, page 217, there is an output summary related to health care. Can you advise how the new nurses and midwives enterprise agreement is going to benefit the health system? How is it going to improve patient outcomes?

Ms HENNESSY — Thank you very much. We are of course very proud that we have struck a historic agreement with our nurses and midwives, such a critical part of our workforce. I am very proud that we have managed to arrive at that agreement without one bed being closed and the genuinely cooperative relationship that we have had with our workforce about identifying where and how they will assist us with our reform project as well.

Ms WARD — How much is the cost of the agreement?

Ms HENNESSY — The average gross annualised cost is 3.4 per cent over eight years, and that is a base increase of 2.5 per cent, in line with the fair pay guide; the 0.5 that gives us genuine significant service delivery. Some of those things go to immunisation rates, better patient flow outcomes, participation in additional quality and safety training, along with productivity improvements. Some of those productivity offsets go to improved patient times, better patient safety, increased nurse vaccination rates to reduce rates of infection and improved occupational health and safety outcomes. Our WorkCover bill is about $100 million a year, so every injury that does not result in a WorkCover claim is a significant cost saving for us.

There was a commitment to reduce a day's sick leave from the nurses and some commitments also around both sustainability and waste. Health services are big consumers, whether it be of carbon or consumables. We spend a lot of money on those issues, so there are some other programs in respect of that.

Ms WARD — Why is it an eight-year agreement?

Ms HENNESSY — The nurses, legitimately, seek comparability with our New South Wales nurses. We share a hospital in Albury-Wodonga, for example, where we have nurses who work side by side, where one nurse doing exactly the same rate of work is being paid 20 per cent less than the other nurse. The nurses were seeking greater compatibility and comparability with New South Wales. We also need to do that in a fair and financially sustainable way. Doing that over an eight-year period as opposed to a four-year period meant that the cash flow and cost implications of that were sustainable whilst acknowledging the fundamental issue. Nursing workforce — —

The CHAIR — Order! Mr Smith until 10.34 a.m.

Mr T. SMITH — Thank you, Chair. If I could return to the VCCC, we know that there will be a floor empty when it opens. What proportion of the rest of the hospital will be vacant or under-utilised?

Ms HENNESSY — Mr Smith, I will have to hand over to one of my colleagues to be able to directly address part of that question, but to make clear, the 13th floor was going to be vacant irrespective of what decision was made. There was no capacity to actually address the 13th floor, because it was an addition outside the scope of the current contract, which also relies and is dependent upon a whole range of commonwealth benchmarks and time frames to deliver. Just to be really clear, whether —

Mr T. SMITH — Minister, with respect — —

Ms HENNESSY — it was a private hospital —

Mr T. SMITH — there was going to be a private ward there and you got rid of it.

The CHAIR — Order! Mr Smith!

Ms HENNESSY — or medical research, it was not going to be empty.

Mr T. SMITH — That is all there is to it. Just say you tore up a perfectly reasonable private ward — —

The CHAIR — Order! Mr Smith, the minister was answering your question, and I think the minister was going to provide some background and context before handing it over to — —

Ms HENNESSY — I will hand over to Ms Diver.

Ms DIVER — There is no intention to have any large parts of the new Peter MacCallum hospital to be vacant. When I talked about additional capacity and negotiating the budget outcome and the amount of activity that the hospital will perform next year, that is really in the scale of how many beds in each ward are open and how many chemotherapy chairs are open and how many sessions of radiotherapy are provided. The hospital is providing significant additional capacity. We are moving over the existing capacity — so additional physical capacity, we will move over the patients at that current rate, and then once we have completed the budget negotiations Peter MacCallum will work towards increasing the number of, for example, chemotherapy beds or the number of sessions for radiotherapy.

Mr T. SMITH — Just in terms of a broad proportion of the hospital that will not be utilised when it starts operating?

Ms DIVER — When the budget negotiations are completed and we release the policy and funding guidelines by 1 July, then it will be clear to Peter MacCallum how much additional work they will be able to undertake — and we expect there to be significant additional work to be undertaken by Peter MacCallum. But yes, there will not be every bed opened on the first day, that is correct. We would never do that in a hospital, because we are obviously building the hospital for the future.

Mr T. SMITH — Thank you very much. Minister, you have told us today that private beds at the Epworth keep people out of public beds, you have told us that experts from the health sector have shaped the heart hospital model, that private beds cannot happen at Peter Mac Private, and that your government has overruled the Peter Mac board and supporting clinicians regarding Peter Mac Private. Why does your government insist on treating the VCCC differently to other major providers in health?

Mr DIMOPOULOS — On a point of order, I did not hear the minister say that the government overruled the board. If I did not hear that — —

Mr MORRIS — She might not have said it, but that is what happened.

Mr DIMOPOULOS — That is verballing — —

The CHAIR — Order! I am conscious that we are eating into the opposition's time — —

Mr DIMOPOULOS — Even better, I will make another point of order.

The CHAIR — Order! Mr Dimopoulos! A question was asked of the minister. The preamble forms part of the answer to the question, as you know, Mr Smith, so the minister may wish to respond to the question that has been put to her.

Ms HENNESSY — Because we believe that patients in that environment are required to be able to access an intensive care unit and not go in a goods lift with animal waste to be able to access things like imaging and intensive care units. Because we believe that the promise of the VCCC, which is translational research and medical research to actually try to break the circuit-break issue around cancer and cancer prevention meant that the focus must be on the medical research and the translational research opportunities. To not put too fine a point on it, one in two Victorians will get cancer and one in five Victorians will die from cancer. If we think that a debate about a number of private beds is going to address that issue or enable us to genuinely leverage off the terrific investment and wonderful opportunities that we have in medical research — where the future is is in genomics, in immunology, in getting the right drugs, in increasing Victorians' access to cancer clinical trials. We are currently at 5 per cent on cancer clinical trials; the world's best cancer centres are at 25 per cent. Those are the focus and those are the objectives of what we want the VCCC to focus on. There is a place and an important role for the private health sector. It is not at the VCCC on the current plan that exists.

Mr T. SMITH — Minister, Wendy Harris, the former chair of the Peter MacCallum Cancer Centre, said at the time that $20 million in donations was contingent on the private hospital. What is the value of the pledges made and subsequently withdrawn from the Peter MacCallum Cancer Foundation? Was any reason given when these pledges were withdrawn?

Mr DIMOPOULOS — That question is from last year, mate. Get some new material.

The CHAIR — Order! Mr Dimopoulos!

Ms HENNESSY — Again, I am advised by the chair of the Peter MacCallum hospital that their philanthropic efforts are going very well. I cannot answer the rest of your question and, as I have said time and time again on this groundhog day discussion, a commitment to philanthropy, people usually do not tag it to something. I think that Victorians are generous. The chair of the Peter MacCallum board assures me that their fundraising is going well.

Mr T. SMITH — Would you perhaps be able to come back to the committee with some further information about this?

Ms HENNESSY — If there is anything further I can add to the committee, I absolutely will.

Mr T. SMITH — Minister, why is it okay to have 31 per cent of private patients at the VCCC but not have a dedicated ward?

Ms HENNESSY — Because the VCCC was not designed to have a dedicated private hospital. The wards at the VCCC are for Peter Mac patients, both public and private. This was a different proposition about putting 40 beds in that cannot access an intensive care unit. Our government chose not to approve it. The previous government had the opportunity to approve it and they chose not to.

Mr T. SMITH — I think you should just admit you have got an ideological aversion to the private sector.

Ms HENNESSY — It is not ideology, Mr Smith; I welcome the private sector investment.

The CHAIR — Mr Smith, is there a question? Mr Smith, you are chewing into your own time. The Deputy Chair.

Mr MORRIS — On an entirely different subject, but coming back to Ms Ward's earlier comments — budget paper 3, page 217 — I will address my initial questions to the secretary, if I may. Ms Peake, with regard to the nurses' EBA, does the budgeted figure for health costs for 2016–17 and the forward estimates include the anticipated impact of the EBA?

Ms PEAKE — The normal process in the budget papers is to reflect the ongoing 2.5 per cent adjustment, and then when an agreement is reached, there is the further adjustment that is made, and that is the way that it has been treated in this year's budget papers as well.

Mr MORRIS — So that adjustment has not yet been made?

Ms PEAKE — No. Only the 2.5 per cent in the forward estimates.

Mr MORRIS — Would you anticipate receiving further financial support from the government, or will you need to find it from your own resources?

Ms PEAKE — We will be receiving further support, and all of the costs of the health services will be met.

Mr MORRIS — Can you give us a figure on what the 2.5 per cent is, how much is already in the base?

Ms PEAKE — I might throw to Mr Wallace to step you through the further detail.

Mr MORRIS — Thank you.

Mr WALLACE — If the question is how much is 2.5 per cent worth on the nursing agreement, the best way to look at that is that the nursing salary bill is about $3600 million, so if you have a calculator in front of you — —

Mr MORRIS — That is fine. That gives me the information I need. If I could go back to the minister. Given the secretary's sentiments, Minister, can you guarantee to the committee that the government will fully fund the department and health services for any costs that are incurred in meeting this agreement?

Ms HENNESSY — Broadly, yes.

Mr MORRIS — Thank you. A further question to the minister: the maximum number of years an EBA can be agreed is four. This is obviously an eight-year agreement. How do you propose to enforce an eight-year agreement?

Ms HENNESSY — With a common-law deed.

Mr MORRIS — Thank you. Finally, you talked about some percentages earlier, but I understand the average increases over the four years of the EBA will be 3 per cent, 3 per cent, 3.25 per cent and 9 per cent. Cumulatively that comes in at 4.5 per cent over four years, which is substantially higher than the 3.4 per cent that you are claiming today.

Ms HENNESSY — Which is why we have done an eight-year agreement, Mr Morris.

Mr MORRIS — Would you agree that it is in fact 4.5 per cent over the first four years?

Ms HENNESSY — No. This is an eight-year agreement with an average annualised rate of 3.4 per cent.

Mr MORRIS — I am asking what the cost is over four years.

Ms HENNESSY — And I am saying it is an annualised 3.4 per cent rate.

Mr MORRIS — Just a quick one: you identify 2.5 base and 0.5 productivity. You did not tell us what the other 0.4 was, I do not believe.

Ms HENNESSY — In productivity, the 0.5 is the service delivery improvements and the other 0.4 is productivity improvements.

Mr MORRIS — To the uninitiated, is there a distinction?

Ms HENNESSY — You might say, for example, that improving quality and safety in service delivery could have a — —

The CHAIR — Order! Dr Carling-Jenkins until 10.42 a.m.

Dr CARLING-JENKINS — Thank you, Chair, and thank you, Minister. You are coping very well with the quick changes. It is a different way of working, is it not? I would just like to come back very briefly to my question around elective surgery. I just had a supplementary there, so budget paper 3, pages 78 and 81. I just note in the footnotes that there are estimates that included the commonwealth contributions. Now that the commonwealth budget has been handed down, and the budget reply as well, given that we do not know the outcome of the next election, are you confident that this contribution will continue at the estimated level?

Ms HENNESSY — I might just grab your budget reference to make sure that I am speaking to the correct figure. There are two important components to this answer.

Dr CARLING-JENKINS — This is the contributions to the elective surgery.

Ms HENNESSY — Yes. We have been great critics of the commonwealth government around the $17.5 billion that has been taken out of the health budget over the out years. On top of that we have then had a $78 million clawback of money already paid, based on a formula that was actually agreed on between the previous federal and previous Liberal state government. That is the money that we are pursuing back in the High Court.

In the course of COAG, of course, there was a three-year reprieve that was negotiated at what was a 6.5 per cent rate where we will receive about $280 million from the commonwealth by virtue of their contribution. Very unfortunately on budget night the federal budget papers did not have a 6.5 per cent figure in them. They had a 5.1 per cent figure in them, and so we still have not got fundamentally the out years addressed in terms of the commonwealth investment. It is quite timely that you ask this question, because we have in fact updated our figures around what that funding cut by the commonwealth will mean for various health services. Chair, with your indulgence, if I could hand that document out.

Dr CARLING-JENKINS — That would be great.

Ms HENNESSY — I am confident that the — —

Dr CARLING-JENKINS — Does that include the figure for the effect on the elective surgery?

Ms HENNESSY — I am confident that we will get the next three years in terms of what was agreed with the commonwealth. We still need to resolve this issue where we came to an agreement around a 6.5 per cent rate and then in the federal budget papers it said 5.1 per cent. We are not taking that lying down, because we want the money, effectively, that was promised and that we signed an agreement for.

However, the longer term viability and sustainability of our health system is fundamentally dependent upon the commonwealth government doing two things. The first is making good on the commitments that they gave to the Victorian people before the last election that they would not cut funding to health. So we are going to continue to pursue them on that issue. The second most important thing for the acute sector is investment in primary health. When the commonwealth government does things like puts a freeze on co-payments for GPs, we already know that about 6 to 7 per cent of patients do not go to the GP because they are frightened they not going to get bulk-billed. These people ultimately end up in our emergency departments, so a very prosperous and effective primary healthcare system is absolutely essential to help support the sustainability of the acute system, because we take all. The 10-year effect of those Liberal cuts, 15.4 billion is my updated figure. So for the three years that the commonwealth honours the agreement that the Premier struck it is less money. We are confident in those figures; those figures reflect that. But the ongoing sustainability of our acute system is fundamentally captive to the federal government paying its fair share, both at an acute and primary level.

Dr CARLING-JENKINS — Okay, thank you, Minister, for clarifying that. If I could move on now to budget paper 3, page 91, with reference to the planned increase in critical care capacity, I would like to ask about the 11 new intensive care or neonatal intensive care beds across the state. I would just like to clarify the geographical kind of location or distribution of those in this context. I just wonder if 'across the state' means that they will primarily be located in more of the regional centres where these intensive care facilities are more limited than what is available closer to Melbourne.

Ms HENNESSY — Yes. Thank you for your question. I will hand over to Frances to address where the location and the policy basis upon which those decisions are made, because they are heavily guided by quality and safety issues as well.

Ms DIVER — Those 11 beds are either intensive care beds for adults and children or neonatal intensive care beds, including special care nursery beds. So it is a combination of both of those wrapped up into the 11 beds. First of all, in terms of securing funding for that increase, that is based on the demand for those services — so volume of births, volume of patients that are requiring neonatal intensive care or special care nursery, as well as the adult intensive care. And it is partly linked to the volume of general growth, so if we are going to do more elective surgery patients, we need more intensive care patients.

We are now in a process of negotiating the allocation of that activity to health services, partly based on their demand, partly based on their physical capacity to open those additional beds, and so through that process we will allocate those beds where they needed and that will become obvious in the policy and funding guidelines and statement of priorities that are released — policy and funding guidelines in early July, and statement of priorities in September. So they will be spread across the system based on demand and capacity is the short answer.

Dr CARLING-JENKINS — Okay, thank you. So at that stage you will also know the breakdown between adults and neonates — which beds.

Ms DIVER — Correct.

Dr CARLING-JENKINS — Okay.

Ms DIVER — Roughly — generally it will be around six adult intensive care beds, and we have got five neonatal intensive care beds or equivalents. Neonatal intensive care beds are for the sickest babies and then there are special care nursery beds which are for less sick babies. To ensure we have got appropriate flow of patients through the system we might actually put in two special care nursery beds instead of one neonatal intensive care bed. So we negotiate that with the services based on what the appropriate capacity will be to meet demand, and in fact this year it is likely that there will be more special care nursery beds than neonatal beds, but it all wraps up into 11 ICU bed equivalents.

Dr CARLING-JENKINS — Okay, for sure. So I assume that that is based on the roles of staff — staff capacity, et cetera — as well. There is quite a difference between which staff can — —

The CHAIR — Order! We will break now until 10.52 a.m.

We are about to hear a question from the government.

Mr DIMOPOULOS — Minister, back to BP3, page 217, in relation to the changes to the agency formerly called — was it health complaints? What was it previously called?

Ms HENNESSY — Health services commissioner.

Mr DIMOPOULOS — Sorry, health services commissioner, yes. I think we were cut off earlier. Can you give a bit more detail about the plans to re-establish that entity?

Ms HENNESSY — Yes, and I have managed to follow up some additional information. More generally, there has been legislative reform. To pick up the issue, whilst AHPRA and national bodies are able to regulate the medical professions that sit within the national scheme, we had this great challenge around unregistered practitioners that I spoke to before. People are purporting to provide medical and health advice that they (a) are not qualified for and (b) you used to be able to try and capture some of those through a consumer law process. There were some difficulties; there were some issues that would fall through the gap. That is why that change is there.

In terms of the detail that you asked before, there is outreach to the community to encourage complaints. They are now attending all sorts of forums: aged-care expos, Midsumma. We know part of the issue is the gay conversion therapy as well, an issue that under this new law there would be the ability to address. People are essentially making claims that a particular treatment will result in a particular emotional or health outcome that just have no medical basis whatsoever, but because they were not a qualified doctor you could not pursue them then in the AHPRA or the national scheme. It is essentially filling that regulatory hole.

On the types of complaints that people have most complained about, I have got a bit of a breakdown here: private medical practitioners, 15 per cent; GPs, 8 per cent; dentists, 7 per cent; hospitals, both public and private, 23 per cent; unregistered people, 1 per cent; and there is an 'other' that is 43 per cent — I am not quite sure what sits in that. In terms of demographic information, they currently do not have a lot of useful demographic information, and that is perhaps something we can take on board.

Mr DIMOPOULOS — That is very useful. Thanks, Minister.

Ms SHING — Minister, I would like to go back to what you have already started to refer to in relation to the nurse's EBA and to terms and conditions of employment that apply across the health sector for nurses and midwives. I would like to take you in particular to BP4, page 51, and the Health Service Violence Prevention Fund, the statewide initiative that operates to address occupational violence against the health workforce. Can I ask you to explain how the bullying and harassment strategy that you have outlined will be funded, as well as overseen, managed and implemented?

Ms HENNESSY — Thank you very much. There are two issues there. One is about hospital violence and aggression, which we know is a significant issue for our healthcare workforce and our paramedics. We established a $20 million hospital violence prevention fund to help where hospitals and health services could identify what they saw as their risk and then make an application for funding. We have released some of those grants and have more to come.

Some of those things, for example, include duress alarms for home-care workers. Our Peter Mac home-care workers when they are visiting people in their home are by themselves, and that was identified as a risk and so they use duress alarms. The phrasing here is 'innovative stab vests', but it essentially is protective clothing for security guards at Footscray Hospital — that was the application that that service made. A lot of security and control doors — many of our rural health services were looking for support to put CCTV cameras in. The round 2 applications are soon to be released, and we have expanded the eligibility for that to Ambulance Victoria as well.

In terms of the bullying and harassment strategy, it has actually been a very positive thing, I think, to see so many parts of the health sector workforce identifying that we have significant cultural changes that need to occur within the health system around bullying and harassment. There has been terrific work done by the royal college of surgeons, for example, and the AMA. We have been doing some work as well. I have also included this in our statement of priorities, with health services as well. It is one of the great issues that was identified. I asked the Auditor-General to conduct a review of our health services. I was very, very open and honest that I

perceived that there was a significant issue in the health system on this issue, and the Auditor-General confirmed that, with some suggestions for improvement.

I have established a body that Helen Szoke, who also led the work by the royal college of surgeons, in terms of identifying how we can not just get better cultural change in health services; there is a real issue around people feeling that they will not suffer professionally if they make a complaint. So we have also established a group of people that can go into health services and investigate matters of bullying and harassment in the event that the existing industrial systems do not work or people are frightened about, and I can confirm, Ms Shing, that in fact that is currently underway. We actually have a group in investigating a health service about bullying and harassment matters.

Ms SHING — Thanks, Minister. In relation to budget paper 3, pages 219 and 237, there are performance measures there that relate to activities that go on in and across our hospitals and health services, and they relate not just to health, wellbeing and workload management but also to patient care and patient safety. That ties in directly to the implementation of the nurse-to-patient ratio legislation, and I ask you to update the committee in relation to how that is tracking and whether there have been any unforeseen or unplanned costs or issues associated with that.

Ms HENNESSY — No is the short answer, Ms Shing. Again, it is one of those reform areas where some people thought that the sky might fall in. Fundamentally this is about patient safety. There has been successful implementation. There has been very, very positive feedback from the sector. We have seen the benefits of this in the most recent EBA discussions. In the past our nurses have actually had to bargain for what is something that is essentially the role of the state around patient safety. So we are delighted that we have removed that obligation. There have been no additional costs identified. And, yet again, one of the things that I continue to learn is that when people identify barriers, actually working collaboratively with services and your workforce to remove those barriers is possible with patience and a spirit of compromise.

Mr MORRIS — Perhaps I could go back to the secretary and budget paper reference BP4, page 17 — the cladding on the VCCC. As you know flammable cladding was found at the VCCC. I am just wondering whether that has been removed and if so what was the cost and who paid for it.

Ms PEAKE — Thank you for the question. I will just refer to Ms Diver to give you an update. What I can inform the committee is that the building has been cleared for occupancy and that there was a small area of the building where there were problems with the cladding, and that comes down to a cost for the contractor, not for the state. But I will just ask Ms Diver to elaborate.

Ms DIVER — That is correct. In terms of VCCC there was a small area that has been removed. The issue is resolved.

Mr MORRIS — Similar cladding, I understand, was at least at the Royal Women's. But are there currently any other hospitals with the same or similar cladding on them?

Ms DIVER — At both Bendigo and Box Hill any issues of cladding have been assessed and resolved. Royal Women's Hospital does have cladding that is the subject of further investigation. The building has been declared safe for occupancy. The matter is now with the appropriate authority, which is the municipal building surveyor — that is, Melbourne City Council. Melbourne City Council will be making a determination as to what future rectification works need to be undertaken. I should reiterate that the building is safe for occupation, but in the medium term the building surveyor will determine what action is necessary to ensure that the building complies with the national building code. That will of course be a matter for the private partner that built the hospital.

Mr MORRIS — Okay. Do you have a date on when the — —

Ms DIVER — No, I do not have a date on when the building surveyor — —

Mr MORRIS — You don't?

Ms DIVER — We are actively working with the municipal building surveyor at the moment.

Mr MORRIS — Okay. I do not think I have had an answer on cost apart from your comment about the Women's and the private provider.

Ms DIVER — There has been no cost to — —

Mr MORRIS — No cost to the department on it?

Ms DIVER — Yes, there has been no cost to the government.

Mr MORRIS — Terrific. Thank you. If I could stick with the secretary in terms of questioning but move onto Better Care Victoria — budget paper 3, pages 78 and 80 — page 78 indicates a Better Care Victoria Innovation Fund, but there does not appear to be any funding specifically to actually operate Better Care. So I am just wondering where in the budget is the funding to operate Better Care and how much it is expected to cost to operate it this year and next year.

Ms PEAKE — The staffing that is supporting Better Care Victoria is coming from within our strategy team, so it is an internal resource that we have applied to supporting Better Care Victoria; it is not an additional cost that has come onto the budget. As you have identified, Mr Morris, the funding that has been identified in the budget is the $10 million, which is for the activities of Better Care Victoria, which is really around scaling innovation to increase capacity within our health services.

Mr MORRIS — Can you give me an idea of the staffing and whether it is the same or similar to the Health Innovation Reform Council?

Ms PEAKE — We are really in the process of building up the functions of Better Care Victoria, so we have a team within our strategy unit that previously not only did work around the previous advisory committee but also did health reform work within the department, and those resources have been targeted at this important initiative.

Mr MORRIS — So numbers, roughly?

Ms PEAKE — I would have to take that on notice to confirm the numbers.

Mr MORRIS — If you could do that, that would be good. Contract C4817 indicates that $281 000 is to be paid to Dr Douglas Travis for the establishment of Better Care Victoria consultancy advisory services, and the period is 10 February 16 to 9 Feb 17, so effectively an annual rate of 281 000. I am just wondering what that is actually purchasing.

Ms PEAKE — Certainly. On the back of Dr Travis's report he has been supporting us in looking at the models that we will apply to scale innovation across the system. As you would appreciate, there is a need to think about not only the sorts of technical solutions for improving business processes but the adaptive approaches to spreading good practice, spreading models of care and how we enhance our relationship with clinical networks and make use of those clinical networks to spread good practice. He is also providing us with really important advice around working with health services to identify the sorts of improvements that will add capacity to our health service, building on some of the work that he did in his previous review, as well as working with us on what the long-term form of Better Care Victoria should look like and working with that team within the strategy unit to really focus the activities of Better Care Victoria.

Mr MORRIS — How many days a week is he working?

Ms PEAKE — It is not a matter of set days of the week each week. It is really looking at, over the year, a flexible arrangement with him. It is costed on a number of days over a year, but it is not on the basis of a set time each weeks; it will depend. As we go through the process of working with individual health services, there will be more intensive periods of the year where we are looking at how we take projects, take good work that is happening in one health service and engage other health services that would benefit from that.

There is another strand of work, which is really health services coming forward and identifying that they have a problem, and him working quite intensively with them to look at what other parts of the state that they could learn from. So it is not as sort of straightforward as 'This week it is this number of days'. We have a very big body of work to do to build the capacity across the system.

Mr MORRIS — Sure. You mentioned that it is costed on a number of days over the year. How many days is that?

Ms PEAKE — Sorry, I should have been clear on that. It is costed on a combination of looking at the sort of work and the expert advice that we need for him. It is costed on looking at the preparation for the board meetings to make sure that we are focusing the activities of Better Care Victoria and the sort of information to get a board going and up to speed. I am certainly happy to come back to you with some further information.

Mr MORRIS — If you could give us the precise number of days, that would be helpful. Resourcing: the 281 000 — is that coming from internal sources?

Ms PEAKE — Yes, correct.

Mr MORRIS — Just one other question on this issue. The Health Innovation and Reform Council is classified as a B1 board. Government guidelines for B1 boards say the chair should be remunerated at a maximum $48 958. I was just wondering whether Dr Travis is being paid, as Better Care Victoria chair, in addition to the 281 000.

Ms PEAKE — No, he is not. As I have said, there are functions that we are engaging him on that are broader than the chairing role.

Mr MORRIS — Yes, but there is not an additional stipend being paid?

Ms PEAKE — No.

Mr MORRIS — Thank you.

Mr D. O'BRIEN — Ms Peake, if I just take you to budget paper 3, page 78. In the table there for output initiatives, there is 'Meeting hospital services demand'. I wonder if you can tell us specifically what that is paying for. There is 25 million in the current financial year, and then it is significant over the additional years.

Ms PEAKE — I might actually just get Ms Diver to step you through that money that has been put forward.

Mr D. O'BRIEN — Okay. The question that I want to get to is: was any of that additional supplementation to pay for the additional costs of public holidays?

Ms DIVER — That funding is for growth in hospital activity — so expanded services. That pays for things like additional emergency department capacity, additional elective surgery capacity, additional palliative care capacity, additional chemotherapy, radiotherapy, renal dialysis — so all of our acute hospital services; we work out what the demand is going to be based on population growth demand capacity. That wraps up into that amount of money, and then we allocate that funding to health services.

Mr D. O'BRIEN — Is any of that allocated — —

Ms DIVER — There is no specified line in there that is for public holiday costs.

Mr D. O'BRIEN — Last year, we have seen an increase in the WIES for metro and large regional hospitals of about 3.6 per cent. Is any of that through an increase in public holiday costs?

Ms PEAKE — I think when we talked about this earlier in the year we covered that there is not a line item that is in the budget — —

The CHAIR — Order! Ms Pennicuik, until 11.20 a.m.

Ms PENNICUIK — Minister, I would like to further explore some of the detail that we were going to in terms of Western Health urgent infrastructure works, which we were talking about earlier this morning. So one of the responses that — —

Ms DIVER — Frances.

Ms PENNICUIK — I cannot see your name from here with my eyes.

Ms HENNESSY — It is Frances, Ms Pennicuik.

Ms PENNICUIK — Ms Diver! What Ms Diver said was that the government shifted services from Footscray to Sunshine. My information is that it did not repurpose the three wards that are closed at Footscray Hospital or the Footscray site — I call it Footscray Hospital just because of the history —

Ms HENNESSY — Yes. No, no. Feel free. I do too.

Ms PENNICUIK — due to the run-down state there. Just to follow up on that, that is my advice. My question really is: will the urgent upgrade works focus on upgrades to keep any of those three wards open and the 77 beds in the south block open, because it is quite a number of beds to be closed? My advice is that they are closed because they are not fit for service. Will they ever be reopened?

Ms HENNESSY — Thank you, Ms Pennicuik. I will make a couple of comments, and then I will hand over to Frances to give you as much greater detail as she possibly can. It may be that we have to come back to you to see if there is other information that we can furnish you with. Certainly the funding in this budget goes to the important work that needs to be done on the south block, so that goes to the areas that you have identified. In terms of what has been shifted where and for what purpose: the establishment of an intensive care unit at Sunshine Hospital — previously, if a patient at Sunshine Hospital required intensive care, they were transferred essentially to Footscray. The establishment of an intensive care unit at Sunshine and a critical care unit has meant that they have reconfigured their model of care. I cannot put my hand on heart and say that acquits every single bed that you have identified, and I am certainly happy to see if there is any further information that we might be able to furnish for you, but I might just ask Frances to see what it is that she might have to add.

Ms DIVER — We will need to get back to you with more detail about precisely what the $17 million covers in terms of urgent infrastructure works. But the intention is to upgrade the facilities so that they are more appropriate, so things like shared bathrooms, shared wards and the state of the infrastructure are part of the intention for that $17 million. But in terms of how many extra beds will be opened as a consequence of it, I will need to take that on notice.

Ms PENNICUIK — Yes, thank you for that information. It does seem that if that number of beds is closed, it is a large number of beds, particularly in an area of growing population and growing demand, which I do not think we would argue with.

Ms HENNESSY — No. Definitely not.

Ms PENNICUIK — Minister, in terms of education, for example, I am often querying the education minister as to how the triage of works being done on particular schools is decided upon. It is a mysterious answer still. I am wondering how that is carried out in terms of hospitals and other health facilities, and whether there is any other hospital in the Victorian system that is so run down and has had such a large number of beds closed?

Ms HENNESSY — I will make some broader comments and then hand to Frances to see if she can give you any particular detail. We know that capital in our health system has been significantly underdone. We have made significant capital investments as a government, both in our first budget and in our second budget, and we will continue to heavily invest. To put a comparator to what the previous government invested, I think their last capital was $221 million. We are putting in around $861 million this year. I say that not be provocatively partisan but to demonstrate the authenticity of our commitment to genuinely investing in health capital.

Ms PENNICUIK — Minister, I am not querying that, but I have a short time allocated, so I am just wondering if we could — —

Ms HENNESSY — I will get to the nub of your issue. There is a broader policy issue as well, and that is why we are doing a statewide health services and infrastructure plan — one has never been done right across the state — to address this very issue. I do want to go to Frances, who can answer some of those questions, but also to make the point this is not just about infrastructure; it is also about high-value equipment as well, because the location and placement of high-value equipment across the state goes to the type of care that patients receive. I will hand over to Frances to see if she can quickly add — —

Ms PENNICUIK — Yes. Before you do, some of the equipment we are talking about at the Footscray site goes to the basic equipment, like boilers and — —

Ms HENNESSY — Yes, yes. Infrastructure fund — high-value infrastructure fund.

Ms DIVER — High-value but critical infrastructure I think we would call that. I think there is acknowledgement that Footscray Hospital is in serious need of urgent works, which is why we have got the initial package.

The second thing is that of course it is in urgent need of planning works, so what is the future for Footscray Hospital. Part of that $17 million has planning money for the next development. It is probably just worth mentioning there are a couple of other things that are going on, so we have got the growth in services at Werribee and at Footscray and significant investment at Sunshine and Werribee. In addition to that we are undertaking a western area growth corridor plan to look at what the whole region looks like, including Djerriwarrh Health Services in Melton, to determine what is the appropriate mix of services across those locations. So urgent works now, planning work, broader area planning work, reconfiguration and significant growth in services and infrastructure at Sunshine and Werribee, and I think that will lead us to what the picture should be for investment in Footscray in the future.

Ms PENNICUIK — Is that $2 million for planning works implying that there is some commitment to a redevelopment at the Footscray site?

Ms HENNESSY — We understand that Footscray in its present form is not sustainable — the infrastructure there is not sustainable for the longer term — so at the request of Western Health we have allocated some money to enable them to plan what would the future look like.

Ms PENNICUIK — Thank you. Minister, if we could just finish off. The other question I was asking about, which was Williamstown and Sandringham in the emergency departments — —

The CHAIR — One minute.

Ms PENNICUIK — I think we got to the same point last time. You gave me quite a bit of an answer there, but what I was really looking at is, while the court actions are going on and everything else, whether the government is able to commit to keeping those emergency departments open while ever the other things are resolved?

Ms HENNESSY — We are going to keep investing to keep emergency access for those communities, but we are not prepared to let the federal government off the hook.

Ms PENNICUIK — I hear that.

Ms HENNESSY — And we are pursuing the High Court action with great gusto. I make the point that, by way of contrast — —

Ms PENNICUIK — But in the meantime the emergency wards will stay open?

Ms HENNESSY — We will continue to keep them open until these matters are resolved, yes.

Ms PENNICUIK — Okay. Thank you, Minister.

Ms WARD — Minister, I want to go back to this issue of the federal cuts, which Ms Pennicuik also ended up with. You spoke about not letting the federal government off the hook. Can you explain to us what that means? This would refer to budget paper 3, page 78.

Ms HENNESSY — Thank you very much, Ms Ward. It is absolutely critical for both levels of government to be committed to our health system, whether that is in the primary care space or in the acute care space or in the preventative space. As a government, we have made enormous investments in our health system, but the sustainability of continuing to fill the gaps and to ensure that we have got a prosperous primary care sector, to ensure that we have got terrific investments occurring in the preventative health space, ensuring that our

medical research and med. tech. and pharma sectors are prospering, that the huge costs of capital and the important forms of capital are actually addressed.

We know, for example, at St Vincent's with the Aikenhead site — the Aikenhead Centre for Medical Discovery — that amazing things are being done. St Vincent's has raised $60 million. We have committed $60 million that is in contingency in the budget, but are awaiting the federal government to announce whether or not they will commit the final $60 million. It will be the same story inevitably around the Victorian heart hospital, but we are not going to let them off the hook.

We have had $90 million cut from preventative health. We have had money cut from dental. We have had money cut from sexual and reproductive health services for Indigenous Victorians. At every single time that there is a cut, the state cannot continue to fill those holes.

We have a large number of health services across this state. The current federal budget projections as they stand indicate $15.1 billion still coming out of our health system. We are grateful that we have managed to achieve a three-year reprieve, but the document that I sent around to you shows what that scale is. In terms of the $78 million, we are pursuing that by virtue of High Court action, but other than advocacy, ensuring that governments understand that if you do not invest early in health, you pay for it later and it is ultimately the taxpayer. So things like the GP co-payment, which is a matter that is currently the subject of great debate, these have significant impacts on the costs of our acute system. We genuinely want the federal government to be partners and we genuinely want them to step up and make their investments in our health system and to understand that I think Australians that genuinely really do value the concept of universal access. But these kinds of cuts cannot be sustained when you look at the demand that is going to hit our health system around an ageing population, chronic disease and utilisation.

Ms WARD — Looking at budget paper 3, pages 219–22, it mentions in there changes to the national health reform agreement made by the commonwealth government. There has been ongoing discussion around recalling funding. Can you talk us through that and explain what that means and how that affects the government performance measures outlined in the pages I have mentioned?

Ms HENNESSY — Certainly. I might have to hand over to either Frances or Lance in a moment, but more generally this is what we refer to as the $78 million clawback. That is, we had an agreement — in fact it was an agreement struck by the previous government with the federal government — about the allocation of funding to our health services. That money was for activity that was performed. 'Activity' is health bureaucratese for surgeries and treating a patient. So money that was planned for by health services, money that was spent. This goes back 1.5 financial years — $78 million. The federal government then came and said, 'No, we're taking this money back'.

As a consequence of that, that would mean requiring our health services to pay that money back to the federal government or pay that money back to the state to pay back to the federal government. So we sought legal advice. We were advised that we had a reasonable prospect of success. This is all after we have exhausted polite intergovernmental and bureaucratic diplomatic discussions. But this is the reason that we have landed where we are around the Sandringham emergency department and Williamstown. The scale of money that is required to be paid back — and, as I said, the state is currently filling the hole — is such that it will have a dramatic effect on those health services.

I would feel grumpy if the federal government decided that they wanted to change that prospectively, but to do it retrospectively — for surgeries that have already been performed, for staff that have already been hired and paid, and for services that have already been paid for — is reprehensible.

Ms SHING — What about in the context of regional health services and patient care as far as those federal cuts are concerned, Minister? Can you talk us through what the impact would be in regional Victoria for those cuts to patient care and outcomes?

Ms HENNESSY — To give you a flavour around what kind of figures we are talking about, for Latrobe Regional Hospital that would be $299 million that they would lose over the next 10 years with the federal government cuts. For Goulburn Valley, that would be 261 million. So 261 million is about 650 000 emergency department presentations. These have significant impacts. Whilst these are figures and these are percentages and data, these are real people — —

Ms SHING — That is half of the challenge. In understanding the quantum of cuts and their impact it is very easy for us to sit and look at a budget paper and to understand what the numerical difference is. But in terms of patient care and in terms of the way in which that will affect individuals and communities within regional and rural areas, if you could just give us some further information on that in relation to what these numbers mean in substantive terms.

Ms HENNESSY — So for West Gippsland Healthcare Group it would be $100 million. That would be 248 470 emergency departments. That would be 214 733 dialysis patients. That would mean 16 000 elective surgery episodes. These are not problems that are going to go away is the essence of my point.

Ms SHING — Is that information publicly available in relation to what those cuts would mean?

Ms HENNESSY — I have circulated it here today, and I am more than happy to make it available to anyone who would like it.

Ms WARD — Going back to your earlier response to me, you mentioned dental services. If we go to budget paper 3, page 234, I note the total output costs variance between the 2015 target and the 2015–16 target. That expected outcome is significant. I note that the 2016–17 target then reduces again significantly. Can you please explain why that is?

Ms HENNESSY — I certainly can. Our government has not cut money from dental; I want to make that very clear. You will see that there is a footnote at page 234 that at the time we set this budget there had been no commonwealth government announcement about their plans for dental services in Victoria. Unfortunately on 24 April the commonwealth government announced additional cuts to dental care through plans to abolish the child dental benefits scheme. I know that that will result in greater waiting lists and longer times for dental treatment — —

Ms WARD — Minister, do you know how many children were accessing that?

Ms HENNESSY — I will have to take that on notice, Ms Ward, and come back to you —

Ms WARD — Thank you.

Ms HENNESSY — but particularly in rural and regional Victoria some of these investments are absolutely critical. Good dental health is a platform for general health and wellbeing. There are some terrific things being done. I know up in Shepparton, for example, investments in things like a mobile dental bus, where they go and visit one of the schools. That is an autism specific school. You can imagine for children with ASD how difficult it is to have dental treatment, but they take the bus to this school and the children play on the bus for a little period for a few weeks before they then reach into doing important dental work. I know that out in places — —

Ms WARD — Is that funded by the state government or that was in part funded by the commonwealth?

Ms HENNESSY — That was in part funded by our allocation last year. There is terrific stuff being done in community dental — —

Ms WARD — So that would be affected by these cuts?

Ms HENNESSY — Potentially. You cannot cut the general funding agreement and expect that the same amount of people are going to be funded for it. Community dental services is a prime identifier of victims of family violence. There is amazing work being done out at one of the community health services attached to Dandenong Hospital. Victims of torture are often tortured through their mouth and so they have a whole model of care there that supports people. This is really important and it often goes to people that are incredibly vulnerable as well, so these are cuts that will genuinely hurt the sorts of services that are providing very unique models of care, longer waiting lists for people. It is pretty awful walking around with significant pain in your mouth.

Ms WARD — In dollar terms, do you know what the cuts are to the child dental scheme?

Ms HENNESSY — We are still working through that with the commonwealth. We know there is about a $35 million cut.

Mr D. O'BRIEN — Ms Peake, I just want to quickly go back to the issue I was just talking about with the budget paper 3, page 78. Can I just get on notice the 25 million that was allocated for this current financial year, what that was and who it went to? If I could get that on notice, that would be great, thank you.

The CHAIR — Which line item were you referring to, Mr O'Brien?

Mr D. O'BRIEN — Line item 'Meeting hospital services demand', which has a footnote (a). Moving on, as you know, every couple of years there are additional costs for hospitals as a result of holidays falling on Sundays. In 2016–17 there are two additional days paid at public holiday rates because of the substitute holiday for Christmas Day and an additional holiday for New Year's Day. What funding in the health budget has been allocated for these two additional holidays for this coming financial year?

Ms PEAKE — This is a continuation really of the question, Mr O'Brien, that we were cut off with previously. So I started to say that I think we had some discussion about this at our hearing in February, and, as Ms Diver has outlined again today, the way that we put budgets out for health services is that, following the budget appropriation we go through a period of then determining our budget and funding guidelines and enter into agreements with each of the health services, which is articulated in their statement of priorities around the targets for those health services and what they will deliver. What we do not do is then identify with them or dictate to them how many services are going to be delivered on any given day, and it really is a matter for those individual health services to budget across their year for how they are going to deliver against their targets.

Mr D. O'BRIEN — But when you are preparing those budgets and the contracts with individual hospitals, you are working out what is going to cost you this year, and surely you would be working out those additional public holidays, as you do for the nurses' EBA or any other EBA that affects the health service, surely.

Ms PEAKE — Really, we do not get down to the level of disaggregating at that sort of input level. What we do is look at the demand and capacity across the health service, and we set those targets over the whole year. And, as I have said, it is a matter for the hospital or the health service to then manage to those targets across their whole year.

Mr D. O'BRIEN — I will perhaps turn to the minister and try to come at it from a different angle. I understand perhaps at the individual level we are not going to look at it per hospital or per funding contract, but at an aggregate level there must be when you are working through what the costs are of holidays. I have asked the question about the additional ones for 2016–17, but we have had departmental briefings in the past where the department has actually worked out what the cost is for the entire health system of those additional days in 2016–17. It was listed as somewhere around $50 million. Is that something that you can — —

Ms HENNESSY — I cannot confirm that for you, Mr O'Brien. My advice is that it is in the base, and I would refer to the secretary's answer.

Mr D. O'BRIEN — Okay. I know members opposite are getting frustrated, because we are going back to this, but we asked you in PAEC last year, we asked in the outcomes hearings as well, we asked in the Parliament, and through questions on notice, what are the costs for the additional public holidays — moving on to the additional ones that have been introduced. Why can't we get that figure?

Ms HENNESSY — Mr O'Brien, if there is anything further I can add, I will bring that back to the committee, but it is essentially we are — —

Mr D. O'BRIEN — Answer the question.

Ms HENNESSY — It is in the base.

Ms SHING — It has been answered.

Mr D. O'BRIEN — No, it has not.

Ms HENNESSY — We fund through WIES price.

Mr D. O'BRIEN — But what is in the base? I mean, the Labor election commitment gave a figure. Why can't the government, now in government, give us a figure?

Ms HENNESSY — Because we fund around activity, and there is really nothing more I can add. I can give you an undertaking that I will go back. If there is anything more I can add to the answers to your questions, I will.

Mr D. O'BRIEN — I am just frustrated, Minister. This is money that is spent on public holiday costs, not on additional health services, so why can we not find out what it is? You must be able to work out — —

Ms HENNESSY — We fund WIES, Mr O'Brien, and, as I said, if there is anything further I can add, I will bring it back to the committee.

Mr D. O'BRIEN — Well, we are just going to continue — —

The CHAIR — Another question, Mr O'Brien?

Mr D. O'BRIEN — I will move on. Budget paper 3, page 92, we talked about the Regional Health Infrastructure Fund, and I know you were answering some questions about this before, but the West Gippsland Healthcare Group, Warragul, the planning money there: is that to build a new hospital on a new greenfields site or will it be on the existing site?

Ms HENNESSY — That will be a matter that will be determined in the course of the expenditure of that money. I am aware, having met with Warragul, that there is a piece of land that might be a potential greenfields site. So essentially it is to do the planning around would you go onto a greenfields or not, what is the scale and scope of what is needed, would you do a redevelopment where Warragul is. We do not have the answer to those questions. I do know, particularly through Ms Shing reminding me on many occasions, and having gone and met with some of the leadership team at Warragul, that part of the challenge is the great growth there. The existing infrastructure makes things very challenging around the emergency department and the short-stay unit. And getting a proper service model, you know, I have got to look at how things work from a system-wide perspective as well, so we have West Gippsland, Latrobe and then we have got Bass Coast as well, and we have just got to make sure within that we are meeting the needs of local communities with the right models of care and the right degrees of specialisation at different ones of those hospitals.

Mr D. O'BRIEN — Given you have met with the hospital and with Ms Shing, and presumably other members of the community, you would have heard that they want a new site. Is there a predisposition of the government as to where it will be?

Ms HENNESSY — No. The planning money will provide an opportunity for that work to be done.

Mr D. O'BRIEN — Okay. Budget paper 4, page 51, shows the new Drummond Street building at Ballarat Hospital will be completed shortly. The first floor is for theatres. Is there any funding to fit out the surgical floor in this budget?

Ms HENNESSY — I will just have to take some advice from Ms Diver. Our $200 million regional infrastructure investment fund is available to all regional health services, and Ballarat would of course be very entitled to apply, if that is the case.

Ms DIVER — No. There is no fit-out for additional surgical in this.

Mr D. O'BRIEN — So the latest performance statistics show that there are 1333 people on elective surgery waiting lists in Ballarat. It is a 37 per cent increase on a year ago. There is clearly a demand for elective surgery. When can Ballarat Hospital expect to be funded to fit out and operate these built but empty additional theatres?

Ms HENNESSY — They can apply to the regional infrastructure investment fund, and I am aware of some of the performance challenges that Ballarat has. Ballarat will also benefit from our significant investment that we have made in this year's budget.

Mr D. O'BRIEN — I know you did speak about this earlier, but can they apply to that fund now? Is it open?

Ms HENNESSY — Yes, they can. Sorry, as of 1 July, Lance? Sorry, I will just wake up my finance guy.

Mr D. O'BRIEN — Do you want me to yell a bit more? I can get a bit louder, if you like.

Ms HENNESSY — I mean I know it is enthralling, Lance, but when is the date from which funds will be available to flow from the regional infrastructure investment fund?

Mr WALLACE — From 1 July.

Ms HENNESSY — One July.

Mr D. O'BRIEN — Sorry, but when are we likely to get announcements? That is when they can apply, I understand?

Ms HENNESSY — I will hand over to Frances. I think she might be able to provide you with accurate guidance.

Ms DIVER — There will be an expression of interest process that will go out shortly. We expect to be able to allocate the funds by September.

Mr D. O'BRIEN — Okay. Will that fund allow hospitals to apply for potentially multimillions of dollars?

Ms HENNESSY — Clearly with $200 million in it, it is unlikely that one $200 million application is going to be made available.

Mr D. O'BRIEN — No.

Ms HENNESSY — The reality is that most capital is done in stages as well, and so one of the things — —

Some of the health services that want to talk about potential capital investments are talking about how they might stage and phase those investments.

Mr D. O'BRIEN — Just to be clear on this one: the surgical theatre fit-out would be something that could be done?

Ms HENNESSY — They could make an application to the Regional Infrastructure Fund, like every other regional health service.

Mr D. O'BRIEN — In budget paper 3 page 89 outlines a range of new asset initiatives. The Waranga memorial hospital at Rushworth wants to co-locate its hospital and nursing home that is on Rushworth's main street, which has been an issue for them for a while, particularly as the hospital is quite isolated, and the need for master planning funding is well known to the department and the government. I am sure you have heard from the member for Euroa. Why is there no funding in the budget for the redevelopment of the Waranga hospital?

Ms HENNESSY — The Waranga aged-care facility —

Mr D. O'BRIEN — Well, the co-location of the hospital — —

Ms HENNESSY — is eligible to apply to our $200 million regional infrastructure investment fund.

Mr D. O'BRIEN — So the hospital — —

The CHAIR — Order! Mr Dimopoulos until 11.50 a.m.

Mr DIMOPOULOS — Minister, can I bring you to BP3, page 79, in relation to refugees? There is a line item 'Increased refugee and asylum seeker arrivals', starting with 2.9 million in this coming financial year. I just wonder if you could give us an outline of what this funding will do and how many refugees it is expected to support, and is it adequate, do you feel, to address the expected needs or demand?

Ms HENNESSY — Yes, if you just permit me a moment to look at my notes on this.

Mr DIMOPOULOS — Sure. Perhaps even some background about how the figure was arrived at and what we expect the numbers to be?

Ms HENNESSY — Yes. So the precipitator for this investment was the federal government making an announcement that they would support and enable, I think it is, 12 000 Iraqi and Syrian refugees through the

humanitarian program. In Victoria we feel very proud of the very wonderful services that are provided to both the refugee and asylum seeker communities right across — from health services to primary care to aged care. There are some amazing people doing amazing things. So this budget puts an additional $10.9 million over four years for the health and human services component to support that settlement in Victoria. That will assist with community-based refugee health services and getting targeted support to co-locate them with commonwealth-funded settlement services in priority areas.

So there are many things that the commonwealth pay for in respect of this humanitarian intake, but there are some things that they do not. I am the first to have a crack at the commonwealth for not stepping up and giving money where they should, but on this I also think that the states have an obligation, and we are very happy to meet our obligation. Some of the kinds of things that we know that this community — —

We understand there are about 12 000. Ordinarily you would think that Victoria has 25 per cent of the population. We have traditionally stepped up a little bit because we have such a terrific health service and health sector with terrific expertise — —

Mr DIMOPOULOS — And values.

Ms HENNESSY — Yes, absolutely, but some of the areas around health screening, with immunisation obviously being an issue. So existing immunisation measures are going to be supplemented to cover the purchase of things like vaccines that are not currently covered by the commonwealth vaccine program.

Mr DIMOPOULOS — Minister, just a brief supplementary?

Ms HENNESSY — Sure.

Mr DIMOPOULOS — Before I ask that supplementary, I just want to acknowledge the member for Essendon, who is a bit gagged because he is the Chair. He is a big supporter of issues of equity for our refugees and asylum seekers. He has asked about that at various PAEC meetings in the past. Just quickly, in a minute or less if you can, how many of that cohort that the commonwealth government promised have already settled in Victoria?

Ms HENNESSY — We only have a reasonably small number here at the moment. I think that we have got about a hundred on that particular humanitarian intake. Just having looked at my notes, we anticipate settling around 4000 Syrian and Iraqi refugees over two years, and the advice from the commonwealth is that that intake is set to increase steadily from mid-2016. The Minister for Multicultural Affairs, Mr Scott, is the minister responsible for coordinating our whole-of-government response, but certainly in the health sector, with health screening, we have got a large number of unaccompanied minors as well that will be coming to Australia and perhaps Victoria. The psychosocial support that is required will also be supported in this investment. I also want to — —

I do not know if it is the done thing to give a PAEC shout out, but there are many people from the not-for-profit community that are putting their hands up to do extraordinary things and to say — for example, St Vincent's and some other people have said, on something that was going to be an aged-care development that is not ready yet — 'We're happy to turn that into housing' or There's a lovely primary school next door; we're happy to take some students there', and so trying to find those models, and traditionally trying to identify areas where there are existing Syrian and Iraqi communities —

Mr DIMOPOULOS — Support, yes.

Ms HENNESSY — so there is some semblance of cultural architecture, I suppose, for people as well.

Mr DIMOPOULOS — Thank you very much.

Ms SHING — Minister, thanks for your answers in relation to the initiatives around refugees and asylum seekers. You have also referred to measures around immunisation coverage. I take you to BP3, page 239, and performance measures relating to immunisation coverage. How many whooping cough vaccinations have been procured to date?

Ms HENNESSY — A lot. Just permit me time to check my notes.

Ms SHING — Yes, thank you.

Ms HENNESSY — Magically the number has appeared! This is a really terrific program. We know that 130 000 — so the uptake on this has been extraordinary. The pertussis virus — again, we are coming into winter, and we always look to Europe to see what their flu experience has been. If you go and talk to nurses, for example, that have cared for babies with whooping cough, they will tell you stories that I will not share with you here today because they are pretty awful and it serves no demonstrable purpose. But the critical issue is this is a program that our government restored, that was cut by the previous government, and there is a need.

The key change that has occurred around vaccinations for pertussis, or whooping cough as it is more commonly known, is that a pregnant woman can actually be vaccinated up until the third trimester, and the clinical evidence is that the antibodies that are actually in the vaccine will transfer to a newborn baby. So that strengthens the ability of a newborn baby to be immune to whooping cough as well. But again we are forever calling upon people to vaccinate and immunise, and whooping cough is certainly no different. Amanda, I do not know if you have any other observations that might be of interest to the committee.

Ms CATTERMOLE — I think you have covered it, Minister.

Ms HENNESSY — The answer is, 'Not really'. That is completely acceptable.

Ms SHING — Thank you, Minister, for that information. How is the work in relation to that eternal vigilance required on increasing base rates of immunisation delivering better immunities for the community at large?

Ms HENNESSY — This remains an ongoing challenge right across the community. You will see in the budget outputs that we are actually going to hit target in the budget outputs of around a 95 per cent rate. What that does not show, however, is that there are some age cohorts and some locations where the community has still not yet hit 95 per cent, which is what we need to deliver herd immunity. So, for example, off the top of my head, I can recall that the City of Port Phillip in under-5s is still at 86, the City of Melbourne is at 89. We need to get to 95.

Ms SHING — But they are metropolitan concentrations in relation to being below herd immunity?

Ms HENNESSY — That is exactly right. The data does show some concerning figures in some rural locations, but I have been cautioned by people who understand this in far greater detail than I that that is sometimes to do with just a very low figure, and so one unimmunised person throws the rate out significantly. We have a whole range of activities underway. Amanda, did you want to talk a little bit about what we have been doing in terms of particularly trying to grow our immunisation rates on top of no job, no play — other things we are doing to grow our vaccination rates?

Ms SHING — Thanks, Ms Cattermole. Just in the next 40 seconds if you wouldn't mind.

Ms CATTERMOLE — Thank you. I can add a little bit. Certainly the minister has covered a great part of it. Just in terms of particular places where the immunisation rate might be lower, we spent quite a bit of time working with local councils providing them with data and with information and toolkits so they know what is going on and they can also work with communities to bring up those immunisation rates and work with local services about how they can tailor their services accordingly where they need to.

The no job, no play initiative has also augmented that work, and in that respect we have developed further communication material for immunisation providers. One of the recent, I suppose, groovier initiatives has been a smart phone application, and that assists parents with timely vaccination. So we are trying to find all of the different ways that we can communicate and educate so that we improve vaccination rates.

Ms SHING — How very groovy. Thank you. I might use that next segue to refer to medicinal cannabis questions. Minister, I take you to BP3, page 79, and the access to medicinal cannabis initiative. What does that budget funding set out on that page actually pay for?

The CHAIR — Order! Mr Smith, until 12.00 p.m.

Ms SHING — I will take that on notice if I may, thank you.

Mr T. SMITH — Minister, my question is to the secretary, and I refer to budget paper 3, pages 238–39. In April there was a hepatitis scare, and letters were sent to 650 patients who had been potentially exposed to the infected worker. How many people notified have now been tested?

Ms PEAKE — Certainly. Just give me one moment.

Ms DIVER — Seventy-six.

Ms PEAKE — So I think the answer to your question is 76.

Ms DIVER — Sorry, no, I was saying page 76.

Ms PEAKE — Apologies. Sorry, Mr Smith, do you want to just ask me the question again?

Mr T. SMITH — There was a hepatitis scare, and letters were sent to 650 patients who had potentially been exposed to the infected worker. How many people notified have now been tested?

Ms SHING — Sorry, what is your reference, Tim?

Mr T. SMITH — Pages 238–39.

The CHAIR — I assume you are referring to calls to the food safety hotline.

Ms PEAKE — Thank you for the question, Mr Smith. I am just going to ask Ms Cattermole to take you through that.

The CHAIR — It was hepatitis A, wasn't it, Mr Smith, you were referring to?

Mr T. SMITH — Yes.

Ms CATTERMOLE — I think you might be referring to the hepatitis B circumstance. As at 2 May, 529 patients who received the letter raising that issue have responded by contacting the department. To date 181 of those patients have been tested, 173 have returned a negative result to date and the results are pending for 8 patients.

Mr T. SMITH — So has anything changed as a result of this scare in the context of the department's emergency responses?

Ms CATTERMOLE — As part of this, like all of these kinds of processes, we undertake a full review having a look at the circumstances in which this occurred and we always do an analysis of whether or not there is anything we can learn from these processes, and that is underway concurrently with ensuring that we continue those contacts and engage with those patients.

Mr T. SMITH — Thanks very much. So just to clarify, there was no patient who tested positive?

Ms CATTERMOLE — That is correct.

Mr T. SMITH — Okay. Thank you. On to another topic, Minister, commonwealth health funding, budget paper 5, page 160. In 2015–16, 4.069 billion was budgeted to be received from the commonwealth and in this budget you report that in fact you expect this year to receive $62 million more than planned, at 4.131 billion. You repeatedly claim a $73 million cut to commonwealth funding for Victoria, whereas in the budget on the numbers you have presented you are actually expecting a $62 million increase, so could you explain this?

Ms HENNESSY — Yes, I can. In fact I might get Mr Wallace to take you through the sausage-making that is federal funding. A lot of that goes to activity, as opposed to the direct funding formula, so I will enable Mr Wallace to take you through the answer to that question. Just to make clear, I did say 78 before and you are right to say it is 73 that I say, and that is a retrospective two-year cut.

Mr WALLACE — The state is funded for commonwealth funding on an activity basis, so the state receives 45 per cent of the additional activity of patients in the year, and also the state receives funding for indexation and that is at the efficient price, which is set by the Independent Hospital Pricing Authority. The numbers that

are outlined in budget paper 5 reflect the best estimates of additional activity under the NHR agreement, covering both the indexation component and also the activity component.

The issue that we have been discussing relates to what funding was additionally promised by the federal government in prior agreements. Supposedly additional funding was indicated that it was to be provided and as a result of changes to funding arrangements some guaranteed funding is no longer available. The other issue is the $73 million reduction — —

Mr MORRIS — Chair, I am very much aware of the time. I think we have pretty much had what we need from that, thank you.

Can I move on. I seem to be addressing all my questions to the secretary this morning. On the issue of acute training, budget paper 3, page 223 indicates the anticipated cost of acute training and development, with 306 million budgeted but only 255 million anticipated to be spent this financial year. I am just wondering why the significant decline?

Ms PEAKE — I might take that one on notice.

Mr MORRIS — If you could. I would be interested to know whether things originally intended were not funded or were postponed or whatever.

Ms PEAKE — Certainly. Very happy to get you further information.

Ms HENNESSY — Mr Morris, Mr Wallace has indicated that he might be able to provide some general insight as well.

Mr WALLACE — All I just want to indicate is again under the National Health Reform Agreement there has been some reclassification going on to align the Victorian state budget descriptions and classifications with the national health reform. We will take the question on notice, but I think you will find that it is mainly to deal with classification matters.

Mr MORRIS — It would be helpful, not just on that issue, if we could have a more fulsome indication of what those reclassifications are. That would help.

Mr WALLACE — Sure.

Mr MORRIS — I am interested also in the number of rural generalist GP procedural positions. They have declined from 19 in 2014–15 to 15 in 2015–16 and now an expected outcome of 11 next year. I am wondering if you can indicate which areas now no longer have rural generalist GP procedural positions that had them in 2014?

Ms PEAKE — Again, very happy to come back to you with some further information about that.

Mr MORRIS — Okay. If I can move on to the PrEP trial. The reference is budget paper 3, pages 238 and 239. Minister, you made an announcement on 30 January about an expanded trial, up to 2600 Victorians being able to access PrEP. Is there any funding in this budget or in this financial year or the next one for the expanded trial and, if so, can you point me to where it is?

Ms HENNESSY — Our contribution is built into the base, Mr Morris. Last year we made a $1.4 million contribution with a co-funded partnership with both Alfred Health and the Victorian AIDS Council. The real issue around access to PrEP is about commonwealth classification, so we have done a number of things. It was announced on Friday, 6 May, that PrEP has been approved by the TGA as well. That is a very, very positive move and so we will obviously continue with our trial because there will be valuable clinical insights for us. But the whole reason that the state and wonderful places like the Alfred and the Burnet Institute and the AIDS council came together to make that investment is that we were very concerned about PrEP not being approved by the TGA and the delay and the potential HIV risk in that particular period of time. That is a trial that we will continue on and we will acquit ourselves, but fundamentally getting greater — —

Mr MORRIS — Sorry, just to be clear: is the 1.4 expended or is it going into this trial?

Ms HENNESSY — It is in this trial. We committed it last year and — —

Mr MORRIS — Okay. Just one final quick question. The 2600 participants, when do you anticipate that will be reached?

Ms HENNESSY — Unless anyone else on the health and human services panel here can assist me, I will have to take that on notice and am happy to come back and provide you with an answer to that question.

Mr MORRIS — Thank you, Minister.

Ms HENNESSY — My pleasure.

The CHAIR — I would like to thank the witnesses for their attendance: the Minister for Health, the Honourable Jill Hennessy; and Ms Peake, Mr Wallace, Ms Diver and Ms Cattermole. The committee will follow up on any questions taken on notice in writing. A written response should be provided within 14 calendar days of that request.

Witnesses withdrew.