PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Budget estimates 2020-21 (Foley)

Melbourne—Friday, 4 December 2020

MEMBERS

Ms Lizzie Blandthorn—Chair
Mr Richard Riordan—Deputy Chair
Mr Sam Hibbins
Mr David Limbrick
Mr Gary Maas
Mr Danny O'Brien
Ms Pauline Richards
Mr Tim Richardson
Ms Nina Taylor
Ms Bridget Vallence

WITNESSES

Mr Martin Foley, MP, Minister for Health,

Professor Euan Wallace, Secretary,

Mr Terry Symonds, Deputy Secretary, Health and Wellbeing,

Mr Greg Stenton, Deputy Secretary, Corporate Services, and

Mr Chris Hotham, Deputy Secretary, Infrastructure, Department of Health and Human Services.

The CHAIR: I declare open this hearing of the Public Accounts and Estimates Committee.

I would like to begin by acknowledging the traditional Aboriginal owners of the land on which we are meeting. We pay our respects to them, their culture, their elders past, present and future and elders from other communities who may be here today.

On behalf of the Parliament, the committee is conducting this Inquiry into the 2020–21 Budget Estimates. Its aim is to scrutinise public administration and finance to improve outcomes for the Victorian community.

Please note that witnesses and members may remove their masks when speaking to the committee but must replace them afterwards.

We ask that mobile telephones now be turned to silent.

All evidence taken by this committee is protected by parliamentary privilege. Comments repeated outside this hearing may not be protected by this privilege.

Witnesses will be provided with a proof version of the transcript to check. Verified transcripts, presentations and handouts will be placed on the committee's website as soon as possible.

We welcome Minister Foley to discuss with us the health portfolio, and officers of your department. Minister, we invite you to make an opening statement of 10 minutes. This will be followed by questions from the committee.

Mr FOLEY: Thank you, Chair, and can I thank the committee for the opportunity to discuss in detail the current 2020–21 state budget as it applies to the health portfolio.

Visual presentation.

Mr FOLEY: Nothing matters more than the health and wellbeing of people that are close to us, and as we begin our state's recovery this will be the focus of this department and its officials and representatives. We want to make sure that our healthcare system is there for those who need it and when they need it, and we are intent on finding new ways to deliver better care, particularly for our most vulnerable. It means looking after the Victorians who look after us through our health system.

The Victorian budget will deliver in 2020–21 some $9 billion over the forward estimates to ensure our world-class hospitals and our local health systems come out of this global pandemic stronger than ever. It is a $9 billion investment in which every Victorian can have confidence that those close to them will be taken care of. This is made up of $7.2 billion of funding in outputs and $2 billion in funding in assets.

In terms of budget growth, what this slide is designed to do is to highlight the investment in the health portfolio in a wider context. The Andrews Labor government is investing $19.8 billion in the health portfolio over the remainder of the 2020–21 year. That is a 21 per cent increase compared to the last year, and this is in total a 71.3 per cent increase compared to six years ago when this government was elected. In terms of breaking down the funding into its key parts, there are really six groups—ensuring better outcomes for patients; building better hospitals and better services; investing strongly in regional Victoria; focusing on boosting Aboriginal health and wellbeing; a significant focus on alcohol and drug services; and, perhaps most importantly in this particular year, responding to the COVID-19 pandemic. It is also designed around better outcomes for patients.

Throughout the pandemic, our hospitals and local healthcare services have strived to keep our communities and our workforce safe. We want to help bring them back through investing $2.8 billion to support our state's health services. This in part deals with Victoria's pandemic preparedness; our hospitals across the state have, in doing so, had to wind back elective surgery. Now, having worked with our community to drive down the numbers of infections, noting that today is another day of zero cases, the Andrews Labor government will ensure that Victorians have a blitz on the surgeries that they need and will seek to do so through a massive $300 million elective surgery blitz. We are also investing $121 million to increase the delivery of hospital services to patients in their home and community settings through our Better at Home initiative, ensuring that all Victorians can receive the care that they need from the security of their own home.

We are also seeking to build better hospitals and services, and our hospitals and local healthcare services have really been both the backbone and the heartbeat of our state's response to this pandemic. That is why this budget delivers $2 billion to build new hospitals and upgrade existing ones, including $562 million to expand the Frankston Hospital and $75 million for planning and early works for the new Melton hospital, making sure that families in our outer suburbs and established growth areas can make sure that they have the care and comfort that they deserve. The government will also be investing $61.1 million to continue the planning and purchase for new community hospitals across 10 different communities, seeking to respond to increased demand, ensuring the best care in those local communities. Continuing on, on slide 5, with building better hospitals, in addition to this we are investing some $40 million to improve energy efficiencies in some of our public hospitals and a $30 million investment for clinical technology refresh programs, which I am sure will be wildly subscribed to.

We are also seeking to plan for future growth. We are providing $23.2 million for the Angliss Hospital expansion. We are providing the Better at Home hospital care in the home program, seeking to deliver better care in more appropriate circumstances. There is investment in the Maryborough hospital expansion program. There is the improving rural health outcomes program, the women's and children's wing at the University Hospital Geelong, and expanding care for the Wangaratta hospital and its community.

There is, as I indicated on the day of the release of the budget, $10 million for the planning to redevelop the Royal Melbourne Hospital, to establish a new site and potentially for the women's hospital. This will seek to activate our vision for a world-class health, research and education infrastructure investment around the Arden renewal precinct in North Melbourne.

In regard to investing in regional Victoria, we want to make sure that our recovery from this global pandemic reaches every corner of our state. That is particularly true when it comes to regional and rural Victorians and why we are investing to redevelop and expand our regional hospital and healthcare services, including $384.2 million for the Warrnambool Base Hospital next-stage redevelopment and $217 million for the Latrobe Regional Hospital redevelopment, including three new operating theatres, 30 additional inpatient beds, an expanded maternity unit and six extra ICU beds. There is also $3.6 million to commence planning for the next stage of the new women's and children's hospital in Geelong and a $7.6 million investment to redevelop the Wangaratta hospital. Victoria's Regional Health Infrastructure Fund, which has been a significant initiative of this government, will receive a further boost of $120 million to support regional and rural health services. We want to make sure that hospitals and health services right across Victoria can do that important job of looking after locals and families close to their communities.

In regard to investing in public health and wellbeing, this government is continuing its rollout in this space of significant investment and support, particularly when it comes to child and maternal health. This includes areas such as a $23 million investment to continue to provide access to the voluntary assisted dying scheme, allowing Victorians who suffer incurable illness a compassionate and dignified choice at the end of their lives. It involves a $20.6 million investment to expand the Healthy Mothers, Healthy Babies program to rural and regional areas and respond to demand pressures for maternal and child health services, ensuring that mums and babies right across the state have the support they need to thrive. There is a $16.7 million contribution to our commitment to medical cannabis treatments and delivery of services and a $7.5 million investment in the Very Special Kids program for an eight-bed paediatric respite facility in Malvern.

In regard to supporting and boosting Aboriginal health and wellbeing, we want to make sure that not only do we invest in but we invest with the support and the say of Indigenous Victorians to make sure they get the needs and the support they deserve. That is why, across the whole Victorian budget, we are delivering the

biggest investment in Aboriginal communities ever. Throughout pandemic Aboriginal communities and governments have worked in close partnership, and can I particularly acknowledge the success which those Aboriginal-controlled investments have seen in such an outstanding result with such a remarkable low level of infections and a high level of community engagement in delivering that from our VACCHOs and Aboriginal-controlled community organisations. Not only have they kept cases low, they have made sure that the community remains strong and even perhaps closer connected.

We will continue that partnership with a $22.6 million investment to support Victorian Aboriginal communities during the coronavirus pandemic across the entire health, human services and Aboriginal affairs portfolio, including a $40 million investment to establish service delivery funds across health and human services that will provide ACCHOs the resources to hire additional staff in priority areas.

In regard to alcohol and drug services our government is continuing its investment in the space, with a $51.4 million investment in drug treatment rehabilitation, helping turn Victorian lives around in the areas of addiction.

The CHAIR: Sorry to interrupt you there, Minister, but the time for the presentation has expired and I will pass the call to the Deputy Chair, Mr Richard Riordan.

Mr RIORDAN: Thank you, Chair, and welcome, Minister and health officials. I would like to start this morning, Minister, by referring to budget paper 3, page 214, and the department's output summary, which includes funding for the department's operations. It was announced by the Premier on 31 November 2020 that DHHS will be split into two. Minister, were you involved in discussions to split this department?

Mr FOLEY: I thank you for that question. The announcement for a machinery-of-government change to the Department of Health and Human Services was made by the honourable Premier and, as the committee will be aware, that announcement takes effect on 1 February 2021.

I was very pleased to see that Professor Wallace will continue on as the Secretary of the Department of Health and that the current Deputy Secretary, Ms Pitcher, will be the secretary of the other department.

In regard to the processes whereby government arrives at these conversations and decisions, there were of course extensive conversations across the department and across government, and in that regard I was a participant in those discussions.

Mr RIORDAN: Okay. Thanks for that. So in being a participant, were you an advocate for that decision? Was it something that you were keen to see?

Mr FOLEY: All decisions of this government are made in a collegiate and collective way, and I support all decisions of the government.

Mr RIORDAN: Okay. Prior to the decision being made, was there a review undertaken by the department into the prospect of this split?

Mr FOLEY: In terms of the factors that are inputted into the decision to establish a dedicated health department in particular, there was significant commentary both within government and within the community. I do note for instance that Dr Alan Finkel, the now soon-to-be-former national commonwealth chief scientist, gave significant commentary in his very worthy report—which, as it happens, I have a copy of—the *National Contact Tracing Review*, which was commissioned by national cabinet. I would recommend that the committee have a look at that as indeed the upper house inquiry into contact tracing did.

Mr RIORDAN: But just to the point, Minister, was there a review specifically into the splitting up of DHHS?

Mr FOLEY: In terms of trying to answer the question, there were multiple inputs into the complex reviews and decisions around how government arrived at deciding how to respond particularly to the pandemic and the need to make sure that health and particularly public health has the focus that it needs in regard to establishing the highest possible performance focus on how it gets return from its investment and structures. So in regard to the decision that the government arrived at that was announced earlier this week, the decision, through the

machinery-of-government changes, was the subject of wide discussion both internally within the government and, as I was indicating, through a report for the national cabinet on the national contact-tracing review.

Mr RIORDAN: So in summary, Minister, there was no specific report recommending the split of the department.

Mr FOLEY: As I have indicated, the factors that go into establishing government's decisions in machinery-of-government changes are multifaceted and significant, from a range of sources. One of the most significant in helping frame my consideration of that was the national cabinet contact-tracing review report, which in its work talks about: what are the aspects of a high-performing, optimum health structure from the learnings that 2020 and the global pandemic have produced? And when you consider Dr Finkel's report and you look at what are the characteristics of an optimum, high-performing structure for particularly public health, I think you will find a happy crossover between some of the features that Dr Finkel had identified and the announcement that the Premier made earlier in the week. In regard to how to give effect to that, we have got some time between now and 1 February to build the most appropriate structures, particularly when it comes to health. Of course there is also the other half of the department's operations as to how to have a particularly strong focus on community recovery. Whilst I have been allocated the significant responsibility by the Premier to coordinate the health side of things, we should not forget that the other half of the equation, the community response, now falls to—

Mr RIORDAN: Minister, I think you have had enough time to filibuster there. The question was: was there a review? The answer is, you are telling me, that there are a variety of documents you have drawn upon. Therefore we come back to the fact of the Premier's announcement. When were you first made aware that the Premier was making the announcement to split the department? Because clearly the split is not based on a particular piece of work that recommended the split. So when were you made aware that the Premier was going to split it?

Mr FOLEY: I was intimately involved in every step of the process from the formation of the concept, its development and its discussion across stakeholders and across internal partners in government and at each step of the way in both its framing and its delivery. So I was probably aware that the honourable Premier would be making this decision the moment that cabinet collectively arrived at that decision. But of course cabinet considerations remain in confidence—

Mr RIORDAN: All right. I guess for Victorians we might reflect on the fact that the last time the Premier made a spontaneous decision without a review or reports it did not end so well, so my—

The CHAIR: Mr Riordan, I would remind you we are here to scrutinise the budget papers and not past decisions.

Mr FOLEY: I cannot let that comment stand.

Mr RIORDAN: I just wonder if as current minister you were—

Mr FOLEY: I cannot let that comment stand, Chair.

The CHAIR: Thank you, Minister.

Mr FOLEY: The suggestion that the honourable Premier made a spontaneous decision to split the Department of Health and Human Services is incorrect, and the record needs to reflect that.

The CHAIR: Thank you.

Mr RIORDAN: But you did confirm to us that the first you were aware of it was when cabinet made the decision.

The CHAIR: No, Mr Riordan, that is not what the minister said.

Mr FOLEY: I did no such thing. You can seek to verbal me all you like, Deputy Chair, but in regard to the process I think I did indicate that from the earliest conception of the notion all the way through to the cabinet decision I myself and indeed a large number of my officials and other cabinet colleagues were involved in developing the concept, and I think it is one that is in the interests of the people of Victoria.

Mr RIORDAN: Okay. So does the Finkel report, which you have referenced as a key—

Mr FOLEY: One of many.

Mr RIORDAN: source document for this split, for example, talk about the need for a department of families, fairness and housing?

Mr FOLEY: No, I do not think it does. It talks about what an optimal public health organisation looks like, and as the Minister for Health, that was my key focus. In terms of substantial other areas of responsibility, once you have an organisation of the breadth and depth of the Department of Health and Human Services, and if you take the in-principle decision that a stronger focus is needed on public health, you are therefore required to deal with the structure and service delivery arms of the remainder of the department, significant as they are, and come up with a suitable and organisational machinery-of-government structure that reflects that. So—

Mr RIORDAN: As a minister—

The CHAIR: Mr Riordan, could you allow the minister to complete his answer.

Mr RIORDAN: Well, yes, I know, but he is taking a very long time—

The CHAIR: Mr Riordan, you continue to put propositions to the minister and the minister needs the opportunity to answer. Minister Foley.

Mr RIORDAN: The minister also needs to bring his answers within a reasonable amount of time. Minister, just one last question on that—

The CHAIR: Deputy Chair, the minister may not have had a full opportunity to reply to your proposition. Minister, is there anything unanswered?

Mr RIORDAN: Well, he has chewed up half my time on one set of questions. Minister, just a final question on that—

The CHAIR: Deputy Chair, I will allow the minister an opportunity to respond to any propositions that were left unanswered. We have had this discussion at this committee previously. Minister.

Mr FOLEY: Thank you, Chair. So in regard to the non-direct health portfolio components of the Department of Health and Human Services, the idea that you could have a stronger focus, particularly in a recovery from the pandemic and the economic and social consequences of it, through a dedicated health department for the public health and community aspects on the one hand there and the community recovery aspects in the other department, I think reflects a real-world, mature judgement on behalf of the government which has had widespread stakeholder and community support. And it is a sensible use of limited public resources—significantly increased public resources—in the most effective way for both a public health outcome and a community recovery aspect. That is a decision that I strongly support.

Mr RIORDAN: Minister, just on that point that you see this split as a sensible use of scarce public resources, do you therefore conclude that the decision that you and the Premier made in 2015 to in fact put the departments together for the last four and a half years was not a sensible use of public resources?

Mr FOLEY: No, I do not accept that at all. What I know is that—

Mr RIORDAN: You accept the split is now a sensible use, but when you put it together it was—

Mr FOLEY: If you would allow me to answer the question. In response to the unprecedented global pandemic that 2020 has seen and the consequences of it both on our community, on our public health sector and on the wider health sector, the circumstances of 2020 bear no relationship whatsoever to the circumstances of 2014 and 2015, when the Department of Health and Human Services, for very good public policy reasons at the time, was brought together. When the circumstances change and when the evidence as to what government response needs to happen to respond to those circumstances, the government's response and the government's structures change. So in regard to your proposition that somehow the 2014–15 decision was somehow incorrect, no, I do not accept that proposition whatsoever. What I accept is that in 2020, in response to

unprecedented change and impact seen from the global pandemic of the COVID-19 virus and based on the evidence and based on the circumstances at hand, government made a very sensible decision to have a dedicated focus on the one hand on public health and recovery through that aspect and on the other a department focused on community recovery and responses.

Mr RIORDAN: So as the pandemic has been going since March and you have made this decision, your only reference to this committee is the Finkel review. Is that right?

Mr FOLEY: No, I do not think I have indicated that at all. I think I have indicated that discussions with a wide variety of stakeholders both internal to government and external to government have proffered many views on this issue. I think anyone who has had an engagement particularly through the health portfolio over the course of 2020 would have seen the informed commentary of a series of both industry experts and industry commentators and people who assess the structures of public health come to the conclusion that a greater focus was needed on the health side of the recovery, and that is what the government has agreed with. Dr Finkel's report happens to bring that together in a very succinct description of what a high-performing structure of a public health organisation looks like, and in that context I referred to it as the perhaps the most cogent opportunity to bring together—

Mr RIORDAN: Okay. Thanks, Minister, we have got the general gist of that.

The CHAIR: Mr Riordan.

Mr RIORDAN: Look, he is looking at the clock and just working the time down. We have got the picture. He said the Finkel report. We need to move on.

The CHAIR: Mr Riordan, I think the minister is addressing the Chair, which is appropriate.

Mr RIORDAN: Thank you, Minister.

Mr FOLEY: My short-sightedness does not allow me to read those figures. I would love to be able to read the clock, but I cannot.

Mr RIORDAN: Well, let me assure you the committee has heard enough of that answer. We need to move on. There are other questions and other elements to the budget.

Mr FOLEY: If you give me—

Mr RIORDAN: My next question—

The CHAIR: Mr Riordan, you cannot continue to put—

Mr RIORDAN: Chair, you have a role to ask the minister to get his answers out in a timely fashion. We have got 3 minutes left out 18 and we have got through one question because he just goes on and on and on.

The CHAIR: Mr Riordan, I think a bit of self-reflection would be useful. And following the minister's answer you continue with a proposition that invites the minister to then answer that proposition again.

Mr RIORDAN: Well, I was trying to elicit from the minister what evidence for a massive split of the department that only four years ago he thought was a good idea to put together—he has now pulled it apart. We wanted the evidence for that. He cited one document. That is fine. We now need to move on.

The CHAIR: Mr Riordan, I think the minister has not just—

Mr RIORDAN: He has had 15 minutes to tell us what other documents—

The CHAIR: Deputy Chair, herein lies your problem: you continue to put words in the minister's mouth.

Mr RIORDAN: I have not put any words in his mouth.

The CHAIR: You just said that the minister cited one document, whereas if you had actually listened to the minister's answer, you would have heard that there were collegiate discussions across government in a range of different ways and with stakeholders for a period of time. The minister is in—

Mr RIORDAN: That is exactly right—it is a complete answer from *Utopia*. There is nothing I can refer to anywhere with an answer like that, so we are moving on—

The CHAIR: Deputy Chair, the minister is entitled to answer your—

Mr RIORDAN: because collegiate stakeholder engagement meetings and discussions with really valuable people are all very well. I wanted a document. He has provided only one document. We will move on, Chair. I am happy with that answer.

The CHAIR: Deputy Chair, you are the person running down your own time. The minister is entitled to answer—

Mr RIORDAN: With considerable assistance from you, Chair, which is most unfortunate. My next question is to the Secretary of the department. Secretary—

The CHAIR: Deputy Chair, the minister is entitled to answer your propositions. I will allow the minister an opportunity to answer unanswered propositions. Was there anything there, Minister, that you needed to answer?

Mr FOLEY: Thank you, Chair. In fact there was.

Mr RIORDAN: Chair, on a point of order, this is obscenely ridiculous. You are aiding and abetting the chewing up of 18 valuable minutes for budget discussion. There are other questions. This questioner is satisfied with his answer. We will move on.

The CHAIR: There is no point of order, Deputy Chair. Minister, you have the opportunity to answer the question; I ask you to be concise. Then, Deputy Chair, you will have the opportunity to ask questions insofar as your time remands. I actually cannot see how much time you do or do not have until the alarm bell sounds. Minister.

Mr FOLEY: For the record, I cannot read that clock. It is far too far away for me as well. So in regard to the range of factors that help decide and input into the government's careful consideration—

Mr RIORDAN: On a point of order, I did not ask for a range of factors; I asked for a document. You do not have a document. We will move on. Secretary, the question—

The CHAIR: Deputy Chair, you did not ask specifically for a document. Your question—

Mr RIORDAN: I specifically asked for what review or document, not—

The CHAIR: Deputy Chair, your question was wideranging and included a number of propositions, and the minister is entitled to answer them.

Mr RIORDAN: There was not a number of propositions.

Mr FOLEY: If I could perhaps just quickly summarise in regard to the issues you raise, Deputy Chair, the characteristics—

Mr RIORDAN: Well, you had better be quick, because you have got 44 seconds to summarise.

Mr FOLEY: Thank you. The characteristics of Dr Finkel's report point to all of the aspects of how a high-performing Australian state and territory health organisation can lever off its response to COVID-19 but do so in the context of what makes a high-performing health department, and amongst other factors at the heart of the government's response was the COVID-19 response and recovery. Whether it is stakeholder input, commentator input or the collegiate views of many experts in the area—

Mr RIORDAN: I make the observation—

The CHAIR: Deputy Chair.

Mr FOLEY: the government stands by its decision to create the department of health.

Mr RIORDAN: that you gave the minister an opportunity in my last 44 seconds to detail something. All he did was repeat—repeat—his commentary on the Finkel report, which we established 15 minutes ago.

The CHAIR: Well, perhaps, Deputy Chair, if you did not repeat your questions, then—

Mr RIORDAN: I did not repeat my question.

The CHAIR: Deputy Chair, you no longer have the call. The call is with Mr Gary Maas, MP.

Mr MAAS: Thank you, Chair, and thank you, Minister and your officials for your appearance today. Minister, if I could take you to budget paper 3, page 63, and specifically to maintaining hospital performance funding, would you be able to explain to the committee how this funding will support our healthcare workers and those health services that have supported us through the pandemic?

Mr FOLEY: Thank you, and yes, I would also reflect on budget paper 3 and its very strong focus that 2020 is really, and with it the global pandemic outcomes and responses, to make sure that the safety and wellbeing of everyone involved in the system needs to be at the heart of what these learnings have been, and this budget with its almost $2.8 billion investment over the next four years to maintain hospital performance seeks to ensure that every Victorian has that care and support, including, can I say, the efforts of our frontline healthcare workers right across the system.

The government has sought, with the support of hospitals, through the COVID-19 pandemic to ensure the increased costs, the changing patterns and the changing needs of that healthcare worker frontline experience—and safety has been at the heart of the learnings of that. This seeks to build on previous investments, but 2020 has been a year like no other in the challenges for this workforce. That is why there is a $2.8 billion investment over four years into our acute care services, with $862 million in the coming year to provide that hospital capacity, addressing critical infrastructure funding assurance through hospitals and making sure that the state funding component deals with the kinds of things that worker frontline experience and frontline learnings have developed, particularly when it comes to issues such as additional staff costs as a result of some of the PPE, medical supply, planning, rostering and embedding the social-distancing principles into how our healthcare system, which was designed with very different principles in mind, needed to adapt over the course of 2020.

Health services have reprioritised staff, they have come together in a collegiate model that has been quite innovative and welcomed in what has been very difficult circumstances, and health services have responded in an enormously successful way. This funding that you have pointed to will be critical to boost both hospitals' response to demand and changing patterns of demand as Victoria starts to open again through the summer period whilst making sure that our workforce is as safe as we can possibly make it, with our workforce at the heart of driving how that investment in safety is allocated.

Mr MAAS: Thank you, Minister. You mentioned that demand for some services will increase as the state does start to open up safely—or continue to open up safely. I understand of course that elective surgeries have resumed. How is the government ensuring that hospitals have enough resources to meet up with the elective surgery waitlist?

Mr FOLEY: So as part of the response to the pandemic, elective surgeries in both the public and private sectors were put on hold, and I want to thank all those Victorians, particularly those in the queue for those services, for the enormous sacrifice that they made in that significant effort. I want also to thank both the public and private hospitals for their role in that.

But as non-urgent elective surgery resumes in full as of 23 November, we know that that decision based on public health advice has had significant impacts. We know it has been an anxious time for many Victorians whose surgery has been delayed, and our commitment has been to make sure that we catch up on that backlog as soon as we possibly can and to ensure that those who need support and surgery the most are prioritised. I do in making those comments note that category 1 urgent surgery continued on and was almost universally delivered on time in those respects, but certainly in regard to category 2—not so much category 3—surgery

waitlists, there are significant backlog issues there. That is why in regard to this current budget there is some $300 million allocated to ensure that the blitz in this space is delivered. That will require significant cooperation and engagement with both our public and private hospitals—the workforce surrounding them from surgeons all the way through to other non-medical and non-clinical staff—and it will be a substantial effort to make an impact on the growing waiting lists, which at the end of September had grown to some 66 242 people. We want to make sure that whether it is that list or indeed the time spent waiting for surgery—as perhaps a more nuanced measure of how governments respond in this space—it is dealt with. And in that regard the efforts of our health system have seen category 1 patients, as I indicated, pretty much remain at the same level as what it had in previous years. We want to make sure that we really work hard over the coming weeks and months ahead to repay the sacrifices and efforts that Victorians right across the state have made in the impact that this has had, and that is what that funding is for.

Mr MAAS: Thank you, Minister. You have already alluded to this, but I will ask you: is there any capacity as a part of the elective surgery blitz to work with private hospitals?

Mr FOLEY: Yes there is. The impact of the virus in 2020 has seen an unprecedented level of cooperation between the public and private sectors from the start of the pandemic and indeed has been the subject of a national partnership agreement between all jurisdictions in the public and private sector. That is why earlier in the year the government announced a $60 million package to undertake elective surgery for the then more than 7000 patients in both public and private hospitals, and that was in addition to the significant contribution that the commonwealth government had made. The partnership between private hospitals and public hospitals was necessary in many ways, firstly to address the demands of the overall community when it came to how we managed the impact of the virus on both systems, and now into a system where we share the joint responsibility of having an impact on the backlog of elective surgeries. It made sense to get as many patients as possible into elective surgery to the entire capacity of the overall system—both public and private—to address this, which is why the department is working across both systems to ensure that the constructive partnerships between those systems that have been built over the course of 2020 are now leveraged off for this important work in addressing the significant waiting lists that, sadly, have grown during the course of the 2020 pandemic but which this government knows the communities of Victoria, the workforce in our health system, both public and private, are committed to. And $300 million will go a substantial way to ensuring that that waiting list is brought back to manageable levels, and that is a significant priority of this budget.

Mr MAAS: Thanks, Minister. If I could take you to health capital investment now, and specifically budget paper 3, page 78, there has of course been significant investment in the physical infrastructure of our health system. Could you please take the committee through the capital investment priorities which are outlined in this budget and how they will improve the care that Victorians receive across the state?

Mr FOLEY: Absolutely. You will see particularly in the acute health system, but not just in the acute health system, that the investment on the capital side of the ledger for the state is quite significant. Whilst the government went to the most recent election with a series of commitments in this space, which have either been initially funded or now continue to be funded in this budget, we expand significantly on that series of commitments through this funding package.

The first of those I would like to draw the committee's attention to is building the world-class hospital for Frankston families. That will see an additional 120 beds, two new operating theatres, 13 new emergency department beds, expanded women's and children's health services and additional maternity inpatient beds, a women's clinic, a paediatric clinic and paediatric inpatient beds together with improved oncology facilities and a significant expansion of mental health support services as well. In regard to the processes for that, we are confident that we will see substantial investment in the delivery of that project over the oncoming weeks, months and years.

I could also point to the initial investment of $75 million in the acquisition of land and design processes for the Melton hospital. This will be a project in one of the fastest growing parts of the country. By 2050 the Melton catchment will be the equivalent size of what Canberra is today, and the need for that fast-growing community to have its own dedicated facility is one that the government is strongly committed to. I want to particularly give a shout-out to the work of the Member for Melton and his community for their strong advocacy for that project. I was very pleased to recently catch up with the chief executive of Western Health, and Western Health will be the health service that will deliver this project. It will do so in close conversation and design with the

Melton community and a reference group to establish both the most appropriate location and design, and engagement with that community is well underway.

There are a substantial number of other projects in regard to how, right across the state, either the delivery of expansion of existing healthcare facilities or the work of investing in new facilities will roll out. But I did want to just particularly call out a few initiatives that whilst not of a new hospital scale are nonetheless critically important in both innovating and delivering significant investment in existing facilities, such as the clinical technology refresh program. Information technology is at the heart of so much of what the health sector needs to continue to learn and improve as it goes, and the clinical technology refresh initiative is one ensuring that there is improved delivery of information both across and between health services; improved support for patients, diagnostics and other clinical services; and enhanced cyber security, as we have seen over recent times many of our public health services hacked and data interfered with in that response.

That is an important project. So too is the engineering infrastructure and medical equipment replacement program. We need to make sure that critical engineering infrastructure—whether it be everything from chillers, lifts, boilers, nurse on-call systems and electrical upgrades or whether it be the continuity of health service delivery and compliance with increasing regulatory demands, specifically when it comes to issues about how agencies respond to COVID-safe environments and making sure the workforce and the wider patient and local communities are protected—is a significant component of our investment here. That also will extend to critical medical equipment supporting operating suites, improvements in emergency departments and improvements in surgical wards, ICUs and neonatal and maternity services, and specialist areas will also be eligible to be replaced. And that is all about not just improving services but reducing risks to patients and staff, as I have said, amongst other things, through the COVID response.

In regard to other aspects of innovation particular to this budget, I would point to the expansion of the rural infrastructure fund for health services, which has been a program that has been run since 2015. There is a substantial uplift in the funding for that program, and I know from the positive responses that we have had from a significant number of regional and rural health services big and small that there is significant interest in those organisations participating in that.

I also note that for the first time there is a Metropolitan Health Infrastructure Fund designed to serve a similar, not small-scale, significant-scale but more decentralised program of support and catch-up for infrastructure programs. This will be a significant investment in the quality and amenity of the infrastructure of our health services, not just our large tertiary hospitals but other organisations in the community setting—community health centres, Aboriginal-controlled and other community-controlled health organisations—that reflect local priorities and seek to maintain and enhance service capacity, modernise facilities and, in a rapid-delivery operation, make sure that the money that is needed to be invested in local communities to improve those local health services is delivered as soon as possible. It also touches on the 10 community hospital investments amongst a range of others.

Mr MAAS: Thank you, Minister. I might just leave it there. Thank you, Chair.

The CHAIR: Thank you, Mr Maas. I will pass the call to Mr Sam Hibbins, MP.

Mr HIBBINS: Thanks, Chair, and thanks, Minister and your team, for appearing before the committee this morning. I want to follow up on some questions I actually asked the Minister for Mental Health, but I believe they relate to your portfolio as well, in regard to behavioural assessment rooms that are being used in hospitals. Now we established that admission to a behavioural assessment room is not counted in terms of being admitted to a hospital, but I would like to just ask some questions about how they are actually being used. So I am supportive of these rooms, but do you collect data in terms of how long people are actually being admitted to behavioural assessment rooms before they are then admitted to hospital?

Mr FOLEY: I will just very generally start off, and then I might ask for the assistance of my department officials. But what we have seen is a substantial increase in presentations for mental ill health and presentations particularly in the acute settings over the course of 2020, and that is a disturbing and increasing trend for the system but most obviously for individuals and their families. Having had the benefit of being the previous Minister for Mental Health, there has been a series of initiatives over a number of years to seek to address that; 2020 has seen the drivers of that escalate substantially—and the demand in that space.

There is the proposition for assessment hubs. They go by different names but are a triaging system as people present in acute settings in different ways. For instance, just up the road at St Vincent's there is a model around a cafe arrangement, which seeks to take people out of the hectic and sometimes unhelpful environment of an emergency department and settle people in a less hectic arrangement. There has also been substantial investment in hubs. In terms of behavioural assessment rooms I might perhaps seek the assistance of Mr Symonds, whose responsibility extends to hospital oversight for that particular model.

Mr SYMONDS: Yes. Thanks for the question, Mr Hibbins. There is funding provided for 21 of these rooms, as you may know. I understand that 12 have completed construction already. As I said on Wednesday, I am not aware of us collecting specifically how long people spend in a behavioural assessment room. It would contribute to the time that they spend inside the emergency department, which we do count. I might just add that the proportion of patients staying 4 hours or less within emergency departments is actually slightly better for the 2019–20 financial year than it was the year before. I think I made the comment on Wednesday that the proportion of mental health patients who are staying 8 hours or less is also slightly better than it was the year before. So the time spent in behavioural assessment rooms would contribute to the total time spent inside the emergency department. I am not aware that we collect it separately, but if we do, I am happy to provide it.

Mr HIBBINS: Okay. Great. Thank you. Are there any examples of—I presume if you calculate the data on the individual behavioural assessment rooms—people presenting with mental health issues that are staying longer than 24 hours in waiting rooms or the emergency department?

Mr FOLEY: Yes, is the answer. That has been one of the troubling outcomes of this year. Whilst we have seen patterns of presentation vary, and in fact they declined significantly in the first wave—presentations in acute settings, including mental health presentations—and at the commencement and for a lot of the second wave that also was the case, we did see, of those groups, a substantial increase in the proportion of those presentations that related to mental ill health and the complexity of those presentations. As the months of the pandemic continued on, the response of those presentations did in fact become more acute as a proportion, and we did in fact see an increase in longer stays.

That report—it comes in periodically from the health services. I do not have it here with me in terms of the specifics, but I have personally been involved in the release of some of those details about the length of stays in largely my former role as Minister for Mental Health. And that is a significant concern for us all. It is part of the reason for, as I am sure the Minister for Mental Health would have pointed out, the over $220 million investment in a range of responses during the course of this pandemic year, but more importantly the more than $840 million in this budget that goes to delivering on a range of priorities, including the so-far nine interim recommendations of the royal commission into our mental health system. But you are certainly right, Mr Hibbins, in highlighting that as the pointy end of the mental health crisis that our system is facing.

Mr HIBBINS: Great. Thanks, Minister. I would like to move on now to drug services on budget paper 3, page 227, 'Clients on the pharmacotherapy program', which is your pharmacotherapy—so it is your dispensing of methadone and what have you. I am interested to see that the 2019–20 actual is about similar to the 2018–19 actual. There has been some anecdotal evidence that throughout this year, due to the pandemic, the supply of heroin has actually dried up. Is there any evidence of that and then any increased demand in people needing to access methadone and the like?

Mr FOLEY: I do not have the police or the border force evidence at hand, and nor would I, but in terms of alcohol and other drug imports, and particularly the focus on harm minimisation, that is a significant priority for the government. And it is a responsibility that I continue to maintain in machinery-of-government changes. In regard to the impact that the pandemic has had—and this is largely anecdotal from conversations with both community service and alcohol and drug services and enforcement agencies—it is still a little bit hard to tell, particularly given the illicit nature of much of this activity, to be definitive, even after a good 10 months of the pandemic. But there is that anecdotal evidence that suggests that initially the supply chains dried up globally, including into Australia, and that that saw changing patterns of drug activity. That seems to have—through, shall we say, private sector innovation—been somehow or another got around through whatever sources, which is a worrying trend, and we continue to see changes in the way in which illicit drugs in particular are both imported and produced and, for a period of time there, have an impact on the drug-using community. In regard to methadone in particular, if I understood your question correctly, I do not believe that it had an impact on

methadone, obviously, as not an illicit drug. But if I understood your question, did that then have an impact on changing patterns of user—

Mr HIBBINS: The reason I ask is to establish whether there is actually an opportunity for people who were formerly using heroin to now go onto the methadone program. Also, specifically in terms of the barriers that might be in the way, particularly the dispensing fee that pharmacists charge, Victoria is the only state not covering the dispensing fee. Is that something that the government is looking at to actually reduce the barrier to methadone programs?

Mr FOLEY: In terms of the dispensing of methadone amongst other opioid replacements, there are a range of vehicles where that happens. Pharmacies are one—and yes, you are quite correct: Victoria does not meet the costs that pharmacists face in that regard. In regard to a whole heap of more community-based arrangements about how methadone is distributed, there is a bill, I am pretty sure, before the Legislative Council at the moment that talks about how—whether it be through needle exchange programs and other more localised programs or directly engaging with marginalised user communities—to look to other methods of support for both naloxone and other prospective ways in which services can be delivered. In regard to pharmacists in particular, that continues to be an issue that both the pharmacy guild and the alcohol and other drug sectors prosecute, but at the moment we do not have a plan to change that aspect of it. What we do plan to do is look to how other methods of engagement with user communities can be developed and, if you like, more nuanced to the manner in which those communities, who are largely disengaged from mainstream society, have distribution systems that are relevant and safe to them.

Mr HIBBINS: Great, thank you. I would like to move on to sexual health now. Prior to the outbreak there were actually some increases in infections like syphilis occurring. Are there any particular initiatives within the budget to address sexual health?

Mr FOLEY: In terms of specifics I might seek some support from my officials at the table, but just in recent weeks the government has alerted the wider community to a range of areas in which essentially care and attention to a whole range of health expressions have been deferred—cancer, particularly breast cancer and [inaudible], and sexual health and particularly sexually transmitted diseases is another. We recently alerted Victorians and our agencies to the fact that some sexually transmitted diseases are starting to make an unfortunate comeback, and we can attribute that in part to the deferred engagement that Victorians have had with health during the course of the pandemic. But what I might do is perhaps ask Professor Wallace if he can specifically address that.

Mr HIBBINS: More specifically too, I understand that a review was actually conducted into sexual health in 2019 and it made some recommendations for a stronger statewide clinical sexual health system—so in terms of how the government is actually responding to that report as well.

Mr FOLEY: I ask Professor Wallace to perhaps specifically address that.

Prof. WALLACE: Thanks, Mr Hibbins. I do not believe in this budget there is specific additional funding for new initiatives in sexual health. In terms of government responses to recommendations from the review, I might take that on notice.

Mr HIBBINS: Okay, great. Thank you. I would now like to move on to obesity, which is actually one of your departmental performance statements. Now, just following up on previous estimates hearings, the then health minister indicated that the government was developing a childhood obesity strategy. Can the committee get an update in terms of where that strategy is at?

Mr FOLEY: Thanks. I do know that obesity continues to increase, particularly amongst young people, and that is a major contributor to many, many poor health outcomes and many poor social outcomes as a result. In regard to how the inquiries and efforts that have been established into how to respond to that both at a national and Victorian level, I have been involved in discussions with the still relatively new CEO of VicHealth around some of their activities aligned to this work. But in regard to the specific program that I know the government has been involved with through 2019 and before, again I might—with your indulgence, Chair—seek the support of my officials to address that insofar as we can. Perhaps Professor Wallace?

Prof. WALLACE: As you know, addressing obesity in populations has been a priority of the department for some time. We now have around one in four children under the age of 18 identified as obese. A recent study from Deakin University has found that the burden of childhood obesity is particularly borne heavily in our rural areas. In comparison to children growing up in metro Melbourne, the rates of childhood obesity in our rural centres can be as high as 35 per cent, so clearly it is an important health priority. It has lifelong implications for these children, as they grow up through adolescence and into adulthood with higher rates of type 2 diabetes et cetera. Last year the former minister, Minister Mikakos, indicated that we were developing a childhood obesity strategy, and our department continues to develop that whole-of-government approach to childhood obesity with the intent of developing a prevention plan. I think we would come back in future years to show what that prevention plan would look like and how we would tackle clearly a pressing problem for not just Victoria but most of the Western world.

Mr HIBBINS: Yes. Thank you. It is a pressing problem and it is one of the department's performance statements, and it has been 18 months since the minister indicated that a strategy would be developed. So obviously—

Prof. WALLACE: I mean, if you would forgive us—I agree; we have had some fairly pressing health issues this year, but it very much remains a priority for the department to tackle.

Mr HIBBINS: I guess that goes to my next question. It is a departmental performance statement, but in terms of the performance measures there does not seem to be a corresponding measure. The latest information is that it has been increasing, and it is quite significantly high. How do you actually measure your performance and your performance statement about reducing obesity on the one hand as an objective but then have no actual performance statement that actually corresponds within the budget?

Prof. WALLACE: Look, it is actually a very important question. It goes to the wickedness of this problem at a whole-of-population level. Clearly the ultimate outcome measure is the rate of obesity and the rate of children of various ages, the proportion of children of various ages, who are overweight and obese. But if we use that as the only outcome measure, it will be years before we see any change, and we will not know if the initiatives are working or not working. So in developing the prevention plan a core component of that plan will be both a mixture of process measures and early outcome measures. What those will be I am not in a position to share today, but I think—

The CHAIR: Sorry to interrupt you there, Professor, but the member's time has expired. I will pass the call to Mr Danny O'Brien, MP.

Mr D O'BRIEN: Thank you, Chair. Good morning, everybody. Secretary, can I ask about the medically supervised injecting centre? Budget paper 3, page 63, references the funding for that. The department's website says that the final site will be selected after a consultation process at the end of 2020. Has that happened as yet?

Prof. WALLACE: Sorry, Mr O'Brien, can you repeat the question?

Mr D O'BRIEN: Has the final site for the second supervised injecting centre been selected? According to the department's website by the end of 2020 a final site for the supervised injecting room will be selected within the City of Melbourne. Has that been completed, Secretary?

Mr FOLEY: I appreciate, Chair, that the member has asked the Secretary—I do not intend to do anything other than allow that to happen—but I have, perhaps, the most intimate knowledge of that whole process on this side of the table. As you would know, former Chief Commissioner of Police Ken Lay has been engaged by the state to work through that process with the City of Melbourne and other stakeholders. Ken was given the prospect of reporting before the end of the year. As you know, the Victorian government had nominated 53 Victoria Street, Melbourne, as its preferred site, the location of Cohealth's community health centre, which amongst other things does deal with alcohol and other drugs.

Mr D O'BRIEN: Yes, Minister, I have got all that. I just want to know whether that has been finalised.

Mr FOLEY: No, is the answer.

Mr D O'BRIEN: Thank you.

Mr FOLEY: Ken Lay has not yet come back to the state on the outcomes of those conversations.

Mr D O'BRIEN: Okay. And when do you expect that will happen? I take it that it will not now happen by the end of this year.

Mr FOLEY: No, I have had conversations as recently as last week with Mr Lay, and we are still hopeful—in fact more than hopeful—that the response will be forthcoming in the time frame that the government has set.

Mr D O'BRIEN: Okay. So we can expect an announcement before Christmas then?

Mr FOLEY: I cannot guarantee it; it is a complicated process. But I certainly would hope that that would be the case.

Mr D O'BRIEN: Have any sites other than 53 Victoria Street been considered?

Mr FOLEY: Not from the Victorian government's point of view. We have nominated 53 Victoria Street as the most appropriate site, but we have made it clear every step of the way that if other stakeholders should come up with alternatives that meet the same criteria that Professor Hamilton set in her review as to why we need a second such facility in the City of Melbourne, then of course the government would be open to consideration.

Mr D O'BRIEN: And have you had any of those brought to you? You just told us that you spoke to Mr Lay last week.

Mr FOLEY: No.

Mr D O'BRIEN: But no other sites have come up?

Mr FOLEY: No, there have been no propositions put to us for alternative sites.

Mr D O'BRIEN: So we can assume, then, if the decision is very close, it is going to be at 53 Victoria Street, right next to the Queen Vic market.

Mr FOLEY: Well, we will not pre-empt the work that Ken is doing on behalf of the government. It is a very significant investment in a very important project, and I would not want to pre-empt his report back to government.

Mr D O'BRIEN: No, I understand that, but it is the government's preferred site.

Mr FOLEY: Yes.

Mr D O'BRIEN: You said you would consider it if someone else brought it up. You have now told us that no-one else has brought it up, so we can probably assume it is going to be at Cohealth Central City.

Mr FOLEY: Well, sometimes assumptions can be rash and ill advised, Mr O'Brien, and rather than assume, I will wait for Ken's response.

Mr D O'BRIEN: Okay. Who has been involved in the consultation process?

Mr FOLEY: As I understand it, Ken has had a series of conversations and meetings with many, many organisations. This is not exclusive, but it would at least involve the City of Melbourne, Cohealth, Housing Choices, the market community, the market traders organisations, the residents in and around 53 Victoria Street, the traders groups, other service providers in this space in the City of Melbourne, the Salvation Army—

Mr D O'BRIEN: Presumably the police—VicPol?

Mr FOLEY: Yes, Victoria Police, Ambulance Victoria, the local health service providers, particularly the Royal Melbourne and St Vincent's, and the resident community groups, amongst others.

Mr D O'BRIEN: Given the clear opposition from the City of Melbourne and the Queen Vic market traders to this location, why won't you consider another site?

Mr FOLEY: I do not think I said we would not consider any other site. I said that the state—

Mr D O'BRIEN: Well, we can play semantics, Minister. You said it is the preferred location and that no-one else has raised a second site—that is the point. Are we looking at another site at all?

Mr FOLEY: I am not aware of anyone having raised an alternative site with the Victorian government, but I know that Mr Lay is involved in discussions with a whole range of stakeholder groups, and rather than pre-empt where that work will land, I think it would be respectful of that process to see what Mr Lay reports to government on.

Mr D O'BRIEN: Can I ask some data questions, then. Secretary, since September 2019 how many fatal heroin overdoses have occurred in the City of Melbourne?

Prof. WALLACE: There were 51 deaths in the City of Melbourne last year. Between 15 January and 19 September there were 51, and the city has the second highest ambulance attendances for heroin overdoses after the City of Yarra.

Mr D O'BRIEN: I have got those figures, Secretary. I am just after how many since September last year to get the updated information.

Prof. WALLACE: I do not have those numbers with me but I will provide them.

Mr D O'BRIEN: If you could provide them on notice, that would be great. Thank you. Can I just go to the North Richmond centre now, Secretary, if I could. How many individuals accessed the facility in 2019 and 2020 to date?

Prof. WALLACE: Again I will provide those to you on notice.

Mr D O'BRIEN: Okay. Likewise, how many overdoses have occurred in the suburb of Richmond since March 2020?

Ms RICHARDS: Excuse me, Deputy Chair, just a point of order.

The CHAIR: Ms Richards.

Ms RICHARDS: I would just like to be able to follow along with the budget paper references, if that is possible.

Mr D O'BRIEN: I gave that earlier, Chair. It is budget paper 3, page 63.

The CHAIR: Sorry, Mr O'Brien, can you repeat that in your microphone?

Mr D O'BRIEN: Budget paper 3, page 63. I did provide that at the start.

Ms RICHARDS: Thank you.

Mr FOLEY: If I could perhaps assist, Mr O'Brien—

Mr D O'BRIEN: If you can assist with the data, Minister, that is all I am after.

Mr FOLEY: The sources of the data. I would refer you certainly not to the 2020 data, which is still a work in progress, but I would refer you to the publicly available report that Professor Hamilton and the government released earlier this year, which details quite extensively—

Mr D O'BRIEN: Will that give me data since March 2020?

Mr FOLEY: Well, as I indicated—

Mr D O'BRIEN: No, that is what I am asking.

Mr FOLEY: As I indicated, the data since March of this calendar year is still a work in progress, but I would report that if you follow the North Richmond Community Health centre's website and its most recent

annual report, it touches on a lot of this data. But you are quite right—in terms of the data since March 2020, that continues to be a work in progress—

Mr D O'BRIEN: Okay, thank you.

Mr FOLEY: other than noting that any heroin overdose in the North Richmond community that is not the subject of the oversight of the expert professionals in the supervised injecting facility is an incredible risky venture and that on the whole notion of the supervised injecting facility and the enormous number of injections of heroin and other opioids that have taken place in there I do note that not a single life has been lost through those injections in the MSIR as opposed to the lives that have been lost in the streets and alleys of the community of Yarra.

Mr D O'BRIEN: Yes. Minister, how do you plan to guarantee the safety of residents in both Richmond and presumably the site in the City of Melbourne, which we will take as coming soon, both of which are—and this new one is likely to be—in very high traffic locations?

Mr FOLEY: Both the safety of the users of the facility and the wellbeing and safety of the surrounding communities are at the forefront of our response. Obviously I could point to the record investment in policing and other services—the responsibility of Minister Neville—but in regard to my responsibilities, I would point to the significant package that attended the release of Professor Hamilton's report earlier this year which involved, amongst other things, not just money but trying to establish a whole new range of forums in consultation with Victoria Police, with the Yarra council and with the communities, both the public residents and the nearby private residents, to establish communication, practices and priorities for investments in both built form and social capital to make sure that the user communities and the surrounding communities, which have been cohabiting with each other for the best part of 30 years, are able to do so in a way that minimises harm and maximises community safety, whether that be built form, lighting, physical structures, as well as opportunities for better health, relocation and connection with services. That is one of the really important and exciting parts. Also, Ken Lay—

Mr D O'BRIEN: Is there a chance, Minister, with respect to the new City of Melbourne facility, that either police or PSOs or other forms of security guards will be stationed either onsite or close by?

Mr FOLEY: Well, it is not for me to pre-empt Ken Lay's work or indeed what model of care that the new facility will be based on, but these facilities are not designed to be policing facilities. As you will be aware, with the Richmond facility, the legislation that sits behind it specifically excludes it from certain parts of the criminal justice system when it comes to the use of what are otherwise illegal substances, so the notion of a direct police presence in the centre, I would have thought, would have run counter to that model of care.

Mr D O'BRIEN: Well, the original question was actually about protecting local residents and others and businesses in the vicinity. I know I did ask about—

Mr FOLEY: Having said all of that, with Mr Lay's direct experience in this space both as chief commissioner and through the work he has done in the national drug prevention space for governments of all kinds, I would imagine that would be part of the reason that he has engaged extensively with Victoria Police during the course of his consideration. I look forward to his report and, among other things, addressing that.

Mr D O'BRIEN: Thank you, Minister. Secretary, I refer to budget paper 4, page 214, the department's output summary, and it includes reference to Better Care Victoria, and also to the departmental questionnaire response, which on page 41 indicates that the Better Care Victoria Innovation Fund is lapsing, has been cut, is not continuing. Under the question 'Reasons why further funding is not being sought', the answer is:

> Not applicable.

Why is it not applicable that we get an answer as to why this program is not ongoing?

Prof. WALLACE: Thanks, Mr O'Brien. As you know, the Better Care Victoria Fund was a fund established to drive initially improved access through ED and patient flow. It was expanded with the establishment of Safer Care Victoria in 2017. It was a series of single-year, initially $10 million, funding programs, and then in its last year, $15 million. With the establishment of Safer Care Victoria, in consultation with the Better Care Victoria board, the program of work broadly in three portfolios was expanded and more

targeted to broader health system improvements. So the three portfolios were the innovation projects, and the fund has supported a number of successful innovation projects that have gone on to feed into broader health improvements. I think of the Geri-Connect project, for example, in Loddon Mallee, where they have connected specialist geriatricians into aged-care facilities and prevented unnecessary admissions of aged-care residents into EDs, into the hospitals, through reductions in poly-pharmacy, reductions in falls et cetera. The second component of the fund was around leadership development, and under Safer Care that leadership development has supported several tranches now of clinical leadership enhancement across the sector. And then the third tranche was around whole-of-system improvement, what Safer Care Victoria would now call collaborative improvement programs. So, for example, again, they funded and supported—

Mr D O'BRIEN: Sorry, Secretary. That is good background, but the question is: in response to why further funding is not being sought, the answer is 'Not applicable'. Why is it not applicable? Why is this program not continuing?

Prof. WALLACE: Apologies. The program is not continuing because essentially Safer Care has acquired the whole program, and those three pillars of ongoing funding into the future are part of Safer Care's work. So in the future Safer Care will continue to seek funding not through a Better Care Victoria fund as a standalone fund but for specific improvement programs, leadership development programs and innovation programs.

Mr D O'BRIEN: Okay. The Travis review that you referred to in 2015 said that innovation and improvement was vital to the future of Victoria's health system. Acknowledging that in the wake of a pandemic I am sure it is even more vital, how much funding is being provided to Safer Care Victoria to continue this work?

Prof. WALLACE: Well, Safer Care Victoria has an ambitious improvement program ahead of it. Again, it has got three whole-of-state improvement programs running. They have been interrupted, without question, by the pandemic. So, for example, they have got a whole-of-state program—

Mr D O'BRIEN: Sorry, Secretary, the question is how much funding has been provided? So the better health innovation fund ended on 30 June. It is not being continued. I wanted to know—and you have indicated Safer Care Victoria will continue its work—how much funding has been provided for it to do so?

Prof. WALLACE: The Safer Care budget is in the order of $40 million a year, and each individual project obviously has its own budget scoping. The $50 million last year that was dedicated to the Better Care Victoria fund, not all of that was spent because of the pandemic, because many of those innovation and improvement programs were put on hold. That money will be rolled over into this year to allow Safer Care to continue those projects.

Mr D O'BRIEN: How much was that?

Prof. WALLACE: From memory, I think it was about $7 million.

Mr D O'BRIEN: Okay. With the previous program 63 Victorian health services and over 1700 staff engaged with the fund, including 47 regional and rural services. Will they still be able to seek funds from Safer Care Victoria?

Prof. WALLACE: Very much so. In fact I think some of the landmark successes of the program have been in our rural services. I think of the 'Think Sepsis. Act Fast' program that originated at the Royal Melbourne and Peter Mac was rolled out across I believe 21 or 23 health services, most of which were rural health services. Safer Care Victoria has got a very rural and regional-focused improvement agenda. Again, of the 20 hospitals that are participating in the Safer Baby Bundle, reducing stillbirths, many of them are in our regional centres, and they have reduced stillbirths across our state by 27 per cent.

Mr D O'BRIEN: Thank you, Secretary.

The CHAIR: Sorry to interrupt there. Thank you, Mr O'Brien. The call is with Ms Pauline Richards, MP.

Ms RICHARDS: Thank you, Minister and officials, for your appearance today and for a year of what must be extraordinary service as well. I would like to take you to budget paper 3, page 78, and unpack a little bit more about the government's health capital investment. I am going to be parochial, with the Chair's

indulgence, but I was pleased to see funding allocated in the budget papers for the next stage of the community hospital program. The parochial element of course is that my community in Cranbourne will benefit from that. Can you outline for the committee what the funding will deliver? And you do not have to be too Cranbourne-specific; I will let you go beyond.

Mr FOLEY: Thank you, Ms Richards. Yes, I can. I should declare an interest early in that Fishermans Bend, which falls in the electoral district of Albert Park, is equally a nominated growth area for such funding.

You are right. Under the asset initiatives allocation of this budget there is some $675 million committed to build the 10 community hospitals close to a range of growth areas. For the record those are Craigieburn, Cranbourne, Pakenham, Phillip Island, Sunbury and Torquay, as well as the City of Whittlesea, Eltham, Point Cook and Fishermans Bend. These are all communities—particularly, as you know, yours—that are highlighted by significant growth in population and changing patterns of health demand that require health services to be more engaged directly in the community in localised settings, whilst of course continuing delivery of Australia's and Victoria's quality high-care system faster, closer and more community engaged.

The service delivery equation and how the partners are brought together for that vary across the needs of the 10 communities but are joined with regard to some high-level consistencies for those. Early intervention primary community care is a focus; a strong emphasis on paediatric care; a strong emphasis on chronic disease management, particularly some of the programs that you would want to see in partnership with community health centres and primary healthcare providers, aimed all at managing health needs locally. The $675 million will, amongst other things, provide that chronic disease management, a series of day procedures, dialysis and chemotherapy, diagnostics, family and early childhood services, family safety services, community drug and alcohol services, mental health services, pathology, pharmacy, the expansion of public dental health care and, depending on the needs of the community, particular specialist needs that would reflect the differing and particular needs of those communities.

How these issues about emphasis across the 10 are resolved, both in terms of services and engagement with other partners in the communities, is being largely locally driven through community consultative arrangements and forums that have been established to plan, develop and engage with community service providers. Those community consultative groups involve local government, health service providers, diverse community representation, particularly Aboriginal community health organisations, and community members who reflect more independent approaches to these issues.

The budget in particular will provide funding to acquire land in those areas where land is yet to be acquired, and that would particularly apply to Cranbourne, Pakenham, Torquay, Whittlesea, Eltham, Fishermans Bend and Point Cook. It will also enable capital planning to continue to work around design, so those commitments that the government made in the 2018 election are delivered on. We really know that in the last nine months the delivery of that has both been slowed down but also sharpened in terms of where the needs are. We have seen changing patterns of how communities want to seek access to their changing health needs. We have seen a massive growth in telehealth, and we have got to make sure that these facilities, if they are going to be embedded in these communities, also take account of how changing patterns of both consumer and patient requirements and preferences and the technology for service delivery from clinicians and community health providers takes account of that. In many respects we will not be going back to much of the service delivery model pre pandemic. As horrendous and traumatic as 2020 has been, there have also been some important learnings about how service delivery can be more deeply engaged at a community level, with better health outcomes as a part of that.

So I look forward to hearing from all of those community hospital consulting communities about how they understand the particular needs of their communities, worked out in partnership and collaboration with both primary healthcare providers, community healthcare providers and diverse communities with the overlay of quality and rigour from the health network partners, and coming together to provide the next stage of important innovation and delivery of localised, community-based health services, not just in those 10 communities but providing a model of how that is going to work more broadly across our state.

Each of the 10 are varied. I look forward, when circumstances allow, to joining you on the Cranbourne proposed site, but I did have the pleasure of joining the Member for Sunbury at his nominated facility, an important partnership between Western Health, Sunbury Community Health centre, the local primary

healthcare network and the local community providers. Each one is different. In the Sunbury context it is an important expansion and delivery of a range of existing services in a particular hub of that fast-growing community. And I think all of them will serve different purposes in their communities but shared purpose, essentially, of a range of community, clinical and other support services in an accessible manner, governed in a way that is relevant to those local communities, all with a view to improve health outcomes and community outcomes in your and other communities.

Ms RICHARDS: Thank you, Minister. Just staying on capital investment and staying on BP3, page 78, it is clear that COVID-19 has had a devastating impact on the economic situation of the state and on many communities. I am interested in getting some insights into the estimated economic benefits of the government's investment in health infrastructure.

Mr FOLEY: Thank you, Ms Richards. The contribution pre-pandemic that health makes to not just the physical and emotional wellbeing of Victorians but the economic wellbeing of the state is enormous and, can I say particularly, is the mainstay of many communities when it comes to employment. Indeed it is not unusual in particularly regional and rural communities for the health network to be amongst the largest employers in town, and by the time you expand that to other primary health support arrangements, as our community ages and as disease of many types evolves, the importance of our health sector over and above the contribution it makes to our health and wellbeing is a significant factor when it comes to the economic drive of our state.

The truth is that we find ourselves in incredibly challenging not just public health times but economic times, with Australia experiencing its first recession in some 30 years and in the June quarter a shrinking of gross domestic product of an unprecedented 7 per cent, which is the largest since records began. Whether it is the community hospitals program and the contribution that it will make in construction, direct employment planning and the some 1900 jobs that it is expected to deliver during those planning and construction periods, let alone the 1000 ongoing positions; whether it is the grants that we are rolling out through this budget which are expected to deliver more than 1200 jobs; whether it is the engineering infrastructure replacement program, important in dealing with not just some of the ongoing facilities issues that we have seen across our health network but ready-to-go projects that will target specialist and small organisations for economic activity; or whether it is the very large projects that we will start to see, where we expect some thousands of jobs, but particularly modelled around the Metropolitan Health Infrastructure Fund, and we would expect that to drive some 600 direct employment opportunities during the course of its project. When it comes to the Regional Health Infrastructure Fund the projections are that it will directly contribute to some 360 jobs through projects funded under that arrangement. Indeed when it comes to regional and rural infrastructure projects more generally but health in particular the government's purchasing arrangements seek to prioritise regional and rural providers through its Local Jobs First policy as well as the Working for Victoria platform that delivered in response to the economic and jobs impact that the global pandemic has had.

These are significant investments. These are smaller in regard to total output but not smaller in regard to impact and the immediacy of those impacts. These are projects that are particularly focused on getting support out the door in the period of this remaining budget and starting and contributing to the green shoots of economic recovery while at the same time continuing the delivery of the responses to the health, wellbeing and recovery of all Victorians.

Ms RICHARDS: Thank you, Minister. I refer you to budget paper 3, page 21, and for the benefit of my colleagues on the committee I have noted that the budget includes a particular focus on rural and regional health services. There is a number of hospital upgrades, including the Warrnambool Base Hospital. Can you outline for the committee the government's infrastructure investment across our rural and regional health services?

Mr FOLEY: Thank you, Ms Richards. The government knows that from one corner of the state to the other people reasonably need to look to their local communities for the local support and services they need. We want to make sure that the historic and continued disparities between access for services and health outcomes that Victoria's regional and rural communities continue to labour under are addressed. That is why, as important as the capital investment is, it is not the only aspect; it is literally the bricks and mortar that provide the expanded services that our state needs to make sure are applying from one end of the state to the other. So I think Victorians can have confidence that this budget is a further significant step in making sure that those capital investments are being made right across the state in our healthcare system.

There is the $384.2 million Warrnambool Base Hospital redevelopment, which I know the Member for South-West Coast made direct representations to me about, and I am pleased to see that we delivered on that project as an important part of our capital expansion. This project will deliver the next stage of redevelopment, including the logistics hub, which will have a wider benefit than just that health service, enhancing the capacity of the emergency department; significant investment in operating theatres and acute inpatient beds; we will, as is important, relocate supply and linen services to a new site; and the development of a new regional health logistics distribution centre. It is an important contribution, as one of the learnings from the pandemic has been the important role that, if you like, hubs and clusters of health services in regional Victoria have had to support each other in what has been a very challenging 2020.

There is also an initial $217 million investment for the next stage of Latrobe Regional Hospital's development, which will see three new operating theatres, an expanded maternity unit and a further six ICU beds. There is an additional $80 million to what has already been invested in the complete rebuild of the Ballarat hospital, which of course services both the Ballarat and the wider Grampians region, which will see three new operating theatres, an expanded maternity unit and a new central energy plant, which I know that the two members for Ballarat in recent days took great pleasure in announcing to their local community. It will also see $66.1 million to acquire land and continue design and planning for the community hospitals that we have touched on, some of which are in regional Victoria, particularly in the Surf Coast, Torquay and Phillip Island. There is a further $7.5 million for the Wangaratta base hospital to refurbish and expand the maternity accommodation, for electrical upgrades and clinical systems. There is $3.6 million for the new design and planning for the women's and children's hospital in Geelong. And there is a $1.7 million initial contribution for the future expansion of the Maryborough hospital. These all build on substantial arrangements elsewhere—as I have said, the Ballarat Base Hospital, our Goulburn Valley hospital and other investments.

Ms RICHARDS: Thank you, Minister. I understand the Regional Health Infrastructure Fund has been incredibly popular since it started in 2016. Could you outline some of the health services that benefit from the program and what sort of projects this additional funding will deliver? That is BP3, page 21. I am conscious I have got only a couple of seconds left.

Mr FOLEY: Of course. Now reaching some $470 million since this fund was established in 2016, and that initial investment has grown year by year from the initial investment of some $200 million, I know that the Regional Health Infrastructure Fund, with the many, many—over 360—projects that it has funded, including 52 projects that have been over $1 million, is wildly popular, and I am sure that it will continue to be so as we see the call for expressions of interest. I know that many members and many health services from right across regional Victoria have already expressed an interest in this project.

The CHAIR: Sorry to interrupt you there, Minister, but the member's time has expired. Given the length of this session as well, I think now is probably an appropriate time to break for a short rest break. We will resume at 10.20. Thank you.

We will reopen these hearings with Minister Foley. Mr David Limbrick, MLC, has the call.

Mr LIMBRICK: Thank you, Chair, and thank you, Minister and team, for appearing today. I wanted to start with a couple of things around the overall assumptions in the budget. In budget paper 2, pages 22 to 24, there are a whole bunch of assumptions that are used by Treasury for the outlook, and many of those assumptions are based on the success of the actions by your department. One of the ways that these measures are going to be presumably implemented is through the state-of-emergency continuation and the directions that are being used under the state of emergency. What I wanted to ask, Minister, was: how are you going to ensure that, when these directions are issued, to your satisfaction they will be the least restrictive of human rights?

Mr FOLEY: Thank you for your question. It goes really to the deep basis of the response. BP2, page 22, 'Key assumptions'. You are quite right; when it underpins economic forecasts, essentially, it locks in the notion that you cannot have an economic recovery without it being based on a health recovery. The whole notion that you hit on is at the heart of the *Public Health and Wellbeing Act*. When the extreme measures of the declaration of emergency happened—and now as a result of legislative changes are rolled over on a monthly basis, given the length of time that it has been happening—making sure of the least restrictive arrangements possible and the proportionate application of those least restrictive arrangements is both at the heart of the legislation and at the heart of the rollout of the responses. How I, as the minister responsible for the *Public Health and Wellbeing*

Act, seek to ensure that that legislative underpinning is delivered is something that strikes at the heart of what I think about every day in how those restrictions are both rolled out and reviewed constantly. Essentially I act on the advice of the public health unit, and particularly the advice of the chief health officer and his deputies, and other arrangements.

Striking at the heart of your question is that balance between how do you, on the one hand, slow the spread of a virus, particularly in arrangements where, as we saw in the second wave of the coronavirus spread, there is a need to restrict movements that lies at the heart of that. It is not the only factor, but to restrict citizens' freedom of movement is a really challenging decision to have to make—not the only one—versus the clear public benefit through driving down infection rates and seeking to control them. Essentially the balance is one that you have to work through from the public health advice. I think your question strikes at the heart of not just the philosophical approach to rights and health intersecting but their deep intertwined nature. These are very challenging decisions, but ones that are made with the best of public health advice, and I think based on the advice not just of the public health unit. When you see the contributions from some of the academic and projective work that was done by a whole range of people, particularly the Burnet Institute and others, that then underpinned how long you need to get—in their projections—to a sustainable level of driving down the infections, and the restrictions that that needed to impose on citizens in so many ways was a really challenging space. But I think the balance of the advice from the public health unit has proven to be correct.

Mr LIMBRICK: Thank you, Minister. It is interesting that you brought up this dilemma, I suppose, of controlling the pandemic versus the impacts on human rights. This is something that I have spoken about and consulted with people on many times. Would you accept that getting rid of the transmission within the community does not necessarily show that we have taken the least restrictive actions on rights, because there are countries—

The CHAIR: Sorry to interrupt, Mr Limbrick, but I just remind you that we have an inquiry this afternoon in relation to this committee's reference on the government's response to COVID. This is the scrutiny of the budget papers, so I just ask you to distinguish your questions and separate your questions for this afternoon versus this morning.

Mr LIMBRICK: Thank you, Chair, but I think that these issues are at the heart of the assumptions in the budget, because one of the very key points in budget paper 2, pages 22 to 24, is around when we are going to open up, and opening up is presumably returning those rights to Victorians so that they can move around freely and eventually we can have international travel and this sort of thing. So in the budget paper it states in those assumptions that, I think it is at the end of this year, we will be at a COVID normal and then by the second half of the next calendar year we will be back to normal conditions. So at what stage is the state of emergency no longer required in that assumed time line that Treasury has used for their modelling?

Mr FOLEY: I cannot speak for Treasury, but in terms of at least—

Mr LIMBRICK: But they must have had communications with your department about this, surely.

Mr FOLEY: Yes, indeed in terms of the whole process of how budgets are put together—put through the cabinet process and other arrangements. Without wanting to pre-empt the specific COVID focus of later hearings for the health portfolio, the short answer is for as long as it takes. The longer answer is that the state of emergency underpins so much of the ability of the public health team to put in place some critical local, and indeed our contribution to national, pillars to respond to the pandemic. The most obvious is the establishment of the hotel quarantine arrangements, and essentially the orders that those residents are subject to to limit their movement. They are not free in the sense of being able to—as citizens of Australia and residents of Victoria—freely move around the state when they return. And there are some 36 000 Australian citizens who have currently registered with the commonwealth government to want to return to Australia as soon as they possibly can, and I think some 8000 of those citizens are classified as vulnerable circumstances. So yes, they are increasingly coming from parts of the world that are red-hot with the coronavirus, and increasingly so.

Having to make sure that you balance the economic interests of the state and the commonwealth against the health benefits of ensuring first and foremost the exercises in infection prevention and control gets to that deep challenge that your initial question identified. But I do not think it is one that I have any trouble in reconciling when it comes to making sure that people who are returning to what is now a COVID-suppressed environment

in Australia are subject to the strictest possible limitations for the least period of time that it is deemed safe and appropriate to do so. That is why I have to, in this respect, operate on the advice of the chief health officer when it comes to that. That is not just in the hotel quarantine example, but the hotel quarantine example is the most obvious, and I would have thought that the need for that is going to extend for some time yet, into 2021.

Let us hope that the promising developments around vaccines and other responses prove successful, but even if they do, depending on how that works, we could still see the need for hotel quarantine and restrictions of movement that are associated with that well into 2021.

Mr LIMBRICK: Thank you, Minister, and I am glad you brought up the subject of vaccines, because I was going to ask my next question about that. I do not see any specific funding in here for COVID vaccines. Now, I know that the federal government is doing a lot of work on this as well. Are there any sort of specific things—I am assuming that there must be some sort of rollouts of this that would require education or whatever campaigns. Also, with the vaccines, can you give assurance that these vaccines will only be delivered through informed consent and not through mandatory means?

Mr FOLEY: Working backwards, the rollout of any prospective vaccines has still got to go through a significant TGA risk management and approval—and there are promising signs in that regard—and that component is being led of course by the commonwealth. But I do have to acknowledge that all the states and territories and the commonwealth have been working for some time on what is the most effective rollout process for vaccines, and I would hope that bilateral arrangements between the states and the commonwealth, which are well progressed, would be able to be finalised well and truly in advance of that TGA approval.

The issues around how the commonwealth and the states will then roll that out have been the subject of discussions at the national cabinet level. In regard to your final point, 'Will that be voluntary?'—but I think you used the phrase 'informed consent'—my understanding is that the national cabinet position, and certainly the position of the Victorian government, is that the rollout will be in accord with that national cabinet decision of the distribution of the vaccine: once safe, once approved and once prioritised through various priority communities who will need it first, it will be voluntary.

Mr LIMBRICK: Thank you Minister, and that is reassuring to hear.

Mr FOLEY: But strongly incentivised.

Mr LIMBRICK: Yes. So with these incentives, and assuming there is going to have to be lots of education around that, what sort of funding is there for education here? Because, you know, if it is discovered that there is a vaccine developed and it is safe and effective, you will have to convince people of that, if it is voluntary. So how would you go about communicating that and what in the budget is there to actually handle that communication?

Mr FOLEY: Understanding the guidance from the Chair about how a lot of this might well be the focus of discussions later today, I suspect I am going to draw the committee's attention quite regularly to BP3, page 64, 'Public Health' in the 'Output initiatives', which has the substantial investment of $2.9 billion around coronavirus public health responses. As we then follow in the rollout of the subsequent commentary associated with that, that is a very significant contribution to a whole range of public health coronavirus responses. Amongst other output initiatives you will find the issues around how we engage with the commonwealth, with local government, with communities, with pharmacies and with primary health providers around that. We want to make sure that this is done in a way where, once it is approved and safe to do so, communities are deeply engaged. It will be a logistical exercise like no other this nation has seen.

Mr LIMBRICK: I can imagine.

Mr FOLEY: Assuming that many of the vaccines are two injections, let alone the data and the distribution, this will be a very significant exercise, and it is one of the many reasons for the strong focus on creating the health department as of 1 February, which will be focused on this.

Mr LIMBRICK: Thank you, Minister. I would like to ask about something else in the budget papers. Budget paper 3, page 63, has an allocation to telehealth, Better at Home.

Mr FOLEY: Yes.

Mr LIMBRICK: It is my understanding that telehealth has the potential to result in much more efficient delivery of services. Do you foresee that this rollout of telehealth might result in savings and efficiencies in future health budgets through continuation of this in the long term?

Mr FOLEY: Telehealth has taken off in 2020. The reference here is to, if you like, the health network side of things, where pre-pandemic there were about 2000 telehealth occurrences happening. Since the pandemic we have seen that figure rise to 72 000. The Better at Home initiative seeks to build on what has been a many-decades long focus that Victoria's health system has had on what is the most appropriate location for service delivery. It is designed for improving services rather than any other factor, and the evidence of the past seven months has shown that in addition to the, if you like, bricks-and-mortar tertiary hospital settings there are substantial health improvements to be made through the delivery of health care in a home setting. Not every setting—this is all based on clinical advice and clinical determinations. When I recently visited the Monash Hospital the evidence from their maternity unit was that, interestingly enough, as they had switched during the course of the pandemic to a greater focus on home care of their services, with the support that is needed and the technologies behind it, their measures of success—healthy mothers, healthy babies—had increased over the course of the pandemic.

The CHAIR: Sorry to interrupt you there, Minister, but the member's time has expired.

Mr LIMBRICK: Thank you, Minister.

Mr FOLEY: I am happy to continue this conversation later, because it is a really fascinating part of the changes we are seeing in health services.

The CHAIR: Mr Tim Richardson MP.

Mr RICHARDSON: Thank you, Chair. Thank you, Minister and health officials, for joining us. Minister, I want to take you back to rural health outcomes. I note that in addition to the service and hospital upgrades that you have outlined in the budget papers there is a specific initiative aimed at improving rural health outcomes in budget paper 3, page 14. Could you please explain for the committee's benefit the principles behind this commitment, and what is it aiming to achieve?

Mr FOLEY: I am happy to do so, Mr Richardson, and I thank you for your question. This is extending on the issues that Ms Richards had started me on before I ran out of time—making sure that our areas of regional and rural output initiatives for many, many areas are at the heart of what we are doing. If I understood your question particularly, it was BP3, page 14, and you will see as so far as they apply to the health portfolio. I think I have already briefly touched on the Maryborough hospital expansion. But when it comes to other areas such as the coronavirus short-term regional recovery aspects and that $10 million investment, we know the contribution and want to make sure the amazing work that has been achieved by particularly regional Victorians in essentially being COVID free for a substantial period of time has provided them the ability to drive programs, particularly in the health setting areas, that will underpin both community recovery, community health and economic recovery.

In that particular respect I am more than happy to perhaps look to our friends from the Victorian Health and Human Services Building Authority that could talk about some of that output initiative. Our friends from VHHSBA are more particularly capital focused, but the interplay is quite important. Perhaps I could ask Chris to just briefly supplement those questions.

Mr HOTHAM: Thanks, Minister. I am happy to expand. I think in terms of the headline capital initiatives in regional Victoria we have talked about, RHIF has been touched on—the Regional Health Infrastructure Fund. That is a really substantial increase in that funding. Historically we have had, as has been discussed, $350 million of that over the last number of years. An extra $120 million will go to a number of the critical investments that many of those smaller regional health services need. We have had really strong interest over the last couple of years. It is a fund that is regularly oversubscribed, and many of these upgrades are to the kind of critical base infrastructure that these services need. Often they are the underlying capital works around electricity and water. Equally we have been able over the last few years to provide extra spaces for theatres, extra spaces for beds. It is a very flexible fund.

Beyond that, we have got this year Maryborough, and particularly the Maryborough hospital expansion, which is a fairly substantial investment in the planning needed for that critical investment.

Mr RICHARDSON: Minister, if I could take you now to the support for Victorians on their cancer journey and particularly budget paper 3, which includes $31 million for an initiative improving cancer outcomes at page 83. Can you please outline for the committee's benefit what this entails and how it will align with the world-leading research delivered as part of the Victorian Comprehensive Cancer Centre alliance?

Mr FOLEY: Thank you very much. Cancer continues to be a significant health issue for so many Victorians, and indeed the Victorian Comprehensive Cancer Centre alliance made up of such critical partners as Peter Mac and a number of the other research institutes, the University of Melbourne amongst others, is at the heart of that. I should also note that that work has not been untouched by the pandemic. The areas of deferred care that many Victorians have put in place as a result of their responses to the pandemic include cancer treatment, so this actually becomes increasingly more important, not less, as we seek to improve cancer outcomes. The alliance team—the Peter Mac, the Royal Melbourne and other organisations and universities and their partners—is all about making sure that this $33 million investment over the next four years builds on the substantial leadership work that those groups have put in over recent times. This funding will support projects that build on the limited treatment options for low-survival cancers, particularly lung cancer, which tragically has a 14 per cent five-year survival rate, and pancreatic cancer, which has a devastating 4 per cent five-year survival rate, and make sure that we have increased personal medicines through the testing of genomic precision oncology and other significant investments that will certainly, from initial reports, seek to improve those outcomes.

Also, as part of your earlier question about regional focus, we want to make sure that clinical trials in regional and rural areas improve and outcomes improve. Victorians experience a five-year survival rate, if they live in regional Victoria, of 67 per cent of responses to different forms of cancer treatment. That compares to 71 per cent for their cousins in metropolitan Victoria. That disparity cannot be allowed to stand unchallenged, and it is a major focus for the VCCC alliance. This funding will facilitate the expansion of cancer treatments, particularly teletrials and access to services in regional and rural Victoria. It will also deliver the strategic intent of the 2016–20 cancer plan, the *Healthier Lives, Stronger Economy: Victoria's Health and Medical Research Strategy*. It will also seek to align with work being done in the pharmaceutical sector and their strategies for research. We want to make sure with all of those alliance partners that we not only have the world's leading research into cancer treatment and engagement with communities but also that we have the best delivery of those outcomes and trial them with global partners, particularly when it comes to those Victorians who are disproportionately excluded from access to those treatments.

In that regard we know that cancer, when you measure through the burden of disease measures, continues to be the greatest health burden in Australia, with one in three men and one in four women diagnosed with cancer before they are age 75. In 2018 over 35 000 Victorians were diagnosed with cancer and 11 000 Victorians died from the disease. That is 30 per cent of all deaths. And cancer—I am sure this will not come as a surprise—disproportionately impacts on vulnerable populations, with higher mortality rates not just in regional communities but amongst disadvantaged communities, particularly our Aboriginal and Torres Strait Islander communities, particularly with lifestyle-related cancers. So making sure that this is a focus well into the future—a national focus, a Victorian focus and a community focus—is at the heart of this budget proposition.

Mr RICHARDSON: Minister, can you for the committee's benefit elaborate more on how that funding will improve patient outcomes on their cancer journey?

Mr FOLEY: I can. Whilst data might sound a boring subject in many regards, improving data linkages to accelerate cancer research, particularly given our world-leading biomedical sector here, is at the heart of embedding research outcomes into routine care that will address some of those awful mortality figures and burden of disease figures that I was referring to. In this regard Victoria is exceptionally fortunate to have some of the world's leading cancer researchers based here. I recently had the pleasure of joining the global academic international conference leadership for 2020, remotely, which was a joint partnership between the Peter MacCallum Cancer Centre and the Anderson Cancer Centre in Texas. It was about some of the joint work that they are doing in pioneering innovation and excellence and the delivery of that in cancer research and treatment.

This research is all about not only identifying improved outcomes through new treatments but also new ways of providing that care, particularly through more decentralised healthcare work as a big contributor to turning around those positive patient outcomes that are so desperately needed in some areas of particular cancers. Our medical researchers are part of the leading, groundbreaking work that is being done into both prevention and treatment, and the work that is being done by these groups is well on track to meet the ambitious goal, however challenging 2020 has been in deferring some of that care and treatment, of 10 000 lives to be saved by 2025 under the *Victorian Cancer Plan*.

Mr RICHARDSON: Taking you further, Minister, into the *Victorian Cancer Plan* that is so critical for all Victorians, how does this investment support the government's target to halve the number of Victorians diagnosed with preventable cancers by 2040 as outlined in the *Victorian Cancer Plan*?

Mr FOLEY: Thank you, Mr Richardson. For those figures, particularly for the high-mortality cancers and burden of disease figures, the same group of researchers and efforts point to the fact that at least one-third of cancer cases are preventable and that more than one-half of cancers could be avoided through a combination of regular screening and engagement with services but, more importantly, healthier lifestyles. The leading preventable cancers identified under the *Victorian Cancer Plan* include lung cancer, melanomas of the skin and breast cancer, amongst others. In Victoria we have seen decreased incidence rates for some of these cancers, particularly where primary health prevention focus is at the heart of the response. That is an extraordinarily effective tool, and an example of this is not just in the incidence and mortality rates for lung cancers following the declines in rates of smoking but the rates of cervical cancer due to the success of screening and vaccination programs, again based on world-leading research and program delivery here in Victoria.

Our investment in the VCCC is an investment into health and wellbeing and reducing the incidence of the unnecessary burden of disease and preventable death. Victoria has increasingly some of the best cancer survival rates in the world, but we do not propose to rest on our laurels. We want to make sure that the cancer research and initiatives that lead from the testing and the trials provide us with the tools to continue to refine these programs, continue a strong emphasis on early detection and continue better treatment options, better outcomes and better life outcomes for Victorians who look to these efforts. Our efforts to prevent and detect cancer with access to world-class treatments lie at the heart of that ambitious goal that the *Victorian Cancer Plan* has to save 10 000 lives by the time we get to 2025.

Mr RICHARDSON: Minister, taking you to one of the preventable cancers that you were talking about, skin cancer. Are you able to discuss the role of shade sail grants and that program in that broader skin cancer prevention initiative?

Mr FOLEY: I can. The solar shade grants are wildly popular and are regularly oversubscribed, I can assure you, which just shows how much the message of successive generations and governments of all colours has achieved in changing our approach to avoidable skin cancer burden of disease. Skin cancer is estimated as running at perhaps some 40 000 new cases diagnosed every year in this state alone, and it is regularly a major focus of all governments, as it should be. Melanoma—and there are many types of melanomas—is the most deadly type of skin cancer. Two hundred and seventy-nine people died of melanoma in 2014–15 alone, with 2466 new cases diagnosed each year from that base. It was the fifth most commonly diagnosed cancer in our state, and we know that preventative measures such as shade—not just shade but the public expression of keeping out of the harmful UV radiation that shade alone can bring and the reduced exposure from that—can be critical. We have seen that shade, by the work that this research that VicHealth and others have done, can be up to 75 per cent effective. That in turn is strengthened when used in combination with the well, I hope, acculturated approach to sun protection strategies such as sunscreen, hats, sunglasses and protective clothing. That is why there is $15 million over four years from previous and existing budgets for skin cancer prevention initiatives, including $10 million for shade development in schools, because of course getting young people and protecting their skin through this has a disproportionate effect later in deferred care in the years to come.

Mr RICHARDSON: Thank you.

The CHAIR: Thank you, Minister, and I will pass the call to Ms Bridget Vallence, MP.

Ms VALLENCE: Thank you. Secretary Wallace, I would like to ask a question about budget paper 3, page 217, in relation to acute services outputs. The target there on page 217 for 2020–21 in terms of elective

surgeries is 203 020. The target at 2019–20 was exactly the same figure, 203 020. Could you describe why that elective surgery target has not increased?

Prof. WALLACE: Yes, thank you. As you know, there is funding in our hospital budgets for the regular program of elective surgery, and that elective surgery program in this coming year will continue, but in addition to that there has been additional investment funding of $75 million to provide 10 000 additional procedures and to bring our waiting lists back to where they were before, because, as the minister said before, one of the impacts of the pandemic necessarily has been that in order for hospitals to prepare to respond to the pandemic as modelled early on in the year we had to delay many of our elective surgery programs. So our waiting lists, as the minister said at the beginning, have increased. In order to target those waiting lists there is additional and separate funding specifically for those waiting lists.

Ms VALLENCE: Okay, but in terms of the numbers of patients admitted, that is not changing. Is there a reason for that?

Mr FOLEY: Mr Symonds, who has had some 15 years in specialising in precisely this issue, might be able to assist the committee with some further detail.

Mr SYMONDS: Ms Vallence, I recall the challenge of trying to set a target for elective surgery this year. We have two factors going in different directions. It is only quite recently that public and private services were even allowed to return to their previous levels of elective surgery activity, but even with that permission services are still grappling with how to provide elective surgery efficiently in a COVID-safe environment. So operating theatres, wards and preadmission clinics are all operating at less than 100 per cent, or less than their usual productivity, because of the need to provide COVID-safe care—physical distancing, necessary checks and screens et cetera. So we have had a period of more than probably a third of the financial year operating under capacity; we have an unknown level of decreased efficiency, I suppose, in the remainder of the year; but then we do have additional investment provided by government. The net impact of those three factors is something that is beyond science to predict. We are going to have to let our experience play out.

We opted for a target that reflects the same, optimistically hoping that the additional funding would offset the negative impacts of the pandemic so far, and we may well exceed that, but it was not possible to put those three separate factors together and come up with a precise number around where exactly we would sit. If we get back to the previous year's target, we will have done a terrific job in terms of offsetting the impact of the pandemic to date and also getting over the ongoing inefficiencies of dealing with COVID-safe care.

Ms VALLENCE: Okay. There was funding for an elective surgery blitz as part of the output initiative 'maintaining hospital capacity'. What is the time frame of that elective surgery blitz? You have just described there that there has been a drop in efficiency of being able to deliver on elective surgeries, and yet you are also in the same vein saying that you have got a blitz. Those things seem to be at odds.

Mr SYMONDS: They are not at odds; they are just different points in time. So the blitz begins now that we are able to resume care and the restrictions imposed by the pandemic are off—

Ms VALLENCE: So what is the time frame for the blitz? What is your estimate and what is your planned time frame for the blitz?

Mr SYMONDS: The funding provided in the budget extends over four years. It is primarily loaded across the first two of those years, and I am sure government will look at our progress in those first two years and make further considerations around what additional resources are required beyond that. We are clear that it will go beyond a few months, six months or whatever the previous duration of elective surgery blitzes has been. This is going to be a longer-term effort. We are not going to be able to reverse this in one quarter or something of a financial year. It is going to take at least a couple of years of sustained effort, and that is what the Victorian government's investment provides for.

Ms VALLENCE: Okay. So we understand—

Mr FOLEY: I could further assist—

Ms VALLENCE: that there is at least—

The CHAIR: Ms Vallence, could you allow the answer to be completed, please.

Ms VALLENCE: Mr Symonds has provided the answer. We understand it is around—

The CHAIR: Ms Vallence, I think you will find the Minister has a contribution to make—

Ms VALLENCE: I did not ask a question to the Minister.

Mr FOLEY: I am providing additional information that the committee might well find helpful in—

Ms VALLENCE: You can table that, Minister. Mr Symonds, there is—

Mr FOLEY: No, no, in regard to—

The CHAIR: Ms Vallence, as Chair, I am giving the Minister an—

Ms VALLENCE: As Chair, you are trying to chew up my time.

The CHAIR: You are the one chewing up your time, Ms Vallence.

Mr FOLEY: In terms of the specifically relevant point about when, I can assure the committee, and through the committee, the Parliament, that we are in extensive discussions with all the stakeholders that you would expect—that being the health networks, including the private health providers, the Australian Medical Association, the various colleges—and we would expect that, as Mr Symonds has indicated, the front loading of that substantial investment of $300 million will be imminent in an announcement on how we will start to haul back the impact of elective surgery waiting list timetables. I look forward to sharing both with the committee and with Victorians the outcome of those discussions in the very near future.

The CHAIR: Thank you.

Ms VALLENCE: I think the 66 000 or more Victorians who are waiting for elective surgery would like to see that, and I think two years is probably a little concerning. That funding, you said, is over approximately two years—

Mr FOLEY: Four years.

Ms VALLENCE: and I think it was mentioned that there are around 10 000 additional spots. Is that really going to make a difference over that time to the total of Victorians who are waiting for surgery?

Mr FOLEY: Absolutely. As both—

Ms VALLENCE: The question was to Mr Symonds.

Mr FOLEY: Given that I am on a roll, I will start before I hand over to Mr Symonds.

Ms VALLENCE: No, the question was to Mr Symonds.

The CHAIR: Ms Vallence, the minister is entitled to provide an answer to the question.

Mr RIORDAN: On a point of order, Chair, a questioner is asking Mr Symonds. The minister has consistently shown all morning a desire to gobble up time with long, drawn-out pontifications. Can we please bring it back. We have asked the question to a person. If he chooses not to answer and passes it, then so be it, but the minister cannot just butt in and answer when he feels like it.

The CHAIR: Deputy Chair, there is no point of order. It is not your role to determine who is the most appropriate person to provide the best information to the committee to answer the important questions this committee is asking. I am sure Mr Symonds will also make a contribution, but the minister is entitled to make a contribution to the answer if that is helpful to this committee.

Ms VALLENCE: Well, it is not helpful to the questioner.

Mr FOLEY: Thank you, Chair, particularly in regard to setting the context of the more detailed response, which I am sure Mr Symonds will supplement. Victorians made an enormous sacrifice over the course of 2020 to respond to the deferred care issues here. When it comes to elective surgery and the $300 million allocated—front-ended into how we respond, as measured by, amongst other things, the conservative performance measures set out here—I think it is our expectation that we will be making some announcements about how we deal with that, but without doubt it will take time to make an impact on that backlog, particularly given that we see increased demand year on year anyway for elective surgery arrangements. So the combination of dealing with both backlogged demand and ongoing demand is a huge focus for the department, but not just the department, the coalition that we need to build with private hospitals to respond to that. In regard to the measures—

Ms VALLENCE: Minister Foley, as you had originally referred to Mr Symonds, I would really appreciate—I know Victorians have made great sacrifices, and to that extent I would like to ask: does the department have a fatality estimate due to deferred treatment of elective surgeries? Mr Symonds.

The CHAIR: Ms Vallence, did you want Mr Symonds to contribute to the answer to the question you asked him previously?

Ms VALLENCE: I would like Mr Symonds to answer the question I have just asked.

The CHAIR: So you are withdrawing the previous question of Mr Symonds.

Mr RIORDAN: Please, Chair.

The CHAIR: Well, you cannot put a proposition to the table and then not give people the opportunity to answer it.

Mr RIORDAN: Well, every time we ask a question the minister butts in and then drones on.

Mr D O'BRIEN: You say we have to let him answer it.

The CHAIR: Deputy Chair, Ms Vallence, Mr O'Brien, you cannot put a proposition nor a question to the witnesses and not allow them the opportunity to answer it. Mr Symonds, did you have a contribution?

Ms VALLENCE: And Chair, with respect, you cannot editorialise, and your job really should be getting the witness to answer the question as opposed to rephrasing our questions.

Mr RIORDAN: So some pillar of fairness in your chairmanship.

The CHAIR: Deputy Chair, Ms Vallence, that is exactly what I am seeking to do—get an answer for you from the minister and Mr Symonds to your previous question.

Ms VALLENCE: So Mr Symonds, if you could—

Mr FOLEY: So are we answering the previous question or not?

The CHAIR: Ms Vallence, as Chair, I am requesting that the minister and Mr Symonds complete the answer to your first question before you move on to another one.

Ms VALLENCE: There is obviously something that they are very concerned about; this elective surgery blowout is obviously something the department is entirely concerned about because they are relying on your protection, and they are obviously very concerned.

The CHAIR: Ms Vallence! You are the one who is chewing up the clock here.

Ms VALLENCE: They know that the numbers are so huge on elective surgeries—

The CHAIR: Ms Vallence!

Ms VALLENCE: that the deferral of these is going to cause huge concerns—

The CHAIR: Ms Vallence! It is extremely rude to continue to talk over the Chair and I do not appreciate it.

Mr RIORDAN: Well, it is incredibly frustrating for the opposition to have the Chair butt in and continually protect the minister and not once ask the minister to get to the point.

The CHAIR: Deputy Chair, perhaps if you got your questions to the point, you might get the answers that you might be seeking.

Ms VALLENCE: I think asking for a fatality estimate is pretty much to the point.

Mr RIORDAN: Asking for a fatality estimate is pretty bloody blunt, quite frankly.

The CHAIR: Deputy Chair, Ms Vallence, Minister and Mr Symonds, if you could, that would be appreciated.

Mr FOLEY: If I could assist the committee in this important issue, perhaps I will defer my setting of the context for the issue around the measures of deferred care for elective surgery and then throw to Mr Symonds so he can finalise his answer on that question before we proceed to the next, no doubt, important issue.

The CHAIR: That would be appreciated. Thank you, Minister.

Mr SYMONDS: I am really sorry, but the question now is about the deferred elective surgery?

The CHAIR: Yes, the elective surgery question.

Mr SYMONDS: So the question that I had before was whether or not the $75 million would make a difference, given the size of the increase in the waiting list. Again there are a number of things in play that we do not fully understand. People have delayed attending GPs. They have delayed attending specialist outpatient clinics. So each step of the pathway that leads to someone being on an elective surgery waiting list has also been affected by the pandemic. So we did not know yet the accumulated impact of those factors on what the waiting list will be. There is no secret about the concern—

Ms VALLENCE: Okay, so you do not know what the impact is. If you could please—

Mr SYMONDS: It will be a significant—

The CHAIR: Ms Vallence, herein lies your problem: you continually put propositions as an editorialising over the top of the answer you receive.

Ms VALLENCE: No, my problem, Chair, is that you keep butting in. I think that is pretty express—it is not clear what the impact will be over the time.

Mr FOLEY: I have to object to that editorialising.

The CHAIR: Ms Vallence, we have discussed this a number of times, you cannot put a proposition to the witness—you cannot take their words and put them into yours and not allow them an opportunity to respond.

Ms VALLENCE: There are over 66 000 Victorians, as the government has described, who are waiting for elective surgery.

The CHAIR: Ms Vallence, you have put another proposition—

Ms VALLENCE: I think it is in their interests, and that is precisely my job on this committee—

The CHAIR: Ms Vallence, you are out of order.

Ms VALLENCE: to ask, on behalf of the Parliament, on behalf of Victorians, the 66 000 people who are waiting for elective surgery—

The CHAIR: Ms Vallence, this is extremely rude, disrespectful and out of order.

Ms VALLENCE: if we could please have fatality estimates due to deferred treatment.

The CHAIR: Ms Vallence, I give the minister and Mr Symonds an opportunity to respond to the previous proposition that you put to the table, and if you do not want to continually be pulled up on this then I suggest you stop doing it.

Mr SYMONDS: The Secretary has already answered that $75 million would get us 10 000 additional operations. It may well get us more than that, because we have not completed—

Ms VALLENCE: Yes, we have heard that. We have established that.

Mr SYMONDS: our negotiation. So your question was about the impact it would have. I think 10 000 surgeries is a significant impact.

Prof. WALLACE: Chair—

Ms VALLENCE: Thank you, Mr Symonds. A fatality estimate—if you could progress to a fatality estimate.

The CHAIR: Thank you, yes. Ms Vallence, the Secretary also feels the need to respond to the proposition that you put, and—

Ms VALLENCE: I did not ask the Secretary.

The CHAIR: Well, Ms Vallence, you should not editorialise and put propositions to the witness table that you do not want them to answer.

Mr FOLEY: We cannot let some wild assertions stand unchallenged.

The CHAIR: That is right, Minister, you cannot. Secretary.

Prof. WALLACE: Ms Vallence, it is a very important question you have asked, and the answer to it is clearly complicated. It is more than just a waiting list; it is also the median time on the waiting list for the most urgent cases, and during the pandemic the department established a perioperative expert working group—our elite surgeons across the state—to guide and inform the department about the measures we should take.

Now, one of the outcomes of that is that the median time for our most urgent cases on the waiting list before the pandemic was 10 days; it is 10 days today. So while the waiting list itself has increased because we have delayed surgery, our most urgent cases are still being done, they are being done on time and the time on that waiting list is the same today as it was before the pandemic started.

Ms VALLENCE: Secretary, does the department have a fatality estimate due to deferred treatment? I just want an answer to that.

Prof. WALLACE: No, we do not at the moment, but that is not to say that the work is not being done. So again, there are some very key outcomes of the—

Ms VALLENCE: Secretary, I just wanted to ask if you had an estimate, and your answer was no. I do not—

Prof. WALLACE: Well, we are working with the sector to identify what surgeries have been delayed—not just surgeries delayed, it is about people choosing not to come forward for the diagnoses, so it is not just—

Ms VALLENCE: Yes, and that is fair enough. That is fair enough.

Prof. WALLACE: So it is delayed diagnosis as well as the surgery. And again, our most urgent surgeries, our category 1 surgeries—there has been no delay in the delivery of those.

Ms VALLENCE: Yes, I have already noticed that in the budget papers. Secretary, on that, what is the median wait time for colonoscopy in Victoria?

Prof. WALLACE: Well, as you would be aware, the majority of colonoscopies are done in the private sector rather than the public sector. I do not have the median waiting time for a colonoscopy.

Ms VALLENCE: Could you take it on notice? Would it be possible to take that on notice?

Mr SYMONDS: I might add that we do not have the median waiting time for colonoscopies. The collection of accurate waiting time data for colonoscopies is something that we agree is an important measure for us to collect, but we do not have it at the moment. I think with the pandemic out of the way I am sure we will return to putting systems in place to collect that data and will be able to provide it to the committee in future, but we do not have that data at the moment. I am sorry.

Ms VALLENCE: Thank you. In relation to budget paper 3, page 214, Secretary, in terms of the funding that is dedicated to bullying and harassment within the department, what proportion of DHHS staff have experienced bullying in the past 12 months in relation to the 2019 People Matter survey?

Prof. WALLACE: Thank you. As you know, we take bullying and harassment very seriously. We have got a whole-of-government strategy around bullying and harassment, *People Strategy 2020+*. In the year 2019–20 through our People Matter survey 18 per cent of our staff reported that they had experienced some sort of bullying.

Ms VALLENCE: And sexual harassment?

Prof. WALLACE: Through the People Matter survey, 7 per cent, but there were no claims for sexual harassment and 12 claims for bullying—actually the lowest for both that we have seen over the last four years.

The CHAIR: Thank you, Secretary. The member's time has expired. I will pass the call to Ms Nina Taylor, MLC.

Ms TAYLOR: Good morning, Minister and department officials. I was wanting to explore the Better at Home initiative, budget paper 3, page 63. The budget included $121 million for this Better at Home initiative. Could you please explain to the committee what this initiative is and what it seeks to achieve?

Mr FOLEY: Thank you, Ms Taylor, and congratulations on your ascension to this important committee.

Ms TAYLOR: Thank you.

Mr FOLEY: I have touched briefly on the Better at Home care initiative so far, but I am happy to expand. So $120.93 million over the next three years will be allocated for this Better at Home initiative. That is in three main components: $102.6 million is essentially through an expression of interest process whereby healthcare agencies can put forward innovative proposals to deliver home-care options such as rehabilitation, chemotherapy, post-surgical care and, as I touched on, for instance, support in maternal care as well. We would hope that that would substantially leverage existing investments in addition to that $102.6 million that other agencies would bring from their existing projects to take them to a new level of scale. We are also allocating $12.5 million for the important areas around the technology and support that is needed to sustain those increasing high rates of home care based around the telehealth supports. It is not just phone; it is increasingly visual and iPad use and data use as well where patients and their support, generally their family but also others from private healthcare settings, can provide in almost real time real measures of health data that are so important and pharmacological support as well. Then there is a final $5.8 million to engage clinical workforce in the changed skills and the changed supports that the workforce will need to be able to deliver that care in different locations.

Altogether we are hopeful that this rapid expansion of care through what will be a combination of healthcare settings, telehealth, different technological aspects and different supports for the professional and clinical and community-based workforces associated with that will all come together in a way that can build on Victoria's impressive history of care in the home and in community settings. I am hopeful that this will contribute substantially to different ways that the implementation of care pathways, with the ability to escalate or de-escalate based on people's pathways through their clinical support, will be not just safer but will deliver better outcomes in more-supportive settings. We are also working closely with the commonwealth on how some of those arrangements for crossover between the primary healthcare and the state's responsibilities can be more closely integrated to improve those journeys to recovery for people in our healthcare system.

Ms TAYLOR: Thank you. So on that note, what is the current status of home-based care? Is this a common experience in Victoria, or will this be a completely new concept for families and hospitals?

Mr FOLEY: It is far from a new concept. Victoria in many regards has been a leader in home-based care for many decades under governments of all persuasions. Indeed in the early 1990s this home-based care initiative perhaps took some of its more important steps under Minister Tehan at the time and others. So I do acknowledge the contribution that governments of all ilks have made in this space.

But in regard to other areas, about how this important work can be further progressed, lots of studies—not just in Victoria but around Australia and the world—show that this really does deliver better care and better opportunities for families and patient experience. We know about improved outcomes of care—I did touch on my visit to the Monash maternity facility and meeting families there—not just good outcomes in terms of the physical distancing and delivering health care during the pandemic but better clinical and better start-to-life outcomes for both the babies and mothers.

This was especially the case when it came to communities that would be considered more marginalised in terms of their engagement, particularly CALD communities in the diverse catchment areas that Monash has. Making sure that you have got appropriately trained and supported diverse support that is more attuned to the cultural circumstances of particular families, making sure that the care reflects that diversity, has been particularly important. It does result in shorter stays in hospital. It does that through the home and community support that is able to be brought together, particularly where some people might have other responsibilities, be they work, be they family or be they care responsibilities. It does not disrupt those, so there are better support arrangements in place.

Overall, whether it be the clinical or family or social outcomes, even practical things like reducing the amount of time that people spend travelling to and from facilities, it has been a substantial progress of success over the last several decades, and we hope that on the back of some of the learnings from the pandemic, that have seen it take a whole new step, we can continue to improve those clinical care and family and community benefits that this system has clearly demonstrated it is capable of achieving.

Ms TAYLOR: Excellent. Thank you. I know there was a little bit of discussion before on telehealth, and many of us have had the opportunity to experience that—the benefits and the convenience of that—this year particularly for routine check-ups or consultations with a doctor or medical staff. Will this mode of delivery be supported going forward?

Mr FOLEY: Look, again, we think that particularly when it comes to the state's areas of responsibility the majority of care will continue to be provided by our healthcare networks in healthcare settings, be they in the tertiary sector or in the community settings. But we know that telehealth has taken off substantially; I think I referred to the growth from some 2000 incidents to over 72 000 and growing, just in the state's areas of responsibility, and those indeed are dwarfed by the MBS numbers that we have seen GPs and other primary healthcare settings undertake in more recent times. How we bring those together will largely depend on the type of care. We have learned a lot about how in some sectors—some areas of care—telehealth can supplement, not replace, those models of care and in other areas be part and parcel of, increasingly, the empowerment of patients and communities about self-care.

Part of the Better at Home care package is investing in that software to make sure that that is the case. One of the important partners in the program is Ambulance Victoria, who will be charged with what has been an increasing pre-pandemic and certainly absolutely fundamental feature of the pandemic response about their engagement with aged-care settings. This will be an opportunity to make sure that there is a much closer alignment so Ambulance Victoria's work in partnership with aged-care settings is able to be engaged in a safer, more timely way. We know that part of that package is already being embraced by the aged-care sector. We know that the commonwealth will continue to play an important part in enabling telehealth—and I do note that Minister Hunt at the federal level has now made ongoing the removal of some of the previous restrictions about the MBS when it comes to making sure it is more accessible for primary health providers.

I know from my previous experience in the mental health portfolio that telehealth is not for everyone, but it is particularly perhaps not the case when you need that initial relationship-building between the care provider and the patient in a localised setting. Whether it is specialists, whether it is consultant physicians, whether it is nurse

practitioners or midwives—across the whole allied health practitioner forms—there are of course some areas of clinical practice and medical support that do not lend themselves to this area. But equally there are many that do. I do acknowledge that Minister Hunt pointed to the fact that there have been some more than 40 million telehealth consultations over the course of recent times, and I think that shows the inescapable reality that models of care have changed for good in this country. I use 'for good' both in terms of good outcomes for patients and care-providing and 'good' in terms of safer, more timely provision of care by our medical and specialist community.

So in that regard we want to make sure that the important work that is done by our health services is also integrated as closely as it can be with our primary healthcare partners, be they community health providers, be they specialist communities—either CALD or Indigenous—or the alcohol and other drug supports or in the mental health provider support services or in the maternal and early childhood development areas. We think there is an enormous prospect that the good work of the past few decades will substantially add to the value that our location-based healthcare services, be they tertiary or community, will build for the future. So I look very much forward to the Better at Home package building on those achievements and making sure that Victorians get the level of care, the support that they are looking for, in increasingly new and innovative and effective ways.

Ms TAYLOR: Thank you. I think it would be useful for the committee to explore how public drunkenness is being addressed. If I could refer you to budget paper 3, page 63 and page 71, firstly could you please explain how the funding outlined in table 1.13 will support the decriminalisation of public intoxication, alongside the implementation of a health-based approach, outlined on page 71?

Mr FOLEY: Thanks for that question. Can I particularly start by acknowledging the contribution that the tragic death of Aunty Tanya Day in police custody has had in focusing this issue in the community's mind. I want to acknowledge the tragedy of her death and I want to acknowledge the bravery of her family and supporters in making sure that this long-unresolved issue is dealt with. Over 30 years since the deaths in custody royal commission recommended that this issue be dealt with, the bravery of that family and that community amongst Indigenous Victorians has finally come to this well-overdue point.

I want to point out of course that whilst this policy response is led by the Attorney-General, the solution of a public health frame as opposed to a justice and enforcement frame lies in this portfolio. I am very pleased that we have got an initial $16 million allocation to help deliver the services and support for a health-based approach should the Parliament, as I hope it will, repeal the offence and commence the rollout of that program in this budget.

I want to thank also the work done by the expert reference panel that has recently reported and the release of that report by the Attorney-General in recent times. The public health response in this area is critical to making sure that what should be dealt with as a health issue rather than an enforcement issue is at the heart of what the royal commission all those years ago and the most recent report, *Seeing the Clear Light of Day*, highlight. It builds on our 14 residential rehabilitation facilities. That has been substantially expanded under this government, and we want to make sure that that is really built on over times to come. We want to design that system in consultation with, first and foremost, the Victorian Aboriginal-controlled health organisations, but also at the table Victoria Police and our health networks, because this is not a solution that will be found by simply moving the problem around of how people respond to public drunkenness.

Overwhelmingly, as the *Seeing the Clear Light of Day* report shows, the vast majority of people who are arrested and dealt with through the existing provisions are young males in one-off offences. There is a very small number, less than 10 per cent of people charged with this offence every year, who reflect a high-risk, high-needs community. So making sure our response responds to those two different parts of the equation is really, really important and in making sure that it is not just a system of sobering-up places, as important as they will be and targeting them in the communities that the data shows are most at risk and that most of these offences occur in, the focus of this response needs to be in those communities that are disproportionately over-represented by that smaller number of repeat offences being used, and that is disproportionately our Indigenous community and our alcohol and illicit drug-addicted communities.

Designing, with those communities and their representatives, the appropriate response over the next two years—understanding, as the Attorney-General has indicated, that the release of this report and the pending

legislation do not envisage a change in this space in legislation occurring for a further two years—is one of the most health and legislative reforms that I think this Parliament will consider in coming times.

The CHAIR: Sorry to cut you off there, Minister, but the time for consideration of the health portfolio has expired. We thank you and your officials for appearing before the committee in this capacity today. The committee will follow up on any questions taken on notice in writing, and responses will be required within 10 working days of the committee's request.

The committee will now take a short, 10-minute break before resuming consideration with you in order to discuss the ambulance services portfolio.

I declare this hearing adjourned.

Witnesses withdrew.