PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

2021–22 Budget Estimates

Melbourne—Friday, 18 June 2021

MEMBERS

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

WITNESSES

Mr Martin Foley, MP, Minister for Health,

Professor Euan Wallace, Secretary,

Professor Allen Cheng, Acting Chief Health Officer,

Ms Jodie Geissler, Deputy Secretary, Commissioning and System Improvement,

Mr Jeroen Weimar, Deputy Secretary, COVID-19 Response,

Mr Chris Hotham, Deputy Secretary, Health Infrastructure,

Mr Greg Stenton, Deputy Secretary, Corporate Services, and

Ms Nicole Brady, Deputy Secretary, COVID-19 Response, Public Health Policy and Strategy, Department of Health.

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

On behalf of the Parliament, the committee is conducting this Inquiry into the 2021–22 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.

Mobile telephones and computers should 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 back Minister Foley, this time for the consideration of the health portfolio, and officers from your department and the Acting Chief Health Officer. Thank you for joining us this afternoon. We invite you to make an opening statement of no more than 10 minutes, and this will be followed by questions from the committee. Thank you.

Visual presentation.

Mr FOLEY: Thank you, Chair. I acknowledge the First Peoples and traditional owners of the lands on which we meet, and I pay my respects to their elders past and present and to all elders who may be with us here today.

Can I thank the committee for the opportunity for making this important presentation, particularly in regard to the Victorian state 2021–22 budget, delivering better health outcomes for all Victorians, and doing so as part of our ongoing investment in our world-class health system and wanting to support our healthcare professionals who deliver that first-class care right across our state.

Last year drove home the importance of good—indeed, excellent—local health care in what has clearly been one of the toughest years in our own, let alone global, health outcomes. Now, as we continue to seek to lock in recovery from this pandemic, this budget delivers investments to strengthen our hospital and healthcare systems. Not only will this investment ensure better quality care is available when it is needed, it is also strategically designed to bring other levels of value, particularly around investment in jobs. Whether that be doctors, nurses, cleaners, support staff or indeed—through the capital project—construction workers, it is an investment in our health system, and it is also an investment in our wellbeing and in the Victorian workforce.

In regard to the funding overview, the government is investing $6.58 billion over four years in our health services, programs and agencies, all designed to strengthen our health system and ensure all Victorians have access to the world-class health care, no matter their age or where they live.

This includes some $5.39 billion to deliver on a range of initiatives, including our hospital funding, to deliver more services, provide better care at home for those who want it, improve our rural health outcomes and increase our public health and wellbeing budgets. $1.18 billion will be dedicated to asset funding for a major investment in building hospitals and other health infrastructure so our health services can deliver the highest quality of care for Victorians.

In regard to budget growth, the 2021–22 budget is investing some $19.9 billion across our health portfolio. This continues the significant investment from last year, and indeed year on year, and reflects a 72.3 per cent increase over the last six years. All of that is designed to facilitate better health outcomes for Victorian patients.

Our health system has served us well during the unbelievably stressful COVID-19 pandemic, and we must continue to strengthen it as we recover towards a COVID normal for some time yet. That is why the 2021–22 budget delivers some $3.69 billion over the next five years to support improved service delivery and performance in our hospitals, including $136 million for an elective surgery improvement fund, an $89 million investment to manage demand in our emergency departments and $200 million to support the operation of new beds and additional staff to support them. These initiatives are all designed to boost the capacity of our hospitals to meet growing and changing demand, reduce surgery waiting times and deliver better health outcomes.

In regard to a focus on where public health and local delivery of such health is to go, there is an $822.6 million investment over the next five years to support a greater emphasis on local place-based delivery of services to protect the health of Victorians. This includes the continued operation of local public health units; the work underway in such areas as improvements in our pathology capacity and our wastewater surveillance for infectious diseases; and, particularly, bringing all this together to prevent and protect our communities from coronavirus transmission.

This is all part of a $1.3 billion investment in our public health response to the coronavirus. This investment backs the efforts of our public health team whilst also supporting the commonwealth's vaccine rollout here in Victoria, especially as it faces many challenges. It includes more than $329 million to continue rolling out the coronavirus vaccine program across Victoria and a further $50 million to seek to establish a Victorian part of an Australian capacity to manufacture mRNA vaccines. This will provide certainty of supply for new vaccines and, we hope, a life-saving treatment for Australians, if not other countries in this part of the world. These investments will make sure our hospitals and local health services can continue to do their important role of looking after us all and keeping us safe.

In regard to community-based health outcomes, this program in this budget delivers an additional $91 million for a range of community-based health service outcomes—catch-up for dental services and extra investment in cancer services and in maternal and child health services—with some $38 million to increase the capacity of our alcohol and other drug treatment system by building and opening more residential rehabilitation beds, boosting community-based treatment and having a strong focus for the delivery of those services in our regions. It also establishes $4.1 million to establish three new women's reproductive health hubs and enable an expanded scope of services with longer operating hours for the existing eight hubs. This investment will enable more women to access advice on sexual health and reproductive health issues and help to catch up on deferred check-ups as a result of the pandemic.

In regard to the capital program of building better hospitals and local health services, at the heart of our response we want to continue to be critical to our recovery. The government is committed to investing in our hospitals to ensure that they continue to deliver vital care when Victorians need it most. There is a $1.18 billion asset funding component in this budget to deliver on our election commitments to invest in local health services, including $556 million for 10 new community hospitals to give local families confidence that the best care is available close to home and to also support increased jobs during construction; some $98.9 million for the Angliss Hospital, with a new inpatient unit; $117 million for infrastructure improvements for the continued growth and expansion of the public pathology system; and $99.7 million to ensure young Victorians continue to have the best care through emergency paediatric zones at a range of sites, including Geelong, Maroondah, Casey, Northern and Frankston hospitals. There is also $5.7 million engaged for the funding of planning for

business cases for new adult emergency departments at the Maroondah, at Casey, at Northern, at Werribee Mercy and at the Austin to ensure our EDs continue to grow in response to growth in demand.

In regard to a focus on our regions, of the $1.18 billion investment in new assets and infrastructure as part of our wider, whole-of-government Big Build statewide program, there is investment in the regions. This includes $94.8 million to deliver a new hospital in Maryborough, $18.7 million for an emergency department redevelopment in collaboration with the commonwealth in Swan Hill and a further $20 million for the Regional Health Infrastructure Fund, which has been very popular amongst a range of regional and rural hospitals.

In regard to public health and wellbeing, the Andrews government is committed to strong investment in public health and wellbeing, including a $70 million delivery on our public fertility services commitment from the last election to deliver our promised arrangements on the public accessibility of those services, some $45.5 million through our work with Safer Care Victoria for improving the outcome of 100 000 Victorians for quality and safety of care in our hospitals and in our community and $34.3 million to modernise our health system's collaboration through some of the lessons that we have learned as to how to build a much more systematic approach to our public health challenges.

There is also $10.5 million for new trials for health-first services and for important work such as the Department of Health's contribution to decriminalise public drunkenness. This includes $375 000 to support organisations, and I commend the budget to the committee.

The CHAIR: Thank you very much, Minister. Deputy Chair.

Mr RIORDAN: Thanks, Chair. Minister, first question: since March last year Victorians have lived under a state of emergency that your predecessor initially declared and that you as health minister have continued to extend upon the advice of the Chief Health Officer. Furthermore, it is the Chief Health Officer who authorises the exercise of emergency powers that we have endured for 15 months, including the most recent lockdown that we are still in part under. Was it your choice—was it your decision—not to have him attend the hearings today?

Mr FOLEY: The Chief Health Officer?

Mr MAAS: On a point of order, Chair—

The CHAIR: Mr Maas.

Mr NEWBURY: Here we go. The protection racket starts.

The CHAIR: Mr Newbury!

Mr Riordan interjected.

The CHAIR: Mr Riordan! You are winding down your own time. I cannot hear Mr Maas on the point of order. Mr Maas.

Mr MAAS: Just on a question of relevancy, this is a budget estimates hearing. I just do not see the relevancy of the question.

Mr RIORDAN: Well, just—

The CHAIR: Mr Riordan, I have not invited you to contribute on the point of order yet. Is there anyone else who would like to contribute on the point of order?

Mr D O'BRIEN: Yes, I would, Chair.

The CHAIR: Mr O'Brien.

Mr D O'BRIEN: Just on the question of relevance, the budget papers use the word 'COVID' 1004 times, 'coronavirus' 342 times, 'pandemic' 335 times, 'lockdown' nine times, 'health advice' three times and 'Chief Health Officer' is mentioned four times. How is this not relevant?

The CHAIR: Thank you, Mr O'Brien. Would anybody else like contribute on the point of order? Mr Limbrick.

Mr LIMBRICK: On the point of order, Chair, this seems like a fair question. I do not see why this is an unreasonable question. It seems relevant to the proceedings.

The CHAIR: Would anybody else like to contribute on the point of order? No. I was about to remind Mr Riordan, the Deputy Chair, that this is not the COVID inquiry, which this committee has conducted separately and which Mr Riordan has also asked us to reconsider in the future, but that this is the budget estimates inquiry. I am sure there are numerous people sitting amongst the witnesses that are more than happy to answer your questions as they relate to the estimates and as they relate to the COVID pandemic. I would ask you to phrase your questions in that way, please.

Mr RIORDAN: I have just asked the minister if he—

The CHAIR: With all due respect, Mr Riordan, you did not relate your question to the budget estimates, and I would ask you to do so.

Mr D O'BRIEN: Why isn't he here at the budget estimates? That is the question.

The CHAIR: Mr O'Brien, you do not have the call.

Mr RIORDAN: In light of these budget estimates where we are hearing from every single minister about the effects of COVID and the ongoing costs to their departments, the one person that is totally in charge of all those decisions and who puts that advice out that you as minister and acting premiers and premiers enact is the Chief Health Officer, and he is not here. Do you think, Minister, it is a good look that he was out wining and dining at a party in Canberra while the rest of Victoria were not able to do—

Mr MAAS: On a point of order, Chair—

Mr D O'BRIEN: Here we go.

The CHAIR: Mr O'Brien! Mr Maas.

Mr MAAS: Really, again, on the question of relevancy, I do not understand how this question is relevant to the budget estimates.

Mr RIORDAN: This is a farce. The people of Victoria—

The CHAIR: Mr Riordan, I have given you an opportunity to rephrase. Would you like to make a contribution on this point of order as well? Thank you.

Mr RIORDAN: Yes, I would. As I mentioned earlier on the previous point of order, every Victorian is living under the directions of this one particular individual. Every element of this budget and all umpteen thousand pages of this budget stacked here are influenced by the decisions of this individual. This individual has told families who are grieving that funerals could not be held. You cannot visit sick people in hospital. Weddings are not essential—

The CHAIR: Mr Riordan! On the point of order or not at all, please.

Mr RIORDAN: and yet we learn that while you could not leave more than 25 kilometres from your home—

The CHAIR: Mr Riordan! On the point of order.

Mr RIORDAN: he saw fit to go to a party. Does that make sense?

The CHAIR: Mr Riordan, on the point of order, do you have any contribution?

Mr RIORDAN: To the point of order, it is entirely relevant that this committee needs to know about the person who is making up these decisions that so impact on every single Victorian, and he sees fit to go partying in Canberra.

The CHAIR: Would anyone else like to contribute on the point of order? No? Again I uphold Mr Maas's point of order, and I would ask that Mr Riordan make his question relevant to the budget estimates that this committee is here to consider.

Mr RIORDAN: Okay. Just a further point of order, Chair: are you ruling that any questions that question the advice being given to this minister and to Professor Wallace and to Mr Weimar and to Ms Geissler and to Professor Cheng, who obviously he deals with, and to Mr Hotham by the one person—that they have told us day in and day out for 18 months—is not important for this committee to consider? Is that what you are ruling?

The CHAIR: Sorry, Mr Riordan. I thought you were taking a further point of order.

Mr RIORDAN: Well, the point of order is: we need to know whether anything that the Chief Health Officer says or does or acts upon is no longer relevant to this hearing.

The CHAIR: Mr Riordan, Professor Cheng is here as the Acting Chief Health Officer to answer any questions that may be relevant to the budget estimates process. I would invite you to phrase your questions in relation to the budget estimates, and I am sure the witnesses on the other side of the table will be more than happy to answer them, including the Acting Chief Health Officer. Do you have any further questions?

Mr RIORDAN: I do have further questions, Chair. Secretary, Professor Wallace, can you confirm for this committee: did the CHO pay for his own travel and accommodation for the party he went to in Canberra, or did the taxpayers pay for it?

The CHAIR: Mr Riordan, I would again ask you to make your questions relevant to the budget estimates that are before us.

Mr RIORDAN: I am sorry, the public expenditure is absolutely the core of this, and I am asking Professor Wallace: have long-suffering taxpayer dollars in the state of Victoria been used so the CHO could go to Canberra to a party?

The CHAIR: Mr Riordan, could you please provide a budget reference for the question?

Mr RIORDAN: It does not apply. It is public expenditure, Chair. You are out of order.

The CHAIR: We are dealing with public expenditure insofar as it is part of the 2021–22 budget estimates, and I would ask you to phrase your questions in that way.

Mr RIORDAN: Professor Wallace and the minister sitting here, presumably they are responsible for the CHO, and if they are sitting here, they have approved his leave; they have approved his expenditure. This committee wants to know if they are the ones that have said, 'Yes, Mr CHO, off you go. Have a great time. Party along. Don't drink too much. Come back to work next week after the inquiry. Just disappear from the state for a while so you don't have to answer any questions'. Have the taxpayers paid for it?

The CHAIR: Mr Riordan, do you have a legitimate question or not?

Mr RIORDAN: It is a legitimate question. Have taxpayers paid for the CHO's holiday, his party—whichever way you would like to refer to it.

Prof. WALLACE: Chair, I am happy to answer the question. Mr Riordan, the CHO has been in Canberra at the National Health and Medical Research Council as a representative of Victoria for NHMRC meetings on Wednesday and Thursday. There was an NHMRC grants award evening on Wednesday evening, which the CHO attended on behalf of Victoria, at which Victorians received awards. Our own Burnet Institute, for example, received awards as best young investigator project grants in this most recent round of NHMRC grants. He worked for Victoria while in Canberra on Wednesday and Thursday, and indeed was working yesterday on Victorian government business as—

Mr RIORDAN: Is the extended holiday up there? Is he still away?

Prof. WALLACE: So Victoria and the Victorian government—because he was working for Victoria—paid his travel to go to NHMRC. Now—

Mr RIORDAN: So all the mums and dads who could not see their kids' school awards nights last year, that does not matter, and it does not matter, with all the people that have missed awards, the cancellations and people that have missed out on significant events. That is okay. But, no, the CHO has got to go and get an award for himself in Canberra.

Prof. WALLACE: No, sorry, the CHO was not getting an award. The CHO is a member of NHMRC. He was working for NHMRC. As a jurisdiction that participates in our national medical research processes we have representation at NHMRC. The CHO is one of those representatives.

Mr NEWBURY: Sorry, Minister? Minister, are you trying to insert yourself?

The CHAIR: Mr Newbury, you do not have the call.

Mr Newbury interjected.

The CHAIR: Mr Newbury, you do not have the call.

Prof. WALLACE: He was working in Canberra.

Mr RIORDAN: Okay. So that meeting could not be done by Zoom like everyone else in Victoria has had to do?

The CHAIR: Mr Riordan, your question is again out of order. It is appropriate that you ask questions about the budget estimates.

Mr RIORDAN: I am asking the needs of expenditure. We have just heard that taxpayers dollars have been used to send the CHO away for a very long weekend at a very convenient time. Everyone else in Victoria had to Zoom.

The CHAIR: Mr Riordan, you have the budget papers before you. You may not have read them, but I suggest that you phrase your question in relation to the budget.

Mr RIORDAN: Budget expenditure in the health department under what we are talking about today—these are precious dollars that could be going to hospitals and other things, but the CHO has used them when he could not Zoom, and I am asking if this meeting could not have been done by Zoom.

Prof. WALLACE: I think that is a question for NHMRC, and not for the Victorian government, with respect. It was an NHMRC meeting which the CHO attended on behalf of Victoria, working for Victoria in Canberra on Wednesday and Thursday. He was at work in Canberra on behalf of our state.

Mr RIORDAN: Did the health advice issued earlier in the week by, I think it was the Acting Premier at the time, that if you were further than 25 kilometres from the airport, do not go to the airport—

The CHAIR: Mr Riordan, this is not a meeting of this committee's inquiry into the response to the COVID pandemic. It is an inquiry into the 2021–22 budget estimates and I would ask that you keep your questions to the 2021–22 budget estimates, please.

Mr RIORDAN: Okay. Professor Wallace, moving on, how much has it cost to completely overhaul Victoria's contact-tracing platform?

Prof. WALLACE: The total costs of our contact-tracing platform are not in yet because we have spent money in this current financial year, and those will not be reconciled until the end of the financial year. Are you specifically asking about the Salesforce platform or the total contact tracing?

Mr RIORDAN: Well, how much have you spent to date on the contact-tracing platform?

Prof. WALLACE: The actual platform itself last year cost $34.1 million.

Mr RIORDAN: Right. And how much more is to be spent on the platform?

Prof. WALLACE: Well, again, I think we will not know in this current financial year until the finances are reconciled at the end of the financial year, so I think that is probably a question for a future PAEC. We will be able to tell you what the expenditure in 2020–21 was. The minister has already announced the budget for this forthcoming year in which the expenditure for COVID containment is.

Mr RIORDAN: On 3 May 2021 a $150 000 contract was awarded to Telstra Health for a review of the contact-tracing centre. Have they identified any issues with that yet?

Prof. WALLACE: Sorry, the contract for Telstra—

Mr RIORDAN: For Telstra Health, for a review of the contact-tracing centre. What issues so far have been identified in that review?

Prof. WALLACE: I have not seen the review. I am not sure that the review has reported. Mr Weimar?

Mr RIORDAN: You do not know about the review, or—

Prof. WALLACE: Well, Telstra undertook a review last year. Are you referring to 2020?

Mr RIORDAN: No, 2021. You are saying you do not know about that review?

Prof. WALLACE: It has not reported.

Mr RIORDAN: Sorry?

Prof. WALLACE: It has not reported yet.

Mr RIORDAN: So there have been no issues identified yet?

Prof. WALLACE: Well, it has not reported, so we—

Mr RIORDAN: When are you expecting it? You do not get briefs? I mean, you know, it has been in the news a little bit lately, contact tracing. We are not sort of keeping a close watch on it?

Prof. WALLACE: We are keeping a very close watch on it, Mr Riordan.

Mr RIORDAN: When would you expect the review?

Mr WEIMAR: I do not know. We have no date. I am happy to take it on notice.

Mr RIORDAN: Okay. Professor Wallace, 40 fax machines were ordered last July to assist with contact tracing. How many have you ordered in the last six months?

Prof. WALLACE: I have not ordered any. There are no fax machines involved in contact-tracing processes today. All of the contact tracing is done on the Salesforce platform, including all of the nine local public health unit teams and the central contact-tracing team at 50 Lonsdale. As you might recall and I think as we discussed at prior COVID PAEC hearings, last year Victoria, as did most other jurisdictions, moved from a paper-based to a paperless contact-tracing process, so in Victoria the contact-tracing interviews and communications and texting are all done now in the Salesforce platform. So there are no results being faxed in to Lonsdale Street like there were at the beginning of the pandemic, as there were in South Australia and WA and other jurisdictions.

Mr RIORDAN: Has the Salesforce customer relationship system been fully integrated yet?

Prof. WALLACE: Fully integrated with—

Mr RIORDAN: Into your contact tracing?

Prof. WALLACE: Yes, it has. It is the sole platform on which all contact tracing is done. Again, I think as we discussed at the PAEC COVID hearing, the contact-tracing process is complicated. It begins with the testing being done and then the result being reported from the laboratory, and both of those steps are now integrated into Salesforce, so as the results come in through the laboratory information system they come into Salesforce automatically. That then triggers a positive case, which then triggers an allocation to one of our 10 contact-tracing teams, whether it is in one of our nine local public health units or the central contact-tracing team in Lonsdale. It is then allocated for interview, and automatically a text goes to the person to forewarn them that, 'You are a positive case. You're going to get a phone call from the Department of Health'. And then the phone call itself, the interview, is entered into Salesforce live. It is a cloud-based system, and that is important. So in the interview, or interviews—because typically there are both the positive case and his or her primary close contact interviews going on contemporaneously—now as a primary close contact is identified through the interview that then is entered in Salesforce and then triggers texts and interviews. The central team here coordinate it all, so if you are out in Western Health in Sunshine or you are at Clayton in Monash or the Austin—wherever in our PHUs—undertaking the interview being entered into Salesforce live, our central team can see that information live. It is a fully integrated system.

Mr RIORDAN: So if it is all fully integrated and it is all working, how come we are still buying fax machines?

Prof. WALLACE: We have not bought any fax machines.

Mr RIORDAN: So it is definite—you absolutely have not bought any more fax machines in the last six months?

Prof. WALLACE: I am not aware of buying any fax machines for contact tracing in the last six months.

Mr RIORDAN: Well, no—not necessarily contact tracing, but in your department for managing pandemic issues.

Prof. WALLACE: Well, I would not see purchase orders for fax machines ordinarily. It just would not come across my desk. I am not aware of us buying fax machines. We may have bought fax machines for other purposes, but not—

Mr RIORDAN: I guess the nub of the question is: can you absolutely rule out the fact that in keeping Victorians safe at the moment we are not resorting to fax machines?

Prof. WALLACE: For contact tracing for our COVID response—

Mr RIORDAN: Okay. That is a very specific answer. So what else are we using fax machines for?

Prof. WALLACE: Well, as you are probably aware, health care remains one of the last bastions of fax machines. We have GPs who need to communicate with us—

Mr RIORDAN: So that is what you use them for?

Prof. WALLACE: We have fax machines in the department which are used to communicate with GPs and other healthcare providers.

Mr RIORDAN: I just thought you might have them on your computers by now.

The CHAIR: Mr Riordan!

Prof. WALLACE: Our job is to make communication with the healthcare providers—hospitals, GPs, whoever they are—as simple as possible. If a GP is communicating by fax, then we will have a fax to receive his or her fax. Is sending facsimiles our preferred mode of communication in 2021? Of course it is not. But just to be clear, we have not been buying fax machines for our contact-tracing system.

Mr RIORDAN: Thank you, Professor Wallace. And with 4 seconds to go, we thank you for getting through some answers for us.

The CHAIR: Thank you very much. Mr Maas.

Mr MAAS: Thank you very much, Chair. And thank you, Minister, and thank you, departmental team, not only for your appearance today but indeed for the work that you have been doing for all Victorians in what I think most fair-minded people know is an extraordinarily complex and ever-evolving situation. We thank you very much for that. If I could go to the topic of CALD community engagement, Minister, I would like to take you to the output initiatives in budget paper 3, at pages 59 and 65. I was hoping you would be able to explain how that funding would support Victoria's CALD communities as the pandemic continues.

Mr FOLEY: Thank you for that question, and I think it is fair to say that multicultural communities in particular have faced unique challenges over the course of the past 18 months. There is lot of effort through the outputs that you have identified so as to make sure that we put central to our engagement with those communities an inclusive and direct system of how we deal with those communities' diverse but particular needs, because the one thing that we have found out globally is that this virus does not discriminate based on race, gender and a whole range of other factors. That is why I am pleased that this budget allocates, as part of the $1.3 billion that you have identified at the core public health response, significant components to address those CALD-community-particular needs. They are reflected in both the generality of that response but also particular aspects of it.

That response goes to a whole range, as Professor Wallace indicated—a complete reimagining of the system built around local public health units, an increased focus on wastewater surveillance, a dramatic improvement in pathology and other arrangements to deal with the huge amount of testing that has been coming forward over recent times and how to make sure that the general principle of protecting and supporting communities through these challenging times has been delivered, and that is why as part of this we need to make sure that we support and engage with the CALD communities as part of all of those responses and aspects of their particular communities' needs. So making sure that we increase, for instance, testing in those communities and preparedness for the vaccine rollout has been a strong focus given for a whole range of reasons the disengagement with mainstream health services and from that ranges of particular communities' hesitancies which have needed to be addressed. In the circumstances of outbreaks, as we have seen, which have disproportionately impacted on those CALD communities, are opportunities for engagement and responses that have addressed those issues.

So in that regard the department through this output has worked very closely with community leaders, local councils and particular health services, particularly community and local health services, to make sure that we design and co-design and tailor messages to the specific needs of communities, be it around testing, be it around how to stay safe or be it around vaccinations and how to respond in circumstances where there are outbreaks. The language or cultural barriers which make it sometimes difficult to receive those messages in a mainstream health setting are a strong focus of how we are going about these programs, so providing information about staying safe and the significant focus on public health and engagement activities have been at the core of factors, including delivering 59 different community languages in the material, a lot of it designed with those community representatives to target the particular needs of particular communities.

In terms of how that localised engagement is delivered, funding has been provided through the six local public health units to areas including local government areas in Brimbank, Melton, Wyndham, Hume, Casey and Dandenong as some of the communities with the most diverse ethnic communities and culturally diverse communities in the state and perhaps not unsurprisingly also some of the communities that have had particular challenges during the COVID outbreak. These local partnerships have allowed engagement, outreach and co-design work with local community leaders, particularly through aspects such as the direct engagement of bicultural workers as health champions to build the trust and the engagement around how these diverse aspects of our health system need to play out.

As part of this, the $1.5 million investment in a bicultural worker program provides direct in-language support at testing sites and on the ground in communities such as public housing, at-risk housing and those areas of the community that have particularly diverse make-ups of different CALD community leadership. As part of this, the department established in 2020 a CALD health advisory panel made up of leaders of the CALD health community, bringing together both experts from and leaders of those communities with public health experts to make sure that we had all the decision-makers and all the leaders having their say on the material and the method of engagement and the processes of engagement. All of these measures will be continued on and I hope

refined and built upon over the course of the remainder of the pandemic, however long that might be. We know there is more work to be done in this space, we know there are continual learnings to be made, and I look forward to this particular budget output making a significant contribution to the deep engagement of our CALD and diverse communities, given what strong representation they make to a successful Victoria and how central they will be to a public health outcome that sees Victoria and indeed Australia come out the other side of this pandemic. And I want to thank particularly the leadership of so many of those communities, together with the leadership of the Victorian Multicultural Commission, which has helped us engage in that process to make sure that those communities are at the heart of our COVID response. Thank you.

Mr MAAS: Thanks, Minister. And I guess to build on the broader narrative of Mr Riordan, if we could look at communications: how has the government built on the lessons learned from this pandemic to improve its communications with CALD communities and ensure public health messaging is understood widely?

Mr FOLEY: Thank you. As a flow-on from my earlier comments, very much getting appropriate and targeted and supported communications to our CALD communities is a key part of the public health information that particularly our at-risk communities need to respond to COVID-19. Ensuring that the public and particularly diverse CALD communities know what action they need to take in response to avoiding, slowing down and responding to COVID, let alone the vaccination programs and other support measures, is critical. The Victorian government continues to work through particularly the CALD health task force and the Victorian Multicultural Commission's COVID-19 working groups in those local partnerships I referred to earlier. A key component of that is how to align those CALD-specific messages with the broader public health messages, and that means making sure that we have culturally appropriate support material when it comes to what are COVID-19-safe behaviours—physical distancing, personal hygiene—and other measures of support; making sure that when there are restrictions in place those are understood and delivered in accessible ways; making sure that the critical message of getting tested if you experience any COVID symptoms at all is there; and making sure that as part of that in areas where there are strong concentrations of particular communities we have representatives of those communities at the testing stations and at the support places to assist in any particular concerns members of those communities might have.

We have also found over the course of the last 18 months that measures such as the worker support payment scheme are really critical for these communities, which are disproportionately at the lower paid casual end of the socio-economic and workforce components and need that certainty to make the right choice to follow the public health advice rather than the risk of going to work if they show even the mildest of symptoms. That also goes to issues around support for testing, as we have seen in some earlier outbreaks the disproportionate concentration of outbreaks amongst particular CALD communities. And it also extends to all sorts of other things around QR codes, electronic record keeping and an appreciation of the importance of—as CALD communities, like the rest of Australians and Victorians, move around—the ideas of different jurisdictions' and our own jurisdiction's permit systems to keep track of those electronic records of movement being understood and supported. That has taken place, be it in television; in targeted CALD community radio; in a number of public forums; in lots of digital engagement forums, including the use of multiple online video conferences particularly with leaders; and in some significant social media communications targeting the sometimes hard-to-reach younger members of those communities.

It has also played out differently in the metro region or in the regional parts of the state as different communities engage in different ways as to what is appropriate. So having translated a lot of that material into some 59 community languages, we need to then make sure that it is updated and maintained and that the support continues in a really relevant and—for particular communities—bespoke manner. Making sure it is clear, that it is translated and double-checked by certified translators and then independently checked by a second translator before it goes is all part of making sure that as our CALD communities move—as indeed we all do—well into the second year of our response to this pandemic, we make sure that our CALD communities are partners at every step of that journey.

Mr MAAS: Thank you, Minister. If I could move to bicultural workers now, and I was hoping that you would be able to provide some more detail as to how the bicultural worker program operates, including how it has assisted in the various outbreaks that we have experienced so far this year.

Mr FOLEY: The output money that I referred to earlier to support the bicultural worker program is really important, and what it does is provide trusted, local, respected voices from our CALD communities to engage

directly with the multitude of issues that all Victorians but particularly our CALD communities are dealing with when it comes to the pandemic response. That has included areas such as the direct engagement by those workers in language public health information particularly relevant to their local communities while being support and outreach to members of their community at both a wider community level but sometimes all the way down to specific properties, or whether it be at high-risk housing, public housing and other measures, being that direct support at testing centres where we know there has been significant engagement with CALD communities.

It has also had a direct engagement with our contact tracing and response teams when we have seen particular clusters in CALD communities, and those bicultural workers are brought in to play a direct role with those communities. And it is also about being the eyes and ears of the outbreak, local community intelligence with the local public health units to make sure that you have got an engaged process in place at those local levels. There are groups such as—in the north and the west—IPC Health, who have led a couple of programs along those lines and have been particular models of success, and we have seen that actually picked up. It is actually called the C19 Coalition of community health groups, which right across our vulnerable communities and our CALD communities have led the way in how they engage with bicultural worker programs to be at the heart of the delivery of those arrangements, and I know particularly in some communities from the Subcontinent that in earlier outbreaks it has been critical to the successful management of those through the direct engagement of these CALD bicultural workers. And I want to thank them for it. I hope, when ultimately we do emerge from this pandemic, that those important learnings around how local, trusted, diverse voices in public health delivery, support and engagement can be an enduring lesson that makes sure that we have a better, wider public health response, both now and into the future, to build the resilience and the response of Victoria's public health system and our community health system to achieve the kinds of outcomes that all Victorians rightly expect but which our CALD communities, I think, have in fact been disproportionately excluded from.

There are many lessons, but if there is a particular lesson from this global pandemic, it is how the richness of Victorian society, through our diverse, multicultural and CALD communities, can contribute and build on their contribution to date by making sure that those lessons of an enduring, better public health response engages communities in both the wider public health needs that they have but equally the particular needs for their communities. That will be a significant and enduring outcome I think all Victorians would welcome.

Mr MAAS: Thank you very much, Minister. And I will leave it there. Thank you, Chair.

The CHAIR: Thank you, Mr Maas. Mr Limbrick.

Mr LIMBRICK: Thank you, Chair, and thank you, Minister and team, for appearing today. I would like to direct a few questions to Professor Cheng, if I may. But before I do, for the benefit of my Labor colleagues on the committee, I am going to ask a couple of questions about proportionality. I believe this is directly related to the budget, because whether or not the budget outcomes in the strategic outlook in budget paper 2 are dependent on whether or not health directions are issued, on when they are lifted—whether or not those health directions are lifted or not is going to depend on questions around proportionality decided by the public health teams. That is what I believe the relationship to the budget is.

I would like to explore a couple of issues, but the first issue I would like to look into is around masks outdoors. Now, the messaging initially around masks—and I agreed with this—firstly, was, you know, 'Well, it's no big deal. You just put it on, and you go outside', and that is what lots of people have said about it. It has since come to my attention that there are actually significant harms from masks, and many of these harms were not apparent to me at first.

So one of those harms is that masks—or the lack of a mask—is often used as a pretext by police to arrest people and manhandle them. I have seen this personally with my own eyes, many times, and I am sure you can look at videos on the internet and stuff and see many cases of this. Another harm, which was brought to my attention by a constituent, and subsequently many women came to me with this issue, is one of the reasons that some people cannot wear masks is because they were victims of sexual assault; they have a fear of not being able to breathe properly. I am hoping that you are familiar with this issue. Some sexual assault support services have given out information to women on how to deal with this. But I had one constituent contact me.

Ms TAYLOR: Point of order.

Mr LIMBRICK: She could not—

The CHAIR: Sorry, Mr Limbrick. Ms Taylor has a point of order.

Ms TAYLOR: Yes, I would like to suggest that it is important to remain within the purposive elements of this inquiry rather than those that are rather tangential, and I think it would be rather difficult to comment on what are essentially medical matters when we are looking at budget estimates.

The CHAIR: Thank you, Ms Taylor. Would anyone else like to submit on the point of order?

Mr LIMBRICK: I would like to respond. I have not even asked a question yet, I am getting to the question, but the question is around proportionality and I outlined my rationale before I started asking my question. I think that the public health directions and whether or not they are issued directly relates to whether the estimates in the strategic outlook will be achieved or not, and that directly hinges on the proportionality decisions of the public health team.

The CHAIR: Thank you, Mr Limbrick. Mr Richardson.

Mr RICHARDSON: Just on the point of order, I take Mr Limbrick's point, but how does that relate to the strategic output of budget paper 2 in relation to the approach from policing? How does that relate to the strategic nature of budget paper 2 that has been outlined by the Department of Treasury and Finance, been outlined by the Treasurer? How is that action or enforcement by the police linked to a budget outcome?

Mr LIMBRICK: I have not asked my question yet.

The CHAIR: Are there any other contributions on the point of order?

Mr HIBBINS: Yes. Sorry, Chair, I think Mr Limbrick should be allowed to actually ask the question before it is ruled in or out of order.

The CHAIR: Thank you, Mr Hibbins. Any further contributions? No? I will wait to hear the question, but I would remind committee members that this committee conducts numerous inquiries, one of which is the financial and performance outcomes hearings, and your prelude I think suggests that your question may fall into financial and performance outcomes hearings rather than budget estimates hearings. This committee has also conducted inquiries into the government's response to the COVID pandemic. So I would ask that people keep questions in this hearing to the task at hand, which is the consideration of the budget estimates, not the COVID inquiry and not financial and performance outcomes. Thank you.

Mr LIMBRICK: Thank you, Chair. If I may continue, this person that contacted me said that she could not leave her house, because she could not wear the mask and she was getting abused in public—like yelled at by people and stared at when she went to the shops—and she felt like she had to stay home all the time. So this is one side of the ledger of proportionality: the harm caused by the action. And then on the other side of the ledger there is the benefit of that action. You are far more learned in these issues than I am. I do not claim expertise, but I can read articles, and my understanding is that there is not a lot of evidence around effectiveness of masks outdoors. Maybe you can elaborate on that. So in this situation where we have these harms that maybe we did not understand when we first started having mandatory mask usage—maybe we understand the science around mask usage outdoors a little bit better—how can proportionality continue to be justified given those considerations of the ledger?

Prof. CHENG: So proportionality is at the absolute heart of the public health advice that is given, and that is enshrined in the Victorian charter of human rights. That is something that we have to consider for every decision that we make. So the sorts of steps that we have to take are to say, 'Who might be impacted, and what impacts do the measures that we would like to propose have—what human rights do they impinge on?'. And I think you have outlined some of the potential issues there. And how do they impact on those individuals, and then how might we mitigate those ones? So to say, for example, we do think that masks are a valuable measure in interrupting the transmission of COVID. Now, in which people—and the examples that you give are probably good examples of those—might that be disproportionate? So therefore we try and put in place mitigations to say, 'How can we prevent those harms?'. And there are examples other than the ones that you have outlined; for example, people with breathing difficulties—

Mr LIMBRICK: Yes, I am aware of that also.

Prof. CHENG: and there is quite a long list of exemptions in place. I cannot really comment on how that might be enforced and obviously the way that the community might react—and I am certainly distressed to hear about your constituent—but there are exemptions in place for good reasons, and they are to try and mitigate the harmful effects of that.

In terms of masks outdoors, a judgement was made that while there is transmission, what we are concerned about is that there are people roaming around the community that have it. Even though there is a lower risk in outdoor settings, it does not mean that there is no risk in outdoor settings. Also I think, as I might have said, a mask is no good in your pocket; it is only actually effective when you have it on, and we think that it is generally a small impost to have. It does not cost anything more, because you have to have one anyway. It reminds you when you are going between indoor and outdoor settings that you do not have to keep putting it on and off, so there are benefits in that way. But I acknowledge that every action that we take and obviously many of the public health actions that we take have major impacts on human rights and the economy and society in general. Masks are probably at the lower end of those, but that is not to say that they do not have any untoward impacts, and we aim to try and mitigate those as best we can.

I guess in terms of thinking through that decision about how we do that, when we made these decisions we had the situation where there were infections in the community. We were worried about what we call upstream risk, so who gave that infection to the person. We did not know where they got it from or who they might continue to give it to. I think when we announced the lockdown there were 138 exposure sites and 2500 close contacts, any of which could have become infected. We had to make a decision—'Are we going to try and control this as best as possible as quickly as possible?', so that we could limit the time that we would need mandatory masks and all these other public health measures, because the option was, 'Well, we might let it go, and then we'll be doing this for weeks or months to come until we can get all the vaccines out'. I hope that answers your question.

Mr LIMBRICK: Thank you, Professor.

Prof. WALLACE: Mr Limbrick, can I add to Professor Cheng's—you are quite right; we have learned a lot during the pandemic. There are things we know now about masks that we did not know at the beginning, so we have tried to keep pace with that and share that with the community. If I may read from my department's website:

> What about people who have experienced trauma that makes it difficult for them to wear a face mask?

The very point you raised—

> Some people who have past experiences of trauma are unable to wear a face mask due to psychological impacts. This is a lawful reason not to wear a face mask when you leave home. You do not need to carry or produce evidence proving that you are eligible for this exception.

Mr LIMBRICK: May I respond to that, though. I am aware that you do not need to produce evidence for these exemptions, and I am aware that the exemptions exist. However, I have witnessed many cases with my own eyes of police arresting people anyway and taking them away even though they say, 'I've got an exemption. I've got an exemption'. I saw a video of it—right next to me, when I was there—a guy was being dragged away. I found out later on he had a mental health issue, but he did have a lawful exemption. How do you know that these are actually being enforced the way that you imagine and that the exemptions actually exist the way that you imagine they might be enforced? Is there communication with the police on this so that you can make sure that it is actually happening on the ground, because I see it on the ground, and it is not happening the way that it would be imagined, I guess?

Prof. CHENG: At one level there is constant communication with police. If they say that they are having difficulty enforcing or not enforcing various things, they will tell us on the state control team, for example. Obviously I do not know the details of the specific case you are referring to. We do understand that there are difficulties, but ultimately enforcement is a matter for police.

Mr LIMBRICK: Thank you, Professor Cheng. Another issue on a different subject is, again, vaccines are going to be very important with opening up and removing of a lot of these public health directions. I have read some of the work that ATAGI has done around public communications, and actually it looks quite good to me.

They talk about making sure not to overpromise, things like making sure you discuss consent with patients, informed consent, and giving people time to think about it and understand the risks and benefits of vaccines. It seems quite sensible to me. However, some communications that I have seen—I can give you an example. The other day there was a picture on social media of the Premier getting a vaccine, and he said:

> If you can, you must.

Now, as politicians we have to communicate to people about vaccines. Is this sort of communication in line with the public messaging that you would expect from what ATAGI has written?

Prof. CHENG: Look, I think vaccination is a choice. There is no mandate to get vaccinated.

Mr LIMBRICK: Lots of people feel pressured, though.

Prof. CHENG: Yes, and I think in the short term we can get our way out of this with public health and contact tracing, but in the end our ticket out of this is to be vaccinated. You know, there are a range of pressures—social pressures, peer pressures and so on—to try and encourage that, but it is a choice for the individual, and there is no policy of mandatory vaccination in Victoria or in Australia at the moment.

Mr LIMBRICK: So there is no 'must'?

Prof. CHENG: In that sense, no.

Mr LIMBRICK: Thank you, Professor. Another thing with public communications on vaccines: you would be well aware that there are lots of ideas around vaccines. Lots of people have lots of different ideas about what they do and do not do. I have heard them referred to as conspiracy theories and this sort of thing. But what I have noticed is that there is not a lot of public communication actually addressing and refuting a lot of these things that are going around, and it has sort of created this vacuum. And then that vacuum is getting filled with misinformation. I have seen the same thing with COVID itself. We have seen it with vaccines. There are these vacuums that get filled with misinformation. Is this something that you are aware of and looking at and trying to address a bit better, because I have felt like that has been a big problem with the messaging from—and this is not just state government; I am talking federal government as well. There has been a big problem with this vacuum of information.

Prof. CHENG: Yes, look, it is a difficult issue. I think it would be fair to say that there is probably a proportion of people who are very enthusiastic. There is a very small proportion of people who are very not enthusiastic and will probably never get vaccinated, and then there is a large group of people in the middle who want someone else to go first, perhaps. Most of the communication is directed towards those people who are a little bit hesitant rather than people who just do not want to do it at all. I think it is a difficult issue, and I think one of the issues is that sometimes you do not want to give conspiracy theorists too much oxygen because it in some way validates the message and brings it to prominence, where they might not otherwise get much of a hearing. But equally, particularly frank misinformation does need to be addressed at some level. It is a difficult issue and clearly there are a lot of conspiracy theories around, and you cannot address them all.

Mr LIMBRICK: Yes, of course, and I would not expect you to address them all, but there is a spectrum here, right? Some of it you would say, well, does not make any sense at all, but then there are other things that are questioning some of the science, and unless you are very well educated in that you are not going to know if that is correct or not. I have been in that situation myself. People have presented me—and I am sure all members of Parliament get people presenting them with things that might be a scientific paper that says, 'Well, what the public health team is doing is wrong, and here's a paper that says why'. I cannot provide guidance on whether that is correct or not. Only people with far more expertise than me can do that. Is that something that you are looking at? I can give you a good example: people have been asking me, and lots of people have been talking, about PCR tests and how accurate they are and what is the rate of false positives and false negatives and this sort of thing. People ask me this sort of question all the time. They send me all these papers, but I am not an expert in PCR tests. I have not got a clue about it, you know. I can read the paper and go, well—

Mr D O'Brien interjected.

Mr LIMBRICK: Yes. So is this something that you are looking at addressing and clarifying for people?

Prof. CHENG: Look, for those sorts of queries I think the department would be very happy to, on referral, provide an answer for you. I think—

Mr LIMBRICK: Who should I send that to?

Prof. CHENG: The public health team, but if you send it through me or Professor Sutton, I am sure we would be able to address some of those questions.

Mr LIMBRICK: Okay, I will do that. I am running out of time, so I do not think I will be able to pursue my next line of questioning, but thank you very much, Professor Cheng.

Prof. CHENG: No worries.

The CHAIR: Thank you, Mr Limbrick. Mr O'Brien.

Mr D O'BRIEN: Thank you, Chair, and good afternoon, everyone. Can I begin, Secretary, by following up on what Mr Limbrick was talking about—that is, the idea of having proof that you have got an exemption for a mask. Last year there was a link on the department's website that answered that. It has been taken away. Can I humbly suggest that if it were put back on, it would be good, because I am, like Mr Limbrick, getting a lot of questions about it. There is a link to the human rights commission, I think it is, about it, but putting that link on would be useful.

Can I ask some questions: the budget paper reference is BP 2, page 22, which is again about the localised short-term restrictions that are one of the key forecast assumptions that the budget is predicated on. So my question is to the minister: Minister, why can't Victoria manage small outbreaks without going into a statewide lockdown?

Mr FOLEY: Thank you, Mr O'Brien. So I am not sure the evidence of the last 18 months necessarily supports the broad basis of your question's assumptions. There have been, quite demonstrably, widespread lockdowns that have applied for very good public health policy reasons. There have also been targeted events in responding to smaller scale outbreaks that have not required lockdowns at all, that have been successfully managed down through contact tracing and other measures.

Mr D O'BRIEN: Well, let us take the most recent one, then: 27 May, 12 cases, the entire state gets locked down.

Mr FOLEY: Yes.

Mr D O'BRIEN: Regional Victoria did not have any cases, never has had any cases in this period. Why would regional Victoria be locked down?

Mr FOLEY: Well, in regard to the specific circumstances of regional Victoria at the commencement of this current family of outbreaks, we did of course see positive cases and quite a large number of exposure sites, and a very large number—

Mr D O'BRIEN: Three, actually, Minister.

Mr FOLEY: I have not got to regional Victoria yet.

Mr D O'BRIEN: Sorry.

Mr FOLEY: A broad number of exposure sites—in the many, many hundreds. A number of those were in the regions, in particular the Bendigo area and Cohuna. And in that regard there were quite a number of primary close contacts and indeed secondary contacts that had to be managed through those arrangements at the earlier stage of this particular family of outbreaks.

In regard to how those are then managed downwards through the contact-tracing team and the public health support work, as soon as the advice was that it was safe, practical and achievable to ease those restrictions in regional Victoria, that is what was done. There was a period of time—

Mr D O'BRIEN: But on that note, Minister, as you said, there were three exposure sites in regional Victoria. After two weeks there were still no cases. Those exposure sites had not generated any cases. There

were some false positives that affected Mr Riordan's electorate but turned out to be false positives. So after two weeks of no cases, nothing from exposure sites, why couldn't regional Victoria at least snap back to COVID normal?

Mr FOLEY: Well, these are recommendations that come from the public health team in regard to how arrangements are dealt with in the best interests of managing down as quickly as possible the particular circumstances of each outbreak, as they will continue, it would appear, to occur right around the country and until such time, as we say regularly, there is either a degree of vaccination levels that will provide us safety from the community levels of COVID or there is a quarantine system in place that removes as much as possible the riskiest transmission people from hotel quarantine to dedicated arrangements.

Mr D O'BRIEN: Okay. Can I go to that?

Mr FOLEY: So with those two provisos, if I could, Mr O'Brien, how we then, in a proportionate and measured way, bring together the necessary restrictions in the manner in which they have the least impact on communities but the most impact on driving down the COVID transmission chains is based on a circumstance-by-circumstance set of arrangements that the public health team provide in recommendations to government. And whether it be the Victorian government, other states or indeed the commonwealth government—

Mr D O'BRIEN: Okay. Minister, can I go to that level of risk?

Mr FOLEY: If I could just finish.

Mr D O'BRIEN: No, no, no. I do not want to hear about other states.

The CHAIR: Mr O'Brien, if you could just allow the minister to answer, please.

Mr D O'BRIEN: Chair, I think I have been pretty patient.

Mr FOLEY: You asked a very important question.

The CHAIR: You are not sounding particularly patient, Mr O'Brien.

Mr D O'BRIEN: Yes, and I have got more questions on it, so I would like to move on if I could.

Mr FOLEY: Well, I would like to answer your question.

The CHAIR: Mr O'Brien.

Mr Riordan interjected.

The CHAIR: Mr Riordan.

Mr FOLEY: I would like to answer your question, Mr O'Brien.

Mr D O'BRIEN: Minister, you talked about the level of risk.

The CHAIR: Mr O'Brien, you cannot put a question and then cut off the minister's answer. The minister is entitled to answer the question completely.

Mr Riordan interjected.

The CHAIR: And, Mr Riordan, you are wasting Mr O'Brien's time.

Mr D O'BRIEN: Well, Chair, can you let me know when I let him stop, because if I just go now he will go for the next 12 minutes.

The CHAIR: Mr O'Brien—

Mr D O'BRIEN: Seriously, the minister has been answering the question for 2½ minutes.

The CHAIR: Mr O'Brien.

Mr D O'BRIEN: I am entitled to interrupt and go on. I want to ask another question, Minister, please.

The CHAIR: Mr O'Brien, the minister is entitled to complete the answer to his question.

Mr D O'BRIEN: The minister is not entitled to take up the committee's time.

Mr NEWBURY: It's a tactic.

Mr D O'BRIEN: He has answered my question. It is a tactic. I would like to move on to important questions in relation to this hearing.

The CHAIR: Mr O'Brien, the minister is entitled to answer fully the proposition that you put to him across the table. If you allowed him to do that rather than speaking over the top of people, you might find it a more productive session.

Mr D O'BRIEN: Chair, are you serious? I sat here for 3 minutes and let him go, and now you are complaining that I am talking over the top of him. Will you let us ask the questions?

The CHAIR: Mr O'Brien, I am concerned that you continue, as do your colleagues, to speak over the top of the Chair. What I am—

Mr RIORDAN: If you showed some impartiality instead of your complete and utter protection racket—

The CHAIR: Mr Riordan.

Mr D O'BRIEN: Can I please move on?

Mr RIORDAN: This man would win the Boring Olympics, he goes on for so long. It is a disgrace.

The CHAIR: Mr Riordan, you are demonstrating—

Mr RIORDAN: He has a responsibility not only to the people of Victoria but to Parliament.

Mr D O'BRIEN: I want to ask some questions, please.

The CHAIR: Mr Riordan, you are demonstrating my point. Mr O'Brien, if you would allow the minister to fully answer the question, I am sure you will get the answer that you are looking for, and then, Mr O'Brien, you can ask another question.

Mr D O'BRIEN: I have already got it, Chair. It is not for you to say how long the minister can answer the question for.

The CHAIR: And it is not for you to say either, Mr O'Brien. There is an allocated amount of time. You have asked a question, and the minister is entitled to fully answer it.

Mr D O'BRIEN: I have a question. Minister—

The CHAIR: Mr O'Brien, the minister has not completed the answer to the previous question.

Mr NEWBURY: He has got a mask on. How do you even know if he has finished? Can you read his mind?

The CHAIR: Mr Newbury, if you recall, this interlude started some time ago, at which point you interrupted the minister while the minister was attempting to answer Mr O'Brien's question. If you could allow him to complete that, please, then Mr O'Brien will happily, I am sure, take the opportunity to ask another question. Minister, would you like to complete your answer?

Mr FOLEY: Thank you, Chair, and yes, I would like to complete my answer—

Mr RIORDAN: No wonder we keep having outbreaks in this state. You never get to the—

The CHAIR: Mr Riordan.

Mr FOLEY: and give Mr O'Brien's very important question the completeness that it requires. I was in the process of drawing a comparison with other state jurisdictions and the commonwealth, who have all made it incredibly clear and consistent that throughout these incredibly challenging 18 months all levels of government have acted in accordance with the best public health and medical advice.

Mr D O'BRIEN: That is great. Can I now ask a question on that, Minister—

The CHAIR: Mr O'Brien.

Mr FOLEY: That continues to be the case in this instance and is an important part of how in each set of circumstances, based on the merit of the circumstances at hand, the processes of all the circumstances that are at hand are taken by the public health team into their decisions and recommendations to government, and as governments right across the commonwealth have indicated we are guided by that public health advice.

Mr D O'BRIEN: Thank you. Minister. Speaking of the public health advice and the level of risk, on 27 May the Chief Health Officer, Brett Sutton, said that the replication number may be in the 3.5 to more than 5 range. On 3 June Professor Cheng said that people's behaviour had already naturally reduced the Reff number to about 2.5 and that just before the lockdown was implemented the mandate to wear masks had caused the Reff to drop further to about 1.1 to 1.3. My question is: why was it advised to lock down the entire state when it was known that the Reff was already in the low ones and that the spread was manageable?

Mr FOLEY: Thank you, Mr O'Brien. If I understand the question appropriately, having been, I think, in at least some of those media conferences where these issues around the infectivity of both the Kappa and the Delta variants of concern have been issues of public commentary and part of the public health team's advice as to why a proportionate and speedy response was needed to drive down and break chains of transmission, these particular issues have come up. If I might in a minute—

Mr D O'BRIEN: No, Minister, can you just answer the question.

Mr FOLEY: if it is appropriate, ask the Acting Chief Health Officer to provide a bit more detail in regard to the technical side of this. But having been part of at least a number of those conferences that I think you have cited, I would point out that what you failed to include in your commentary was that some of the commentary regarded how the replication factor would apply in circumstances where there were no restrictions or very minimal restrictions, some would apply differently in terms of whether it was the Delta or the Kappa variant and some would apply differently in respect of different stages of restrictions across the community. So I think it is fair to say that the advice has always been consistent and that the important Reff factor, as it is called, is included in how the public health team's overall assessment is built around that. And with the indulgence of the Chair, I would ask perhaps Professor Cheng to consider supplementing that answer.

The CHAIR: Thank you, Minister.

Mr D O'BRIEN: Professor Cheng, can I ask a specific question supplementary to that. What was the Reff before the lockdown started, so on 27 May, and can you tell me what it is now?

Prof. CHENG: I could not tell you what it is just at the moment, but I believe it was in the range of sort of 1.1 to 1.3. There is always an uncertainty around that. But it probably is important just to note what that actually signifies. The reproduction ratio is the ratio of cases you would expect in the next serial interval. So 1.3, for example, would mean we would expect 30 per cent more cases after six or seven days than we had. So that is still a growing epidemic. What we really need to do is get it below 1. For example, I think at one point last year it was 0.9 or something. That still is a very slow rate of decline. So what was really required was something really to bring that sharply below 1 so that we could have the lockdown as short as possible; otherwise it would be extending on for a long period of time. But 1.3 is clearly too high, and it does mean an epidemic that is continuing to spread.

Mr D O'BRIEN: So what is the most recent Reff that you have seen?

Prof. CHENG: I could not tell you just off the top my head, but the one after lockdown I think was about 0.7.

Mr D O'BRIEN: 0.7. So as in—

Prof. CHENG: Post lockdown obviously.

Mr D O'BRIEN: The last change in restrictions. Okay. No worries. Does the public health team regularly assess the Reff?

Prof. CHENG: We get estimates from various sources, but one of those is the Doherty modelling group, which is commissioned by the commonwealth to do that. We do get reports fairly regularly. We did receive one recently. I just cannot remember that figure off the top of my head.

Mr D O'BRIEN: Sure. We previously sought through the Parliament some of the advice provided to government, and it referred to both a cover brief and a charter assessment. Are you able to tell me whether Professor Sutton was provided with a cover brief and a charter assessment before the last—

The CHAIR: Mr O'Brien, I would remind you that this is the inquiry into the budget estimates for 2021–22. It is not the COVID inquiry, and it is not the performance outcomes inquiry, and we are not in the chamber itself, where you have all of the other opportunities to pursue this line of questioning. I would ask that you keep your questions relevant to the budget estimates, please.

Mr D O'BRIEN: Are you going to rule the question out of order?

The CHAIR: I am ruling the question out of order. I would ask that you keep your questions to the budget estimates, please.

Mr D O'BRIEN: Well, again, the budget, Chair, is predicated—on page 22 of budget paper 2 the key forecast assumptions referred to COVID being contained and only resulting in localised, short-term restrictions, so it is fundamental to the budget's assumptions, and I would like to know whether a cover brief and charter assessment were provided to Professor Sutton for the last lockdown.

Prof. CHENG: I think you will find that I signed the directions.

Mr D O'BRIEN: You will be able to tell me, then.

Prof. CHENG: Yes. We do receive a range of documents. I understand that requests have been made for those to be provided, and I think the department will respond in due course.

Mr D O'BRIEN: Yes. Who provides those? Is it the department or your public health team?

Prof. CHENG: The public health team, and obviously there are various branches within that that contribute to all of this.

Mr D O'BRIEN: Is there any external, particularly legal, advice provided, and if so, what is the cost of that?

Prof. CHENG: I could not tell you that. I understand that it is provided internally.

Mr D O'BRIEN: Okay. Righto. Minister, with respect to that previous parliamentary request for that information, which again is fundamental to the assumptions in this budget, the government claimed executive privilege over cover briefs, so they were not provided to Parliament because, quote:

> Disclosure would …

among other things—

> or otherwise genuinely jeopardise the necessary relationship of trust and confidence between public officials and a minister.

Given the necessity for people to follow the government's directions in this pandemic, what about the trust and confidence between the public and its government? Why won't you release the public health advice? And before you answer, we get the level of risk. The thing I am talking about is why the directions include things like, at the moment, 50 people can be in a brothel inside but only 20 people can meet publicly. And whenever questions are asked about these sorts of completely inconsistent restrictions you just say 'the public health advice'. Why can't that public health advice be released to build trust in the community?

Mr FOLEY: Thank you, Mr O'Brien. So if I understood your question, it was predicated on what I assume to be the position of the Legislative Council in seeking the release of certain documents. Not having been in the Legislative Council myself—

Mr D O'BRIEN: That is irrelevant to the question.

Mr FOLEY: No, I am just trying to understand. You did not say which—

Mr D O'BRIEN: Yes. That is for the response from the government.

Mr FOLEY: That is what I thought, so thank you for that. The public health advice is encapsulated in lots of different forums that are publicly available and publicly discussed all the time. First off—

Mr D O'BRIEN: But it is not, Minister.

Mr FOLEY: No, it is true.

Mr D O'BRIEN: It is not. That is the point of the question.

The CHAIR: Mr O'Brien, could you allow the minister to answer the question?

Mr FOLEY: You assert to the contrary. I assert based on what is publicly available right now and every month is renewed through the Chief Health Officer's report, which is hugely detailed, to the Parliament around the public health restrictions and the reasons and the material around why the restrictions are what they are. I could add a number of other forums that point to exactly the same information.

The CHAIR: Thank you, Minister. Ms Richards.

Ms RICHARDS: Thank you, Minister. Thank you to the officials and the clinicians who are here today to provide this evidence. I would like to return to the inquiry that is the purpose, the reason, we are here and particularly to the COVID-19 testing and refer you to budget paper 3, pages 59 and 65. I am interested in understanding how this funding supports Victoria's COVID-19 testing system. We know this is critically important to identifying positive cases quickly, and I am interested in how that is keeping the community safe.

Mr FOLEY: Thank you, Ms Richards. I should point out that the Victorian government expects that today we will pass 7 million tests that Victorians have undertaken as part of the extraordinary engagement. So many members of our community have personally taken steps to ensure that our public health team can map the transmission of this virus whilst of course doing what they can to keep themselves safe, their families safe and their communities safe. That is, I think, a significant achievement and one that I would urge all Victorians to continue to take extremely seriously, as they do. Even the figures released today point to a figure of some 35 000 tests processed yesterday.

The budget outputs that you refer to pick up through that public health component the important work that testing does as a core part of the COVID-19 public health response. Making sure that our testing system is in place and operating effectively and operating within the national framework at national cabinet and work such as the Finkel report in 2020 put in place is a key, accountable benchmark that our testing teams have done an extraordinary effort in.

Testing takes many forms. There are obviously the 7 million-plus tests that individuals have taken, but there is also wastewater surveillance testing and other parts of the testing system that need to be aligned with that, the most obvious particularly being in the pathology capacity area. How all of these areas come together—and we have testing when it comes to individuals testing for COVID-19 symptoms—is really critical, and it needs to be done in a clinically safe way, but it also needs to be done in a convenient setting. The state has over 200 different locations in which testing can take place, and of course the commonwealth has, through its respiratory clinic network also, a number of testing facilities to supplement that.

Victoria maintains that extensive network, particularly across our metropolitan and regional areas, through a whole series of different measures that are appropriate: fixed drive-through settings; walk-up settings; mobile and roving settings; pop-up industry-specific surveillance settings; port of entry, particularly at maritime and air ports; of course the hotel quarantine settings; particularly high-risk industry settings, whether they be hospitals

or whether they be distribution centres—a whole range of arrangements; and then testing that is also part and parcel of wider programs, such as the national freight distribution arrangements and the support that we have put in place for disability and aged care and other settings. To bring all that together we also then are able to supplement that through a range of other more targeted, bespoke systems. There is the Call-to-Test service, which seeks to assist those people with either mobility or other issues that do not allow them to leave home—be that injury, be that psychosocial or other issues—and that allows them the opportunity to be tested at home.

Testing rates do in fact remain strong, and I want to thank the Victorian community for that. But they are also very important in ensuring that they give us, in circumstances such as we currently face at the moment, the certainty of easing restrictions and fluctuations in that based on the intelligence that that testing, particularly high levels of testing, gives our community and through them our public health teams. I want to make sure that this is used as an opportunity to reinforce the importance of testing as we face the challenges of the next few months as we seek to ramp up our vaccination programs. The two are actually different sides of the one coin, and whilst we obviously will seek to ramp up the vax program as soon as we can based on supply, the importance that high levels of testing have whilst that is also occurring should not be underestimated.

During the times of high demand for testing we are—and these can sometimes vary in regions and scale—able to shift significant resources around through support measures, be it pop-up testing, increasing operation hours, scaling up particular sites that can be designed for that purpose and adding lanes and adding support services. We have shown ourselves increasingly able to not just grow the number of peak demand tests—we have had several days of well over 50 000 tests achieved—but in doing so ensure that we meet all the national benchmarks in terms of turnaround times of the pathology reports. That has been through some of the very important partnerships and projects that we have had in place with the growth of public pathology, but equally I want to thank the private pathology partners for stepping up hugely in this space. We have also, as was indicated earlier, through the contact-tracing and other report teams, been able to digitise and speed up substantially the test-tracking system, which has moved well and truly into the digital age as part of this process, and that has assisted greatly in improving our testing capacity to be a significant part of the toolkit of Victoria's COVID response. It has been therefore able to assist the epidemiological response, and part of that also goes to the genomic and particular clinical responses that might be needed in the cases of infections, particularly of variants of different concerns.

Some of the areas in which our testing system has been particularly effective in terms of high levels of penetration have been, for instance, some more than 9000 international flight crew tests since Victoria introduced the compulsory element of that in 2020, and in terms of the daily testing rates for hotel quarantine workers since 7 December 2020, more than 290 000 hotel quarantine worker tests. Add to that the rapid response engagement functions to try to engage our vulnerable communities and the community health organisations that I referred to earlier through the C19 Coalition as to how they target particular responses in vulnerable and at-risk communities. We want to make sure that there is every opportunity for all Victorians, no matter what their circumstances, no matter where they are, to have confidence in the timing and the delivery so that should they have even the most mild of symptoms they come forward to get tested and that they can do so knowing that that will be turned around in a timely and efficient manner and the response for that got back to them as quickly as possible.

Then in terms of peak demand, as we have seen in recent weeks, what sorts of measures we can put in place to actively assist and support the great patience and endurance of Victorians as they seek to do their part in that testing—active diversion strategies; online wait times; as I have reported earlier, the test tracker functionality on registration and pathology systems; real-time upgrades on the website as to where support might be; all the way back to the important CALD community testing, interpreting and engagement services that I reported on in an important earlier question. Add all that together, and the important work of testing has been fundamental to the nation's response in 2020 and 2021, and I suspect that for some time yet, as we await the full benefits of the commonwealth vaccination program, it will continue to be a central pillar to our community's response to COVID-19.

Ms RICHARDS: Thanks, Minister, and as somebody who has driven through the Casey Fields drive-through to be tested quite a lot, I cannot help but give a shout-out to Monash Health and the crew both there and at the Cranbourne racetrack—top-notch professionals. I am interested in the turnaround time as it relates to the pathology system. I am aware not only that it does help the contact-tracing team identify cases but that it does make such a difference to encouraging members of the community to turn up and get tested, and I

can say it is extraordinary to get those results so fast. So how is the government enabling this through the investment in the pathology capacity? I am referring you to budget paper 3, page 59, and that output initiative identified there.

Mr FOLEY: Thank you. I join with you in thanking Monash Health, who as the state's largest health network have done an extraordinary job, as indeed have all of our health services, but I need to give Monash a particular shout-out given the important role they have played not just in testing but in the hosting of the local public health units, their engagement with at-risk communities and their support for other hospitals in their and other health networks both in their surrounding region and through their specialist leadership. I join with you in marking their leadership in this space.

But you are right: in terms of the $1.3 billion investment in public health outcomes, a key component of that is in the pathology performance that you touched on. Making sure that we turn around quickly those tests is very important not just to the confidence and the lifestyle of the now 7 million tests that we have seen over the course of the last 18 months but also to the support and confidence that the public health team can bring to their strategic and specifically informed public health responses. So I want to give a particular shout-out to the 16 labs who process the COVID swabs which, as the process runs, get collected from our test sites right around the state; the skilled pathologists; the lab technicians; all the way through to the transport and other staff and the public health teams. They work 24/7, and have done so for many, many months now, and have provided increasingly timely and overwhelmingly accurate results to the public and, through our contact-tracing teams, to our public health units. The government has invested some $36 million in expanding the public pathology system's capacity and improving the turnaround times. You speak of Monash Health, and they have been, together with Melbourne Health, the home of five new high-volume analysers that are capable of processing thousands of tests a day in increasingly effective and efficient ways.

We have seen new investment in public pathology services and equipment at Alfred Health, at Austin Health, at Northern Health, at the Royal Children's Hospital, St Vincent's Hospital and the Victorian Infectious Diseases Research Laboratory. We have also seen greater partnerships between our regional health services and those partners to make sure that they get the timely turnaround of regional pathology testing as well. This has meant substantial additional staff positions across all—

Mr RIORDAN: Point of order, Chair.

The CHAIR: Sorry, Minister, the Deputy Chair has a point of order.

Mr RIORDAN: Just going to Ms Richards's questions about pathology, the minister has been answering for quite some time now and he has made no reference to the complete withdrawal of public pathology services in rural and regional Victoria, and—

Mr FOLEY: What is the point of order?

The CHAIR: Mr Riordan, there is no point of order.

Mr Riordan interjected.

The CHAIR: There is no point of order. You have had your—

Mr Riordan interjected.

The CHAIR: Mr Riordan, you are talking over the top of the Chair.

Mr Riordan interjected.

The CHAIR: Mr Riordan, if you do not mind, please. You are talking over the top of the Chair. It is not an opportunity for you to grandstand. You have had your opportunity to ask questions. Ms Richards has the call.

Mr Riordan interjected.

The CHAIR: Mr Riordan, that is not a point of order, and you know very well that it is not a point of order. I do not appreciate it. Minister.

Mr Riordan interjected.

The CHAIR: Mr Riordan! Mr Riordan, the minister does not need your assistance.

Mr FOLEY: What we have seen through that fantastic partnership between a substantially expanded public pathology system and the network of private pathology providers is a huge growth in the capacity of the pathology system that the COVID-19 response requires. There was a time at the start of this pandemic that you might recall in early 2020 when there was a blitz to try and get 100 000 tests in two weeks. We have now established in recent weeks the ability to do over 100 000 tests and meet higher benchmarks of performance and turnaround in two days, not two weeks. That says a lot about, firstly, the support of the Victorian community to come forward and get tested, but equally about the important improvements in both the public and private pathology systems, and I want to give all of those people a big shout-out.

In regard to those performance levels, the commonwealth has set very high standards of making sure that the turnaround times of both within 24 hours and within the next day for pathology tests are achieved, and the Victorian government has significantly met those benchmarks day in, day out for some considerable period of time now. That should further give those highly motivated Victorians the support and the confidence they need that they can, even if they face the most minor of symptoms, get their testing dealt with quickly in a timely manner that gives them certainty and gives our public health professionals the community intelligence they need to deliver our important COVID-19 response.

I want to thank each and every one of those people in our pathology and our public health systems, both public and private, for the support that they have given, but more importantly I want to thank the millions of Victorians who have come forward for those now more than 7 million tests that they have been part of over the last 18 months.

Ms RICHARDS: Thank you, Minister. I will leave my questions there.

The CHAIR: Thank you, Ms Richards. Mr Hibbins.

Mr HIBBINS: Thank you, Chair. Thank you, Minister, and your team for appearing this afternoon. Minister, mothers and midwives are revealing that our public maternity hospitals are under a severe strain due to a lack of beds and staff, and increased demand this year. In regard to the funding line item 'Meeting demand for hospital services', how much of this is specifically earmarked for public maternity or perinatal services?

Mr FOLEY: Thank you for the question. In regard to the important work that all of our public health services do when it comes to both maternal and perinatal health, those particular elements are caught up within the $3.7 billion line items that I referred to earlier to meet our demand capacity and our business rules.

Mr HIBBINS: Is there a specific figure for—

Mr FOLEY: Yes. I might ask Deputy Secretary Geissler to specifically address those, but we want to make sure that the $3.7 billion that is in those particular items—and I am more than happy for Ms Geissler to detail those—picks up important areas, such as the $6.8 million boost for catch-up for key age and stage visits, which is part of the universal maternal and child health program, to make sure of that continuative care for newborns; let alone the important work in such investments, such as the 2019 newly opened Joan Kirner Women's and Children's Hospital, having delivered additional capacity of 20 maternity delivery rooms, 237 beds and a neonatal intensive care for the first time in Melbourne's booming west; or indeed the $50 million Nursing and Midwifery Workforce Development Fund to create opportunities to train and bring in even more MCH supports throughout the birth and early years of children, together with making sure that as part of this there is a $2 million investment in the forthcoming year to develop the skilled, agile and sustainable maternity workforce that our system needs.

In regard to the specifics, with your indulgence, Chair and Mr Hibbins, I might ask Ms Geissler to detail the specific arrangements that you referred to.

Mr HIBBINS: Specific in terms of just how much is for public maternity and perinatal services.

Ms GEISSLER: Sure. So I think it is important to note that activity-based funding will be provided dependent on the number of births delivered. So it is part of our overall demand funding to expend on the

number of births delivered in our public system. So I am not sure I quite understand the question, but it is certainly part of the overall demand funding.

Mr HIBBINS: The question is on the budget line item 'Meeting demand for hospital services', which is on budget paper 3, page 59, and I think it is outlined as $3.69 billion. How much of that specifically will be allocated to maternity and perinatal services?

Ms GEISSLER: So if a public hospital provides care to women giving birth, then that activity is funded as part of that demand funding.

Mr HIBBINS: Okay, thank you. Does the government accept that there is currently a huge strain on maternity and perinatal services?

Mr FOLEY: Thank you, Mr Hibbins. We certainly accept the reality of the figures that show our biggest health service, Monash Health, is facing a significant baby boom at the moment. There is some demographic argument as to does this constitute, formally, a baby boom or not, but I can assure you from direct conversations that I have been involved with, with both large metropolitan and smaller regional health services, that there is a significant demand in maternity services both perinatal and postnatal and at the time of course of birth. And we are seeing how that plays out right across our system.

As Ms Geissler indicated, the funding that I referred to in my presentation about meeting demand growth, which we touched on in the budget papers, is predicated on the financial modelling that we have funding those services. So the issues about funding the delivery of the services should not be in question. That is not to say there are not many, many challenges in meeting the demands more generally. And they go to issues such as workforce, and that is why the specific programs around training and skills development and support for mothers in the whole perinatal process is also critical, and that is both in a community setting and a clinical and acute setting. All of those arrangements are looking to how we can support families, and mothers in particular, through these supports in the most effective manner possible.

Two examples might point to how this plays out differently. I have been in discussions with a number of regional hospitals around how some of their return of maternity services can be managed in a collaborative partnership between the smaller regional hospital and, if you like, the larger notional regional centres—Bendigo, Ballarat, Shepparton, Barwon et cetera. Those smaller hospitals and their managed system of how both specialist and midwifery services can be provided to those smaller settings on a risk-based service has seen maternity services return to those smaller hospitals. At the other end Monash Health, our largest health service, has had a huge demand on its maternity services across its various campuses, particularly from diverse CALD communities. They have used this as an opportunity to engage through outreach programs, particularly given that historically Safer Care Victoria has pointed to those communities as being really at risk when it comes to poorer health outcomes for babies and mothers, to use this as an opportunity to deliver services in a different way that improves not just health outcomes for the babies but for the whole family. Greater use of early community engagement, greater use of self-directed care with support from mothers in a culturally appropriate way has been a particular success at Monash. There is a whole range of other responses that we have put in place to try to deal with those very pressures that you have pointed to—all of which is a detailed answer to your question, but the fundamental premise is, yes, we do agree that there is increasing demand on our maternal and child health services.

Mr HIBBINS: Do you put the current strain down solely to a baby boom or an increase in births, given that the data from births, deaths and marriages does not actually show an increase in births in 2021 from previous years? Is some of it actually down to a strain on resources in staffing and beds—or a lack of resources, sorry, of beds and staffing.

Mr FOLEY: Certainly there are workforce challenges, which I acknowledged in both my earlier answer but more importantly in the funding arrangements that are contained in this budget. Right across our health system, not just in MCH, workforce challenges are amongst our biggest issues that nationally we need to be able to respond to. We saw it coming into the pandemic, but what we have seen during the pandemic is that the demands that we have put on that workforce and the fatigue levels right across the board have been extraordinary. We have asked our clinical and non-clinical workforce time and time again to step up, and they have.

In regard to the specific issue of maternity and other arrangements when it comes to the workforce, I do point out, as I answered in the substantive first part of our discussion, whether it is the $50 million Nursing and Midwifery Workforce Development Fund or the $10 million allocated for the skilled, agile and sustainable workforce development, there is at least that amount of direct investment to try to respond to those direct challenges. In regard to has there or has there not been a baby boom, as I indicated in my earlier answer, the question as to what constitutes formally a baby boom is for others to judge, but I know from anecdotal evidence from real-world discussions with big, small and in-between providers of maternity services right across the state that there is a growing level of demand, and we are determined to work with our workforce, work with our community and work with our health services to address that demand in the best possible way. And, yes, I concede that workforce development is a key part of that.

Mr HIBBINS: Thanks, Minister. You have said previously that there is an arrangement for the public sector to purchase capacity from the private sector in order to deal with increased demand. Can you indicate just how much funding is actually allocated towards that out of the maternal and child health and early parenting services budget line item?

Mr FOLEY: We have seen a lot change over the course of this global pandemic, and one of the earliest reforms that the commonwealth led was essentially an unprecedented level of cooperation and almost alignment of the public and private health systems, driven in the initial parts of the pandemic on the basis that there was a real concern based on global evidence that our health system might well be overrun with COVID cases, and whilst our public health and private health systems have had huge challenges, they have not seen those being overrun examples, as we did sadly see in some other countries. As part of that arrangement, through a national partnership agreement, a wideranging set of arrangements is in place that bring together both the public and private systems to meet all sorts of predicted and possible demands, and we have seen that play out in a range of areas. In regard to the specifics of it applying to maternal and child health and particularly perinatal services, I might have to again seek the assistance of Ms Geissler, who is perhaps more over the detail. With your indulgence, Chair, I might ask Deputy Secretary Geissler to address those specifics.

Ms GEISSLER: I am happy to provide a few more comments. Just going back to your first question around allocations, I just wanted to make the point that there has been an average increase of 5.1 per cent per annum in fund activity over the previous five-year period to 2019–20 for our public maternity care. In terms of allocations for private, that is not the way it works. They are individual agreements that are reached on the ground between health services given particular demands, so we would not know about those allocations until the end of a financial year wrap-up.

Mr HIBBINS: Okay. So would that then be able to be accounted for in the 2020–21 financial year?

Ms GEISSLER: Potentially, but I would have to get back to you on that.

Mr HIBBINS: Take that on notice. And if possible too, in taking that on notice, could you also outline which private hospitals or services are being used?

Ms GEISSLER: I can take that on notice.

Mr HIBBINS: Okay, great. Thank you. Is there any additional funding—is there any funding allocated in this year's programs that actually keep women out of hospital and actually free up beds, such as additional funding for public homebirth services or case-load midwifery programs in the public health system?

Mr FOLEY: Thank you, Mr Hibbins. Again I will say a few introductory comments and then perhaps ask my friends from the department to supplement. But one of the key strategies in this budget for the learnings and the reforms that we see as a potential positive from what has been a dreadful global pandemic's impact on our health services has been the huge enthusiasm for support for services outside of hospital settings. We have seen that in telehealth, we have seen that in all sorts of manners of how services are delivered. I did refer to Monash Health earlier and their highly successful digital telehealth program for maternal and perinatal health where, working with those communities, they were able to, for firstly public health reasons, help women, during the course of 2020 in particular, manage their pregnancies in such a way that there was a minimal level of engagement at the tertiary hospital level and a maximum level of engagement at either a local community or indeed a house-by-house level. I was very pleased to get a brief from both Monash Health and their community partners as to the success of that program. In regard to the specifics of what does that then mean for the actual

process of a delivery of children through that process, those decisions are always—always—clinically based and are always based on the best interests of the child and the mother and the family. But in terms of the specifics, I might ask again, I hope, Ms Geissler to address those issues.

Ms GEISSLER: Happy to. So in this—

Mr FOLEY: Or one of Victoria's leading paediatricians.

Prof. WALLACE: Obstetricians.

Mr FOLEY: Pardon me.

Mr HIBBINS: It is not a competition.

Ms GEISSLER: I am happy to say a few words and then hand over. So this budget allocates $120 million towards our Better at Home initiative, and that is really about making things that little bit easier for patients and their families by providing care wherever possible, whether it is recovering from an illness or surgery at home in the comfort of their own surroundings. As part of that, the department is considering expanding services, and that includes maternity care before and following low-risk deliveries, so that is part of this current budget. There is a lot more that we could say about Better at Home, but I am hoping that answers—

Mr HIBBINS: Yes, okay. Thank you. Thanks. I actually just wanted to ask one more.

Prof. WALLACE: Yes, you go. Please.

Mr HIBBINS: Just back to the private hospitals question, when private capacity is needed, is it available when needed or are there examples of it—is it always available when required?

Ms GEISSLER: It will absolutely depend on the circumstances on the ground.

Mr HIBBINS: Okay. All right.

Prof. WALLACE: I might answer that from my own experience of when I was head of clinical service at Monash. So if we needed private beds, then we would purchase those as we needed them, and typically that is what happens in the system. And I think, as the minister has alluded to, one of the things particularly through the pandemic but even predating that—there are relationships, and better relationships, between public and private to flex and surge as required. So typically those arrangements are made at the time of need and then stood down as they are no longer important.

Mr HIBBINS: Yes, okay. Thank you. And that is the end of my time. Great. Thank you.

The CHAIR: Thank you, Mr Hibbins. Ms Taylor.

Ms TAYLOR: Thank you, Minister and department officials, and thank you for your service to the Victorian community as well. I just wanted to note that. So my first question, and it might actually go some way to acquitting one of Mr Limbrick's questions: are you able to provide an update on any new testing technologies the department is investigating?

Mr FOLEY: Yes. So whilst PCR is considered, if you like, the benchmark form of testing and the one that is more reliable than any other, this is a rapidly evolving technological space. The Victorian government has been engaged in a range—as indeed has the commonwealth, as indeed have private sector partners, as indeed have health services, as indeed have global players all been engaged—of what further mechanisms and tools can be taken to drive different forms of quicker and accurate testing turnaround. Whilst PCR is still, if you like, considered the standard, a whole range of other forms of testing are in fact being developed and well developed. With your indulgence, Chair, I might ask the commander of the COVID response, Mr Weimar, to specifically address elements that the government has been involved in in this space.

Mr WEIMAR: Thank you, Minister. So I think we have already referred to, or the minister referred to, over 7 million straightforward nasopharyngeal PCR tests that we have done across the state over the last 16 months or so, and that is the largest state in Australia in terms of how much we have got through. We have also

developed saliva-based testing and incorporated that into our hotel quarantine system in particular. So the introduction since the end of last year, about December last year, of daily saliva swabs for those workforces that are most exposed to dealing with high-risk potential suspected COVID individuals has been a really important part of strengthening controls around that most high-risk setting. Clearly saliva sampling does not give the same accuracy as nasopharyngeal swabs; it is still a PCR, but it takes a sample from a different place. What we have been able to do is to use it as an ability to get more regular daily cycle testing in, not just by a weekly or twice-weekly nasopharyngeal swab. And obviously much less intrusive for the individuals concerned, given that you are asking hard-pressed frontline workers to do daily testing. It is quite an onerous burden. So that has been a very effective move, and we have done well over a quarter of a million saliva-based tests here in Victoria, and it continues to be something we operate on a daily basis.

We did a lot of work really last year with the Doherty Institute and supported them to look at alternatives to PCR-based testing, and one of the challenges with PCR-based testing is that it is possible to run a very small number of what we call GeneXpert tests through with results in about 2 to 3 hours. So we use those applications where we have really sensitive primary close contacts, where we have a positive case and we are trying to establish whether there is a link to a sensitive setting. So we used it, for example, recently with positive cases where we were trying to consider whether they had got connections to schools or aged care or hospitals to establish as early as we could whether there may be a positive, but the capacity of the GeneXpert testing machines is very small, so you can do a small number of tests very quickly but you cannot do it at a bulk volume.

What we have looked at a number of times is rapid antigen testing, which essentially is something that is widely used in other jurisdictions. One of the benefits of antigen testing is it is outside the lab, so you are not taking up valuable lab capacity, and you can do it locally—you can get a result locally. You can take a swab here and now and get a result within 15 minutes. Allen can give a far better clinical explanation of how it works, but it does provide a result in 15 to 20 minutes or so on the spot, a bit like an on-the-spot pregnancy test. That has many advantages, particularly in environments where your laboratory systems cannot cope with the sheer volume of PCR tests.

The situations we have here in Victoria, given that we are able to run 50 000-plus daily tests if we need to, given that we can run 50 000 tests and get 90 per cent of results within 24 hours, the use case for antigen testing is not quite as strong. And the error rate for antigen testing in terms of false negatives and false positives tends to be significantly higher than with PCR tests, particularly when antigen tests are taken by the individual to use them themselves. Clearly there are other jurisdictions outside Australia where this is more heavily used, but there are fairly high error rates. And if you look at some of the recent commentary coming out of India and the US, we see quite a high use of antigen tests not being effectively utilised and causing some significant problems. Currently we have got approval from the TGA and encouragement from AHPPC to use antigen really for diagnostic purposes, and we use it particularly with our incoming arrivals program in hotel quarantine. So when incoming travellers come in, if they are symptomatic, we will do antigen testing on the spot to see whether they should go to a health hotel or whether they should go into a normal hotel quarantine and then take them through the process. So there are some limited use cases we have but not much more than that.

And then finally we also use serology testing, which is really to establish whether somebody has had COVID in the past but is no longer positive. So it gives you a good sense of if somebody may have had COVID, may not have been symptomatic, may not have known they had COVID, but you are trying to do the detective work after the fact. And we used serology testing only a few days ago to establish one prior positive case that was actually a connection to our recent positive cases who were in Queensland and have been somewhat in the news, and we identified one of their primary close contacts who actually had an infection in the middle of May but by the time he was identified as a primary close contact and by the time we did the testing he had turned negative. But serology established he was a positive and is a possible link again to earlier parts of the cluster.

That is the range of testing we use here in Victoria. We are blessed that we have facilities like the Doherty Institute that are doing phenomenally groundbreaking work, and they have been a critical part of our armoury over the last year or so.

Ms TAYLOR: Thank you. Now I would like to move to wastewater surveillance. I know, Minister, you mentioned that earlier. Noting that wastewater detections sounded the alarm and effectively predicted the

discovery of cases in Melbourne's north, which has led to the present outbreak situation, how is the government investing in this system going forward?

Mr FOLEY: Thanks, Ms Taylor. The wastewater testing system that all of the jurisdictions around Australia use is a much broader population subgroup testing way of getting early intelligence around the presence of COVID. And, as you have been quite right, it was a critical early warning sign when it came to the first outbreaks of what was dubbed the City of Whittlesea outbreak that we are currently still responding to. So the testing is critical in that local community area. Wastewater surveillance testing is so critical to that early warning matter. Whilst it does not tell you who and it does not necessarily tell you exactly where, it does nonetheless point to the presence. The presence can come from, as we see, what is now commonly referred to as viral shedding. This may be historical cases. But nonetheless if there are repeat detections from wastewater testing in a particular area where there are no known cases or where the community intelligence tells you there should not be, that is very much an early warning sign, and what we need to do based on that is then, as we have regularly, use that as a community engagement opportunity to then call upon communities to get tested out of a process of we want to be sure that, hopefully, it is from viral shedding from previous cases. But as we found out in this particular City of Whittlesea case, it was in fact an early warning signal for that.

So we now undertake wastewater monitoring across some 142 locations right across Victoria, and that includes the 70 wastewater treatment plants and 72 sites across Melbourne metropolitan sewerage networks. This has increased substantially from the 87 locations late last year, and given the sophistication and the sensitivity of the testing—all Melbourne-based technology, can I say—continues to increase, we would look to the continued expansion of this system not just for COVID purposes but, yet again, we would hope it would be an enduring lesson that our ongoing public health and infection control processes might well be able to look to for the future. It is an important tool. It is far from our only tool. But it is all about using these lines of output investment to keep that early warning intelligence ticking along and so assist our public health response teams.

Ms TAYLOR: Thank you. If I could direct you to budget paper 3, page 59, can you please explain how the $91 million allocated to community-based healthcare demand will help Victorians catch up on care they missed during the pandemic?

Mr FOLEY: Thank you, Ms Taylor. Yes, that particular output around the general heading of community-based health care is designed to do many things, one of which is the important work on catch-up care that we have dealt with in both this conversation and the earlier conversation around Ambulance Victoria and some of their demand pressures.

What we have seen during the course of the pandemic so far is how many services have both transferred to a digital and telehealth platform and the way in which that has encompassed sometimes quite complex and chronic health needs to be dealt with in different ways. What it has also meant, unfortunately, is that there have been many challenging, chronic and ongoing conditions where treatment was deferred from normal checking and care routines. We know that there are significant risks in not acting to re-engage with both your primary and specialist healthcare services, and we know that community health based responses are the best locations in which to present to health services so as to avoid greater complexity in the future. That is all about making sure that we run down poorer outcomes as soon as we possibly can and, through poorer outcomes, ultimately, greater costs and use of avoidable hospital admissions.

So the $91 million that you refer to is all about delivering that in different segments to make sure that vulnerable, disengaged Victorians have access to services in new, better and different ways than far too many of them have, unfortunately, seen disengagement from over the last 18 months. That includes $37.4 million for public dental services, a significant component of which is targeted towards providing dedicated care for Aboriginal Victorians, and we are working very close with Aboriginal community controlled health organisations for the delivery of that.

There is a $13 million investment in cancer prevention and screening, which will pick up important areas such as HPV vaccinations for some 22 000 extra schoolchildren. There are 25 000 additional breast-screening supports for BreastScreen Victoria, and there is also investment in assessment and appointment supports and an expansion of that important range of new services in the Shepparton community. There is also direct funding for some 6500 colonoscopies that we know were either missed or delayed last year—for those to be brought back along. There is also $6.85 million to boost critical key age and stage visits—touching on Mr Hibbins

earlier point around how we pick up universal maternal and child healthcare programs in this particular coming year. This will assist in re-engaging families and re-engaging those who may have missed appointments and in making sure that those early detection and early assessment and referral and intervention services are able to be delivered in the most timely and clinically relevant way.

There is also, as part of that $91 million, $23 million to operationalise the funding for alcohol and other drug treatment services and a $5.1 million investment for community-based alcohol and other drug treatment services and further assistance for forensic alcohol and drug services. I am particularly pleased that the operational side of that money will disproportionately go to regional and rural alcohol and drug services in Gippsland, in north-east Victoria, in Barwon and in the Grampians region, where all the evidence supports particular over-representation of those communities in alcohol and other drug needs but also points to the effectiveness of rehabilitation services in those communities. In that regard we really do think that this $91 million worth of investment is an important part of delivering not just that catch-up but also staying ahead and delivering arrangements in place that will see Victorians, as we continue to emerge from this global pandemic, able to have confidence in the delivery of their critical primary and community health services.

Ms TAYLOR: Thank you. I would just like to pick up on the matter of public dental. Noting the additional funding that has been allocated to public dental services, could you talk more about how the government is making sure that this additional funding actually gets to the people in the community who need it most?

Mr FOLEY: Indeed. Making sure that our public health dental services—until such day as hopefully there is a universal dental scheme in this country, which we all live in hope for one day—and the improved oral health of Victorians is a really significant part of this $91 million investment. That is why our public dental services have sought every year now to be expanded and now pick up all children aged under 12, young people aged 13 to 17 who hold a healthcare or pensioner concession card or who are the dependants of concession card holders and people who are aged 18 years or over who are healthcare or pensioner concession card holders or their dependants. There are a range of other groups that we have brought in, and our Department of Families, Fairness and Housing has extended care to out-of-home care provided to young people up to the age of 18. We know that with the Home Stretch program that that will raise further challenges for us as well. We also deliver youth justice custodial care support, and we have also extended the program to refugees and asylum seekers, being, as they are, cut off from any form of commonwealth support. And after negotiations and agreement with Victorian Aboriginal community healthcare organisations, as of 1 July 2021 eligibility will be extended to all Aboriginal and Torres Strait Islander peoples in Victoria regardless of their concession card status. I want to thank the ACHOs for their outstanding not just work in getting their community, particularly their elders, through the COVID 2020 but their leadership in what does a better, higher level of health care, not just for their community but for the wider Victorian community, look like.

Ms TAYLOR: Thank you.

The CHAIR: Thank you, Minister. Mr Newbury.

Mr NEWBURY: Thank you. Look, there was a discussion earlier today, and for the benefit of those watching and for committee members I do want to remind and note that the objectives of the committee and this budget estimates inquiry are to benefit the Parliament and the community—I am reading directly from the objectives on the website. The first dot point is:

> promoting the accountability, transparency and integrity of the executive …

So when there is debate in here about whether or not there is a budget paper reference, I can tell you the first objective of this committee is to promote the accountability, transparency and integrity of the executive. So I will move on.

Secretary, how many organisations have been awarded contracts in the last year to assist with contact tracing?

Prof. WALLACE: Just so I understand the question precisely—

Mr NEWBURY: The Department of Health: how many companies, if you want to put it that way, have been contracted to assist with contact tracing?

Prof. WALLACE: Well, quite a few. As we have heard already, the contact-tracing pipeline from end to end involves testing, yes, the laboratories who do the tests—so the actual taking of the swabs—do the results and then the results coming through, managing the cases and their contacts in terms of interviews and then supporting them in quarantine. So there are companies involved in all of those bits of the pipeline. So we have providers who have stood up testing centres—like the marquees, the testing centres. We have providers obviously both public, and you have heard from the minister already about testing. We have got contracts with hospitals both public and private for the laboratories, and we have got contracts with providers for our call centres.

Mr NEWBURY: What about the call centres—how many of them?

Prof. WALLACE: Well, I think we have had four providers over the course of the pandemic.

Mr NEWBURY: Do you have the total value with you?

Prof. WALLACE: I do not because again we are still in the current financial year. It will not be reconciled until the end of the year.

Mr NEWBURY: Okay. You said there were four over the year. How many are currently in place, so existing?

Prof. WALLACE: In this most recent outbreak, because we have surged during this most recent outbreak in our call centres—I might ask Mr Weimar. I think we had certainly two—

Mr NEWBURY: Two?

Prof. WALLACE: Two or three.

Mr NEWBURY: Yes. If it helps, the department's own contracts site suggests there are two. I presume that is up to date.

Prof. WALLACE: Yes. We have contracts in place that are delivering services today and then we have contracts in place that allow us to surge immediately, so again just to go back to this most recent cluster of outbreaks where we have had now 100 cases, something like 10 000 primary close contacts—they all get interviewed. We had almost 90 days of no cases—no cases, no primary close contacts. To be able to surge from that base of zero to a situation where we are interviewing literally thousands of people a day we surged very quickly. So underpinning that is a suite of contracts that have people involved in our call centres and then contracts allow us to surge immediately.

Mr NEWBURY: So there are live contracts effectively which are ongoing and then there are other contracts in case you need surge capacity.

Prof. WALLACE: Indeed.

Mr NEWBURY: In short. The two that I referred to that are on the government's website—they end in a few days time. Those are the live contracts, if I can use that term, in terms of people being available. I do not want you to talk about anything in confidence, but I presume we are going to have a contact-tracing facility after a few days time.

Prof. WALLACE: We are.

Mr NEWBURY: So can you talk me through in general terms, without going through any details: we would be in effectively now, what, a contract negotiation period potentially? Our providers—if the time is nearly up on their contracts, would we be in a contract negotiation period?

Prof. WALLACE: You should feel very reassured that the department, and there is some commercial-in-confidence material here, works very closely with our providers in every bit of the pipeline to ensure that the contact-tracing—we just call it contact tracing—capabilities are maintained and sustained and are ready to respond to the needs of the state at any moment, as we have seen during this most recent outbreak. So, yes.

Mr NEWBURY: Yes. So we are in a contract negotiation period effectively, in commercial terms.

Prof. WALLACE: We have contracts in place—

Mr NEWBURY: When something is coming to the end of its life, you have a discussion about what happens next. I think that is what happens with every contract if you are considering moving ahead.

Prof. WALLACE: Our contracts would either be extended or adjusted in plenty of time to ensure that there is no shortfall in the provision of services.

Mr NEWBURY: Okay. As I understand it, I mentioned there were two currently in place. One of them I believe is, and I am just referring to the government website—

Prof. WALLACE: We have five total providers—

Mr NEWBURY: Five, sorry.

Prof. WALLACE: for the call centre.

Mr NEWBURY: So there are the two that are—if I can call them the big ones. Then there are three that are on standby in case you need surge capacity. Is that right? You mentioned two and two. Is it two and three?

Prof. WALLACE: Again, our call centre—our COVID line if you like—capabilities are quite complicated, as you could imagine, as you would expect. So we have call centre capabilities that have outbound calls that are there to support the contact-tracing element. Remember the cases are being interviewed by our public health teams either in our nine local public health units or in the case and contact teams in 50 Lonsdale, so in the department. Then thousands of primary close contacts are being interviewed either by those teams or by some of our surge call centre teams. There are inbound calls coming in with requests for assistance, for payments, for testing et cetera, et cetera, and then of course we have a call centre function to manage our vaccine program. I think we were here for the mental health PAEC hearing when that day or the immediate previous day the vaccine call centre took something like a million calls, 75 000 in the space of 15 minutes. So we have a suite of call centres, all integrated through our digital systems, all searching, waxing or waning depending on the need at the moment but all ready to serve whichever bit of the pipeline it is, including the vaccination program.

Mr NEWBURY: Referring back to the website, there are two here and the other three I presume are available through the website under a different search function. I may not have used the right search term. I presume they are there. Is that right?

Prof. WALLACE: I would have to take that on notice, whether they are on the website or not.

Mr NEWBURY: Okay, if you do not mind taking that on notice. But the two biggies that I can see are Helloworld at $13.25 million, who is providing that facility up until 30 June, and Stellar Asia Pacific, who is providing a $12.84 million contract over that period. Does that sound right?

Prof. WALLACE: Yes. So both Helloworld and Stellar have provided us services for both outbound and inbound calls over the course of the pandemic.

Mr NEWBURY: Okay. So there are two biggies. Obviously there is a difference between $12.8 million and $13.2 million, but it is a very similar price. So we have got two big providers that are providing the call centre facilities to the Department of Health, and I also saw, just when I was doing a search, that the department took the services of Stellar Asia for an additional $2.7 million for rapid call centre response as an additional contract. That brings the total for that provider over the last year so far to $15.5 million. Does that sound right?

Prof. WALLACE: Again, the final costings will be reconciled by the end of the financial year, but that would be broadly consistent with my understanding of the volume of these contracts.

Mr NEWBURY: I mean, that is a big provider to the department.

Prof. WALLACE: Yes, they are a big provider. Both Helloworld and Stellar have been outstanding providers to us over the course of the pandemic. They have been providing literally tens of thousands of phone calls a day for us, both inbound and outbound.

Mr NEWBURY: Were you aware that the ultimate owner of Stellar Asia just put $1.15 million into the minister's pocket for a property sale?

Mr MAAS: Point of order, Chair.

The CHAIR: Mr Maas.

Mr MAAS: Look, I am more than happy for the Member for Brighton to create some sort of narrative, but at the end of the day everything has got to come back to this inquiry. I am really—

Mr Newbury interjected.

The CHAIR: Mr Newbury, I am hearing Mr Maas on the point of order.

Mr MAAS: I really am at a loss as to what sort of evidence is going to be put into this report, because it appears to me—

Mr NEWBURY: Here is a newspaper report of it. Would you like a copy? Come down and grab a copy. I have got a spare.

The CHAIR: Mr Newbury, could you please refrain from interrupting and being so rude.

Mr NEWBURY: No, I am trying to be helpful. Please pass it down.

The CHAIR: I can assure you, you are not being helpful. I am trying to hear Mr Maas on the point of order.

Mr MAAS: It appears to me that there is no relevance with what opposition members are putting down on the record here. So when evidence comes to be produced in this report, please do not complain that, you know, the sorts of bits and pieces that you want to get in—because you are putting no tangible evidence into—

Mr Newbury interjected.

The CHAIR: Mr Newbury, I am hearing Mr Maas on the point of order.

Mr MAAS: And on another point—

Mr NEWBURY: I mean, at least you could show me the courtesy of reading it instead of just this spurious interjection.

The CHAIR: Mr Newbury, could you please show the Chair the courtesy of allowing this committee to understand and hear Mr Maas's point of order.

Mr MAAS: And on another point, I think we—

Mr NEWBURY: No, no. Can we deal with the first, Chair? Can we deal with the first point of order before we go to a second point of order?

The CHAIR: Mr Newbury, Mr Maas is talking to his point of order. If you would refrain from interrupting, we might all be able to hear him.

Mr MAAS: The other thing is this is our workplace, and I think we all have the ability to come here and to feel safe and to be heard and not to be triggered by the sort of bullying, quite frankly, that we have had to endure today. So I would ask the—

Mr NEWBURY: Do not use your cheat's card when there is mention of corruption. We are talking about corruption. This is a discussion about corruption. Do not throw cheat's cards to cover it up.

The CHAIR: Mr Newbury, would you please stop yelling over the Chair.

Mr NEWBURY: We are in the middle of a contract negotiation period. We have heard from the Secretary, and $1.1 million has just gone into the minister's pocket—in the middle of a contract negotiation period. This is outrageous.

The CHAIR: Mr Newbury, you are out of order. You are speaking over the top of Mr Maas and over the top of the Chair. Mr Maas is raising a valid point, and your rudeness today, from your feet on the table to yelling over the Chair, is totally unacceptable and unparliamentary, and I would ask that you conduct yourself in a manner that is worthy of the office that you hold.

Mr NEWBURY: And I would say, Chair—you can just look at me, right?

The CHAIR: Mr Newbury, I am chairing this committee. I am attempting to hear Mr Maas on the point of order, and you are making it exceptionally difficult, as you have done all day. Mr Maas has the call.

Mr MAAS: Thank you, Chair.

Mr NEWBURY: Why don't we just give him another 18 minutes?

The CHAIR: Mr Maas has the call, Mr Newbury.

Mr NEWBURY: This is a cover-up. Why are the Labor members covering this up?

The CHAIR: Mr Newbury, you are not allowing me, as Chair, to hear the point of order that is being put at the table. Control yourself.

Mr NEWBURY: How long can the point of order go for, Chair?

The CHAIR: Mr Newbury, it is going longer than necessary because you continue to interrupt.

Mr NEWBURY: Can it go for 5 minutes?

The CHAIR: Mr Newbury, you continue to interrupt, and I am not able to hear the point of order to make a ruling on it.

Mr NEWBURY: The Labor members are covering up the Secretary answering as to whether or not he was aware—

The CHAIR: Mr Newbury, your behaviour is unacceptable and unparliamentary.

Mr NEWBURY: that the minister pocketed $1.1 million.

The CHAIR: Mr Newbury, you are the person that is here wasting your time right now. Mr Maas is trying to make a point of order, and you are making that impossible.

Mr NEWBURY: I think the Secretary should be offered an opportunity to provide evidence to the committee.

The CHAIR: Mr Newbury, if Mr Maas could finish his point, we could then—

Mr NEWBURY: This point of order is going longer than the minister's answers do.

The CHAIR: Mr Newbury, that is because you are interrupting. Mr Maas has the call.

Mr MAAS: Thank you, Chair. My point of order comes to relevance and also the way points of order are delivered here. We do not need smacking on the table; we do not need to feel like that in our workplace. So I would ask the member to come back to the budget estimates and to certainly deliver his points of order, or to deliver his submissions, respectfully for everyone who is here and indeed watching this broadcast.

The CHAIR: Thank you, Mr Maas. I would remind everybody at this table that this inquiry is into the budget estimates. The website, as a number of our colleagues have wanted to point out today, refers to good public administration. When we are having the estimates inquiry, we are talking about public administration in

relation to the budget estimates for the 2021–22 budget. At other times we might be talking about the financial and performance outcomes, and at other times we might be talking about the inquiry that we have into the government's response to the global pandemic that we are currently experiencing.

Mr Newbury interjected.

The CHAIR: At the moment, Mr Newbury, I would uphold the point of order and ask that you keep your questions relevant to the 2021–22 budget estimates.

Mr NEWBURY: Thank you, Labor Chair. I move a motion that the Minister for Health be provided 3 minutes and no longer to explain the relationship he has with the ultimate owner of a service provider who has put $1.1 million into his pocket, as we have heard from the Secretary, in the middle of a contract negotiation period.

Prof. WALLACE: Chair, can I—

The CHAIR: Secretary.

Mr Newbury interjected.

The CHAIR: The Secretary has the call, Mr Newbury.

Prof. WALLACE: When I answered your question, I said that there is commercial-in-confidence material. The minister is not involved in the negotiations around any contract. There is ministerial sign-off of contracts on secretarial approval depending on the financial value of the contract, whatever that contract is. But neither this minister nor his predecessor were involved in contract discussions or negotiations with any of our service providers, whether it is those testing stations, the laboratories, the call centres and so forth. The decisions around contracts are then made, depending on financial delegation rules, on my recommendation if they exceed my own financial delegation, or if they are within my financial delegation, then I would sign those myself.

Mr NEWBURY: Thank you. My motion stands, Chair.

The CHAIR: I am sorry. You have a minute and 11 seconds. What is your motion?

Mr NEWBURY: I have moved a motion that the minister be provided 3 minutes to answer questions in relation to the sale of a property at 5 Main Street, Mornington, that sold for 35 per cent above value off market—

The CHAIR: Mr Newbury, that is not—

Mr NEWBURY: at $1.15 million. I have moved the motion, as I am entitled to do, Chair.

The CHAIR: Mr Newbury, it is very unclear what your motion is because there seems to be a lot of commentary about your motion. There is also not a seconder of your motion. You also have 38 seconds remaining, so I am not quite sure—

Mr RIORDAN: I second it, Chair.

Mr NEWBURY: There you go. We have moved the motion.

The CHAIR: Okay. The motion is put and seconded. All those in favour; against—the motion is lost. You have 24 seconds remaining, Mr Newbury. Would you like to productively use this time?

Mr NEWBURY: A reflection from the Labor Chair reflects only on you, Chair. Minister, you have been given the opportunity today to clear your name. You have been given that opportunity, and you have chosen not to. Let the record show that you have not answered any of the questions at the press conference on this issue. You have not used your time—

The CHAIR: Mr Newbury, your time has expired, and I will pass the call to Mr Richardson.

Mr RICHARDSON: Thank you, Chair, and I will try to proceed without defaming anyone. It is all good to be all tough in here with parliamentary privilege, but you walk outside there and you would have a defamation lawsuit on you and you would be paying for the minister's next properties for years and years and years to come. What an outrageous slur on a cabinet minister we have seen today. I apologise to the officials for the conduct today. In a workplace where we should feel safe and secure at all times the shouting and carrying on does not reflect how this committee has been run for a number of years. It is the pre-eminent committee of this Parliament, and we should act accordingly. We will proceed. With some of the state's leading health experts, in the middle of a global pandemic, we are seeing this kind of conduct, so we will get back to some business that affects Victorians, even though the Liberals who called for the Chief Health Officer to be here have not asked any questions of the Acting Chief Health Officer. But anyway, we will proceed.

Mr RIORDAN: A point of order.

The CHAIR: Sorry, Mr Richardson. Mr Riordan has a point of order.

Mr RIORDAN: There were clear questions given by Mr O'Brien—

Mr RICHARDSON: From Danny? He is a National, I thought. Or are you no longer a National, Danny?

The CHAIR: Mr Riordan has the call. Mr Riordan, do you have a point of order or not?

Mr RIORDAN: Well, the point of order was to withdraw the assumption that we—

Mr RICHARDSON: You have been calling Lizzie 'Labor Chair' all week, so forget that.

The CHAIR: There is no point of order.

Mr NEWBURY: Well, that is a fact.

The CHAIR: Mr Newbury!

Mr RICHARDSON: We will continue with budget paper 3, page 59, Minister, and the questions that you were engaging with, with Ms Taylor before, around public dental. I want to take you to an area that I am aware of and that the government has previously raised concerns in relation to: the eligibility of children not accessing important public dental services. For the committee's benefit are you able to explain what is being done to help all the kids who missed out on those services last year?

Mr FOLEY: Thank you, Mr Richardson. Yes, your question is correct. Our previous data shows that prior to 2018 fewer than 20 per cent of eligible children accessed public dental services. They were there, but they were not picked up. That says a lot about how they are framed and how they are delivered. That is why in the 2019–20 budget the government was very pleased to commit $321.9 million over the next four years for the school dental program, delivering on our election commitment to do so. Commonly referred to as Smile Squad, this is in fact the largest and most comprehensive free school dental program in the commonwealth. The Smile Squad provides just that: free dental to students in government schools right across Victoria. The vans provide free check-up and treatment, including cleaning, fluoride application, sealants, fillings, root canals and other non-cosmetic treatments, to make sure that our kids have the best possible healthy teeth. It is estimated that on average this service saves parents about $400 per year per child, and it will free up the wider existing public health dental programs, which are under huge demand, as I am sure honourable members will be aware. The initial phase of this rollout focused on regional and rural Victoria particularly and also then picked up western metro and other metro areas which were clearly, the data indicated, some of the highest risk service areas.

And then COVID-19, particularly over 2020, meant that those services had to be, sadly, suspended. With the initial phase of that program now underway and the easing of restrictions since November 2020, I was very pleased that the program could resume, particularly in Bendigo, Latrobe and Wodonga, and more recently this year we resumed a broader rollout in metro and broader regions. By the end of 2021 the estimates that we are working on are that there will be more than 500 schools participating, providing free dental treatment to more than 200 000 Victorian students this year alone. The necessary long pause in the program during the pandemic response clearly had an impact on the rollout, and that is why we want to turbocharge the program to make sure that we make up for that period in which the program was paused and that we get to all schools by the end of 2023. When fully implemented, Smile Squad will provide free annual checks and free follow-up care to some

630 000 children attending 1531 different Victorian primary and secondary schools. I was very pleased to receive advice from the department of education that following the most recent easing of restrictions at 11.59 pm last night the department of education has now recommenced the full rollout of that program. I very much look forward to Smile Squad really leading not just the outcome for oral dental health improvement for kids now but, by getting these kids, making sure that we into the future generations deliver better oral health care for children and adults in Victoria.

Mr RICHARDSON: Can I take you to the interaction that this policy area has with the government commonwealth government, Minister. The commonwealth government recently announced a further one-year extension of the national partnership agreement on public dental services in the 2021–22 commonwealth budget. Can you explain for the committee's benefit how this funding compares and how it interacts with the state investment?

Mr FOLEY: Yes, I can. All the states asked the commonwealth to essentially extend the program for a minimum of two years on the basis that that would at least give us all some understanding that the national partnership agreement in this space would have some predictability and certainty for providers. The Victorian government and indeed other governments, from discussions with relevant ministers, were disappointed that the recent commonwealth budget maintained it just for a further year but maintained it also at the level of a 30 per cent reduction, which the first Abbott government budget, in 2014–15, delivered to that service, and where it has been maintained essentially, upon my advice—at that level—since. One year is of course better than no years, but the state's request for a two-year extension was not successful. Until such time as there is a genuine partnership, or perhaps a deeper genuine partnership, between different levels of government around how public oral health is delivered, the importance of this area of public health and oral health in particular will continue to be undercooked, and that is an issue of some concern, I am sure, to all Victorians facing the challenges of poor oral health.

Mr RICHARDSON: I want to take you, Minister, now to the topic of elective surgery, and I refer to budget paper 3 at page 59, acknowledging that a lot of this surgery is critical to the health and wellbeing of people. Could you please explain for the committee's benefit the funding that is outlined on table 1.14 and how this will enable more Victorians to get that critical surgery they need as soon as possible?

Mr FOLEY: Indeed. Thank you, Mr Richardson. So, again, I want to acknowledge, as I have a number of times during the course of today, the impact of the still ongoing pandemic on how we have delivered services. Last year, particularly in the very tough, lengthy restrictions that were in place, non-urgent surgeries were wound back for the ability to restrict movement in particularly high risk settings—that were put at risk during the spread of COVID throughout our community and particularly far too many health services. As a result of that, most category 2 areas of elective surgery were delayed, and that has been at significant cost to the impact on the Victorian community. Pleasingly, category 1 and some of the more urgent category 2 surgeries continued on and have continued throughout the process to meet all the benchmarks that we would seek from them.

In regard to this particular budget, there is $136 million to support the public health and hospital services to provide that catch-up elective surgery and ensure Victorians receive the surgery they need and that they get that as soon as possible. That builds on the foundation from the November—that being the 2021—budget, where an initial $300 million for an elective surgery blitz was put in place. That $300 million is estimated to deliver 34 800 elective surgeries to make a significant contribution to that catch-up. Whilst none of us will rest until such time as that catch-up is delivered and we deal with this very important issue for the wellbeing of those Victorians who are on the category 2 waitlist—not so much the category 3 but certainly the significant numbers on category 2—we need to make sure that this funding is used in the most effective way possible. The elective surgery waitlists as a result of that investment have at least now stabilised, and I look forward to this investment highlighting a further impact over time to bring those elective admissions down quarter by quarter.

There is some significant way to go on that, and our public health services have just delivered under 30 000 admissions in quarter 1 and a further 13 000 so far in quarter 2 in terms of the most recent figures. And that has seen a further, across the quarter, 44 000 elective surgery admissions. There is a challenging environment in this space, and the waiting time for category 1 I am very pleased was stable throughout this entire period. Almost all elective surgery figures published on the Victorian Health Services Performance website declined for quarter 3 in 2021 compared with quarter 3 in 2019–20. However, this is expected, as

patients whose care has been deferred are now receiving treatment, and that has to be a good thing. Improvements were observed in quarter 3 compared to quarter 2, and the number of patients treated and the overall percentage of patients treated within time also improved.

So what this particular investment, Mr Richardson and committee members, is all about is recognising the real implications that—having done the hard yards and sacrificed so much over the course of the global pandemic, which is still with us—the Victorian government is investing in to make sure that in so many areas, but in particular elective surgery, we make good on our commitment and address those issues as soon as we possibly can and give Victorians the quality care and hospital service admissions that they have rightly come to expect.

Mr RICHARDSON: Can I take you, Minister, to the $10.6 million that has been allocated to drive shorter waitlists and better outcomes from elective surgery. Can you explain for the committee's benefit this program and the details of this initiative?

Mr FOLEY: I can. Thank you. This investment of $10.6 million will complement the work on the elective surgery blitz by making sure that a same-day surgical model of service delivery—a model that has been particularly well established in comparable jurisdictions globally—is able to enable rapid patient transport and progress through the acute hospital system and deliver faster recovery. Fast-track reassessments of some 60 000 patients are expected to identify those who, as they get closer to their allocated surgical opportunity, can be redirected quickly to primary community care or indeed what preoperative care might be needed to get ready for surgery, or—if they have deteriorated, as is also far too regularly the case—that they can have that surgery fast-tracked. It is essentially a process of making sure that there is a deeper model of care for some 60 000 Victorians on this waiting-list system to make sure that they get bespoke, delivered and much more personalised opportunities for either alternatives, fast-tracking or preparation for elective surgery.

We know that the pandemic has driven assessments for how we deal with these historically high waiting lists for elective surgery. We know that this has created extra risks for patients, and we know that if untreated and unaddressed now, into the future it will deliver even higher risk and higher costs for our healthcare system. Looking to innovations like this, looking to new partnerships forged throughout our healthcare system as well as assisting in alleviating pressure points for elective surgery are important parts of this arrangement. Making sure that this investment will reduce waiting times and provide those Victorians the opportunity to ensure better health outcomes and a quicker process through the system is something that I think our health services are more than up for and indeed has helped identify some best practice models that might be able to be applied here in Victoria. We know that there are some patients who are receiving surgery when it is not clinically optimal for them, leading into poorer outcomes and exacerbating access and recovery issues for them.

This funding package also has a focus on patients receiving preoperative care when needed and so therefore avoiding deterioration that can lead to even more complex, high-cost and intrusive surgeries and indeed extend inpatient delays. This identification and fast-tracking of patients program, particularly those who have deteriorated, will in fact see many category 2 patients recategorised to category 1 to receive the care that they need. Based on the modelling and the work that has been done, we think this will assess and triage individually each of those 60 000 patients and might well lead to issues such as a change in clinical status and as a result of that better management options for how patients will be dealt with throughout that, including whether surgery in fact still represents the best option for them compared with alternative management options. It will lead, we predict, to better clinical preparation for surgery, making it both safer and more timely to get people through, and it will lead to resources required both during and after care being reassessed in such a way as to make sure that innovation is also at the heart of delivering our response to this significant input into addressing our elective surgery waiting lists. I think the some 60 000 patients, should this model be successful in achieving its goals, will provide really valuable learnings for how our system reforms itself into the future.

The CHAIR: Thank you very much, Minister. That concludes the time—

Mr D O'BRIEN: Chair, can I just make a quick comment?

The CHAIR: Mr O'Brien.

Mr D O'BRIEN: Can I please apologise to the witnesses for losing my temper earlier and also to you, Chair, and to the rest of the committee. But I would also like to say that I have lost any confidence in your ability to impartially chair these hearings. But I do apologise again for losing my temper.

The CHAIR: Thank you, Mr O'Brien. I was going to, on behalf of the committee, thank the witnesses for their time in what is a very busy and I am sure difficult and challenging time for all of you, and I apologise on behalf of the committee that you have been met with such unparliamentary behaviour, particularly that of Mr Newbury and his yelling, his feet on the table and his thumping of the table. I do not think any witness at any parliamentary committee should be met with that type of behaviour, and I also think it is extremely difficult and unfortunate for the staff and the secretariat in the gallery to witness that.

We do thank you for your time here today. We know how busy all of your schedules are. We also thank you very much for the swap and the shift that you did to accommodate the committee and to, to the best of your endeavours, provide answers to committee members' questions. We will follow up on any questions which were taken on notice in writing, and responses will be required within 10 working days of the committee's request.

Given some of the earlier issues which were raised at the start of this session, I have been provided with the numbers for Lifeline, which is 13 11 14; and the Sexual Assault Crisis Line, which is 1800 806 292.

The committee will now take a short break before moving to consideration of the child protection portfolio, so we thank all of you for your time.

Witnesses withdrew.