PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the 2022-23 Budget Estimates

Melbourne—Friday, 20 May 2022

MEMBERS

Ms Lizzie Blandthorn—Chair
Mr Danny O'Brien—Deputy Chair
Mr Rodney Barton
Mr Sam Hibbins
Mr Gary Maas
Mrs Beverley McArthur
Mr James Newbury
Ms Pauline Richards
Mr Tim Richardson
Ms Nina Taylor

WITNESSES

Mr Martin Foley MP, Minister for Health,

Professor Euan Wallace, Secretary,

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

Mr Chris Hotham, Deputy Secretary, Health Infrastructure, and

Professor Zoe Wainer, Deputy Secretary, Public Health, Department of Health.

The CHAIR: I declare open this hearing of the Public Accounts and Estimates Committee. I ask that mobile telephones please be turned to silent.

I begin by acknowledging the traditional Aboriginal owners of the land on which we are meeting. We pay our respects to them, their elders past, present and emerging as well as elders from other communities who may be with us today.

On behalf of the Parliament, the committee is conducting this Inquiry into the 2022–23 Budget Estimates. The committee's aim is to scrutinise public administration and finance to improve outcomes for the Victorian community.

I advise that all evidence taken by the committee is protected by parliamentary privilege. However, 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.

We welcome the Minister for Health, as well as officers of your department. We invite you to make an opening statement, which will be followed by questions from the committee. Thank you.

Visual presentation.

Mr FOLEY: Thank you, Chair, and thank you, committee, for the opportunity to appear before you today. On the first slide that we have, the Victorian state budget provides a $12 billion investment to further strengthen and reform a healthcare system that has provided high-quality care through an unprecedented global pandemic challenge. We will do this across six key areas: our COVID catch-up plan, investing in our workforce, delivering care closer to home, maintaining COVID services, continuing to improve care in regional Victoria and in health infrastructure.

Could we jump to the next slide? In regard to the sharp increase that we have seen in critical COVID patients, whether it is that aspect of disrupted care resulting in longer hospital recovery times or indeed people delaying seeing their GP, the past few years have taken a toll on our health system. Now we will rebuild that system, just like we have done before. We will ease the pressure on our hospitals by rolling out our pandemic repair plan for more staff, better hospitals and first-class care. There will be $1.5 billion for the COVID catch-up plan to increase surgical activity across Victoria to record volumes, easily exceeding prepandemic levels by some 25 per cent. Funding will also be provided for 40 000 extra surgeries in the next year as part of this process, building up to a total of 240 000 surgeries every year by 2024. This will be achieved through measures including Frankston Private Hospital becoming a public surgery centre delivering some 9000 surgeries per year; an investment to expand same-day, twilight and after-hours public surgeries and theatre improvements; $548 million for private hospital surgeries for public patients to deliver 51 300 extra non-urgent surgeries by June 2024; a series of new rapid access hubs performing a range of procedures—hernias, cataracts, joint replacements and a range of other measures—starting at centres at St Vincent's, at Broadmeadows, at the Heidelberg repat, at the Royal Women's, at Werribee Mercy, Sandringham, Peter Mac and Barwon; and a $20 million Surgical Equipment Innovation Fund. There will also be more than $80 million to deliver an additional 400 perioperative nurses, upskill 1000 nurses and theatre techs and recruit 2000 healthcare workers through a global workforce recruitment drive.

Jump to the next one. Victoria's healthcare workers have really carried us through the global pandemic. In addition to the workforce package provided for the pandemic repair plan, we will also invest a further $75.6 million in their capacity and wellbeing. This will be through a workforce package provided for in our pandemic repair plan, including a $59 million program that will see more than 1200 registered undergraduate nursing and midwifery students enter the workforce earlier, with supervision, over the next two years. It will also include $4.7 million for allied health advanced practice roles to uptake skilled allied health workers and to improve patient care, while $5.6 million will allow an additional 275 graduate enrolled nurses to hit the ground running in our hospital system with all the supports they need to do so. We will also invest to ensure more Aboriginal Victorians can get the care they need from nurses and doctors who understand their community history and culture. Importantly, we will also be expanding the healthcare worker wellbeing centre to the nursing and midwifery health program to provide one-on-one psychological support for nurses and midwives. There will also be a $5.6 million program for enrolled nurse transition-to-practice positions.

In regard to the next slide, slide 5, we will grow our workforce continually, as we have in the past. Since 2015 the number of doctors, nurses and other staff in Victoria's public hospitals has grown by 25 per cent. Growth continued during the COVID-19 pandemic, with approximately 10 per cent growth in the workforce between 2019 and 2021, and we have not finished yet.

In regard to care closer to home and the Hospital in the Home program, thousands more Victorians will now get access to our best clinicians and to our allied health professionals and nurses from their own homes through a $698 million package to expand the successful Better at Home program. We saw how much difference it made to Victorians who were able to get treatment and support at home during the pandemic, and that is why the program is going to become a permanent option for patients from here on. The investment will expand the program to help more than 15 000 Victorians access home-based care each year in addition to telehealth check-up systems. This package will extend the Hospital in the Home program beds that were established initially throughout the pandemic, increasing the capacity to some 358 virtual beds, providing ongoing care at home for Victorians so they do not need to go to hospital for treatment while still getting world-class care. That is the equivalent of running a major hospital like Footscray Hospital, to enable health services to perform more elective surgeries and to reduce long patient stays in hospital. A further $3.6 million will also be invested for continued delivery of the transition care program, a program which helps patients with a disability transition out of a hospital bed and into community-based accommodation while they unfortunately continue to have to wait in record numbers for their national disability insurance package to be approved. There will also be around $2.1 million invested in a pilot Aboriginal virtual specialist clinic. This will allow Aboriginal Victorians access to culturally appropriate health care and clinicians in regional and rural areas on country.

In regard to COVID care services, because the pandemic has still some way to go, we will keep supporting Victorians who test positive for COVID-19. $1.5 billion worth of funding will continue to support patients in recovery from COVID-19 and the support for our health system in continuing to address Victoria's COVID-19 case load, including establishing and expanding the urgent care centres, expanding general practitioner respiratory clinics that the state has established, and expanding and continuing the COVID-19 positive pathways program, as well as purchasing PPE for healthcare workers and securing a large critical care and pandemic workforce.

To ensure that COVID-19 patients have the best chance of full recovery, we will also spend $521.7 million to support our hospitals treating COVID-19 safely and effectively. There will be a $40 million investment for our local public health units to expand their role—established and tested through the global COVID-19 pandemic—to continue to provide local responses to public health challenges. There will also be $258 million to go towards the delivery of COVID-19 vaccines for Victorians due for their booster shots, with a focus on the most at-risk priority local government areas and at-risk populations to minimise the harm for these communities and to protect the wider health system. A further $110 million will fund the continuation of the nation-leading COVID-positive pathways program and extend the role of the GP respiratory clinics.

In regard to the regions, we are making significant investments right across Victoria. $300 million for the Regional Health Infrastructure Fund will improve access to quality care for regional and rural Victorians. It will fund projects ranging from theatre refurbishments to equipment upgrades. In addition to this, there continue to be new investments in Barwon Women's and Children's Hospital, Shepparton families will see better care for young children and there will be $25 million invested in early parenting centres in our regions. Residents in Mildura and the Mallee region will get support for drug and alcohol addiction through a $36 million investment

for a 30-bed residential rehab and withdrawal centre. Health services in Ballarat, Traralgon and Geelong will provide better care for cancer patients, with $11 million going towards new linear accelerators for radiotherapy. Patients in the west will benefit from a $6.5 million investment for robot-assisted surgery to deliver Ballarat hospital's improved surgery outcomes and reduce recovery times.

In regard to upgrading Victoria's hospitals—

The CHAIR: Sorry, Minister, I will just interrupt you there. The time for the presentation has expired. Mr O'Brien, the Deputy Chair, is eagerly awaiting his turn.

Mr FOLEY: Thank you very much. I will leave slide 9 for your edification.

Mr D O'BRIEN: Thank you, Chair. Good morning, Minister and team. Minister, as Minister for Health, have you now read the Ashton ESTA report?

Mr FOLEY: As you will be aware, Mr O'Brien, the ESTA agency is an agency that reports through government to the Minister for Emergency Services. Graham Ashton, former Chief Commissioner of Police, conducted an inquiry into ESTA's capability—

Mr D O'BRIEN: I am aware of the background, Minister. I just want to know whether you have read the report as the Minister for Health.

Mr FOLEY: My health department, and indeed I, had input into that Ashton report, and indeed insofar as that report then came through the normal processes to government, yes, I have read it.

Mr D O'BRIEN: When did you first receive it?

Mr FOLEY: In terms of the final report? In the same manner in which all cabinet members received the final report.

Mr D O'BRIEN: That was March?

Mr FOLEY: The final report? The final report went to cabinet in more recent times, but as I have indicated, I had input through the normal processes of government and particularly given Health's direct interest into the issues associated with ESTA's performance from the earliest of times of Mr Ashton's review. But in terms of the final report, it made its way through the normal cabinet processes, and as part of that I read—as indeed I am sure did all my other colleagues—the Ashton report in the normal manner.

Mr D O'BRIEN: So was that just Monday?

Mr FOLEY: Well, in the normal processes—

Mr D O'BRIEN: Well, no. You have told me it was received by the government in March. You got it recently in the normal cabinet processes. Was that Monday?

Mr FOLEY: Well, cabinet processes are of course confidential, Mr O'Brien.

Mr D O'BRIEN: You can tell me when it was. It has been released now. It is not that big a deal.

Mr FOLEY: But in terms of cabinet's consideration, the Victorian government, as the Minister for Emergency Services made clear yesterday, is accepting in principle or in reality all of the 20 recommendations, and as part of government I was part of that process.

Mr D O'BRIEN: When were you briefed on it by your department?

Mr FOLEY: In terms of the final report?

Mr D O'BRIEN: In terms of the report full stop.

Mr FOLEY: Given that we are in the health portfolio now, the implications for how the performance of ESTA impacts on the health portfolio is a significant issue. Over the course of the government having engaged

the former chief commissioner, you would expect the former chief commissioner, as he did, to reach out to government and to the various agencies—not just Health but certainly including health. Over the course of Mr Ashton's review I sought, and he welcomed, input from Health, and as the program of Mr Ashton's review of ESTA took shape there were a number of opportunities for my department to have input into it.

Mr D O'BRIEN: But I actually asked you when you were briefed by your department on it.

Mr FOLEY: On multiple occasions, in terms of the evolving position that Mr Ashton went through, as you would expect, from seeking initial information through to the preparation of his final report.

Mr D O'BRIEN: You became minister in late 2020 if I am not mistaken, Minister. The report makes it clear that the problems with ESTA have been there for a long time. Obviously, as you have just indicated, it is a spear point for the health system and has a huge impact down the line into your health department. When did you first seek advice from the department on what was causing the problems that were flowing through to your department?

Mr FOLEY: In regard to the challenges that the health department had, particularly the interface between Ambulance Victoria and ESTA and then through that to the health services, from the earliest of days after I became the Minister for Health, on the issues around how emergency departments and how Ambulance Victoria interface with each other and indeed through that relationship between ESTA and Ambulance Victoria, there would have been numerous discussions, briefings and opportunities with my department, with Ambulance Victoria and with health agencies—many, many discussions. Of course the critical issue is how do we most quickly, safely and effectively process people in the most timely manner through that pipeline of care and delivery of services in the safest and most effective way.

Mr D O'BRIEN: Thank you, Minister. Secretary, can I turn to you and turn to budget paper 3, page 66. Secretary, can you tell me the figures for the new Melton hospital and the Barwon women's and children's hospital for 2022–23? What has been allocated?

Prof. WALLACE: Thank you. So for Barwon women's we have been allocated an envelope of between $500 million and $525 million.

Mr D O'BRIEN: I specifically asked for 2022–23, Secretary.

Prof. WALLACE: The TEI is between $500 million and $525 million.

Mr D O'BRIEN: Yes, but for the next year and indeed for all the out years, both of them are listed as TBC, which I assume is 'to be confirmed'. There is no actual figure there.

Prof. WALLACE: No, and that is a normal planning process in terms of funding major capital.

Mr D O'BRIEN: So there is a TEI there, but, Secretary, in the 2016–17 budget there was exactly the same sort of line item in the budget for the national proton beam therapy centre. It was all TBC for the out years and had a TEI at the end. That has never proceeded. Why should we believe that either of these projects will ever proceed?

Prof. WALLACE: Well, the national proton beam therapy centre, as you might recall, that funding was contingent on partnerships with the commonwealth, and the commonwealth made decisions not to place the national proton beam therapy centre in Victoria but rather place it in South Australia.

Mr D O'BRIEN: So when we see something with TBC and TEI it does not mean it is going to happen.

Prof. WALLACE: They are quite different projects. One was contingent upon shared funding from the commonwealth government; this is Victorian government funding.

Mr D O'BRIEN: And these two are contingent on there actually being funding in the budget, and there is not.

Prof. WALLACE: But there is funding in the budget. We have TEI of between $500 million and $525 million for Barwon and between $900 million and $1 billion for Melton. That is Victorian government funding, not contingent upon commonwealth partnering.

Mr D O'BRIEN: No, I appreciate that, but the point stands. I will move on, Secretary. On pages 54 and 55 there are quite a number of items that are listed for 2021–22, and if you go to the column on the second page, page 55, at the very bottom, $3.5 billion is the total initiatives. Is that correct for 2021–22?

Prof. WALLACE: The $3.556 billion?

Mr D O'BRIEN: Yes. So just confirming: that is money that has already been spent?

Prof. WALLACE: I think the Premier responded to this in his PAEC hearing last week. This is money that—as you are familiar with—was identified in this current financial year which will be spent on those items across these years. For example, and I think the minister covered it in his introductory slides, there is significant funding for ongoing vaccine provision, for ongoing rapid antigen testing—

Mr D O'BRIEN: But, Secretary, sorry, the budget papers specify what is going to be spent in each year. That is why we have the four out years. The point is 2021–22 funding has already been spent or will be by the end of the year.

Prof. WALLACE: Again, I will refer you to the Premier's answers last Friday. This is how budget papers are put together.

Mr D O'BRIEN: Yes. Well, the point is $3.5 billion of the supposed of $12 billion extra spend has already been spent. Is that not the case?

Prof. WALLACE: No. Again, this is a normal structure of our budget papers which identifies funding across the continuum. The $3.556 billion is part of this financial year's—this FY22–23—budget.

Mr D O'BRIEN: Yes. This financial year, which ends at the end of next month.

Prof. WALLACE: No, no, the FY22–23 budget.

Mr D O'BRIEN: No, no. The line items I am talking about, Secretary, are in the 2021–22 column.

Prof. WALLACE: Yes.

Mr D O'BRIEN: You are not telling me that that means that is spending next year?

Prof. WALLACE: It is part of the planning for the budget that this hearing is about.

Mr D O'BRIEN: But, for example, to go to my point: rapid antigen tests, funding for vaccines—that has already been spent. I mean, that is something the Premier tried to tell me last week. It is not going forward; it is money that has already been spent.

Prof. WALLACE: No. So the money has been identified—and again it is about planning—for those items.

Mr D O'BRIEN: Of that $3.5 billion, there are 13 items there that list the commonwealth contributions. How much of that figure is funded by the commonwealth?

Prof. WALLACE: Under the COVID national partnership agreement the commonwealth will fund 50-50 of particular items, so symptomatic testing—and you might recall that last year the commonwealth funded all PCR testing. In January of this year they changed the access to commonwealth funding under the COVID NPA to symptomatic testing only, not surveillance testing. We have continued to provide some surveillance testing in Victoria. It has been a really important component of pushing down transmission numbers in Victoria.

Mr D O'BRIEN: Okay. I understand that, Secretary.

Prof. WALLACE: So—

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

Mr D O'BRIEN: Of that $3.5 billion figure, is it roughly 50 per cent commonwealth?

Prof. WALLACE: No. The COVID NPA is 50-50 for testing, for vaccines—and again, the commonwealth was quite discrete in the provision of the 50-50 for vaccine spend, so it was in new infrastructure from April 2021. The investments that the Victorian government had made in our own vaccine program prior to April were not accessible to the 50-50. So the 50-50 is related to—as you can appreciate, there are very discrete funding rules for what the commonwealth will partner with us for.

Mr D O'BRIEN: Sure. Perhaps can I ask on notice, then, if you could tell me what the $3.556 billion figure is—how much of that is commonwealth funded. Thank you.

Minister, if I can now turn to page 220 of the same document, budget paper 3, which is the health output by your department, and if you go to the bottom line, the total spend by your department, so the health department total, is $27 billion for the current financial year, dropping to $25 billion. Why have you cut $2 billion out of the health department this year?

Mr FOLEY: Well, of course we have not, Mr O'Brien.

Mr D O'BRIEN: Well, sorry, Minister—

Mr FOLEY: If you let me answer, perhaps, Mr O'Brien.

Mr D O'BRIEN: I have just demonstrated that you have.

Mr FOLEY: You have asked a question—if you would be so polite as to let me answer.

The CHAIR: Mr O'Brien, could you allow the question to be answered.

Mr D O'BRIEN: Well, you cannot deny what is there in black and white.

The CHAIR: Mr O'Brien, you do not have to agree with the answer, but you do have to allow the minister the opportunity to answer your question.

Mr FOLEY: Thank you, Chair. Of course budget papers express what was and is planned, and of course what has happened over the course of the last two years, particularly in the course of the global pandemic, is that in a range of ways the Victorian government has had to step into areas, as indeed all states have, that as a consequence of the commonwealth's mismanagement of a range of areas—

Mr D O'BRIEN: Sorry, Minister.

The CHAIR: Mr O'Brien—

Mr D O'BRIEN: No, no. Sorry, Chair—

The CHAIR: Mr O'Brien, could you please stop speaking over the top of me. The minister—

Mr D O'BRIEN: I have asked a specific question about the budget papers. I have given a reference. I have given an actual line item.

The CHAIR: Mr O'Brien, yes, you have, but you have not allowed the minister the opportunity to answer it. You are allowing him to get one or two sentences in before you start to disagree. Could you please allow him the opportunity to answer your question, whether you agree with it or otherwise, before you interject again.

Mr FOLEY: As a result, the Victorian and indeed other state and territory governments have had to step into areas, for instance, assisting the commonwealth in its vaccination rollout program. As a consequence of that one program, for instance, the Victorian government delivered more vaccinations, a higher proportion of vaccinations to its population, than any other state or territory. We did that right across regional and rural Victoria and right across metropolitan Melbourne to record levels compared to any other state or jurisdiction. That was as a result of the commonwealth's mismanagement of the primary care rollout of vaccinations, which

had hitherto been the agreed national arrangement via which vaccination programs were delivered. In addition to that, our testing program, both PCR and otherwise, also had to be delivered right across the state, as did compliance measures, as did a whole range of other communications methods and arrangements for the COVID-19 pandemic. As we have learned through our very high levels of vaccination, to safely live with COVID as much as we possibly can, the need for those programs has evaporated.

Mr D O'BRIEN: Okay.

Mr FOLEY: I do not think you or indeed anyone else would expect the Victorian government to deliver programs that performed a vital part of the COVID-19 response, but as the COVID-19 pandemic evolves, so too does our response. So programs that have rightly come to an end have been reflected appropriately in the budget papers.

Mr D O'BRIEN: Thank you. Secretary, can I go to page 239 of budget paper 3. You would be aware the Victorian Agency for Health Information reports on dental care. At the top of the page there under 'Dental Services', where it indicates 44 000 fewer Victorians will receive dental care because of a cut—which is at the bottom of the page—of $24 million, it indicates that the expected outcome is lower than the target for 2021–22 due to the pandemic. But the figures are exactly the same, so actually the figures are wrong. Was there simply a cut and paste that someone messed up? It initially says the target is 376 000, the expected outcome is 376 000, and yet the budget papers talk about the outcome being lower. What is the real figure?

Prof. WALLACE: Well, the budget papers are put together by our colleagues in the Department of Treasury and Finance, not the Department of Health. But I might ask Ms Geissler—

Mr D O'BRIEN: Presumably they do not make up the figures.

Prof. WALLACE: No, no, surely. I might ask Ms Geissler to talk about our dental services.

Ms GEISSLER: I am very happy to talk to this particular item, in particular that the Department of Health annual report has the correct figures, and the figures in the budget papers need to be amended.

Mr D O'BRIEN: So what is the expected outcome for 2021, for example, for persons treated?

Ms GEISSLER: The actual outcome for 2021—so the actuals column is what needs to be amended.

Mr D O'BRIEN: Yes.

Ms GEISSLER: 272 446.

Mr D O'BRIEN: 272 446?

Ms GEISSLER: That is correct.

Mr D O'BRIEN: Right. Minister, you know how important oral health is. You are bragging about a $12 billion investment. Why have you cut $24 million from the dental services budget? 44 000 fewer people, on your own figures here, are going to receive dental treatment this year, and we have already got enormous waiting lists.

Mr FOLEY: But of course your conclusion is incorrect, Mr O'Brien.

Mr D O'BRIEN: My conclusion comes from your budget papers, Minister.

The CHAIR: Please, Mr O'Brien.

Mr FOLEY: If you would let me perhaps finish, Mr O'Brien. The Victorian government is not cutting dental programs. What the Victorian government is doing—

Mr D O'BRIEN: It says it there in black and white, Minister—

The CHAIR: Mr O'Brien!

Mr D O'BRIEN: $24 million less.

Mr FOLEY: Well, with the greatest respect, Mr O'Brien—

The CHAIR: Mr O'Brien—

Mr D O'BRIEN: Well, sorry, if the minister is just going to make it up—

The CHAIR: Mr O'Brien!

Mr D O'BRIEN: Has he not read his own budget papers?

The CHAIR: Mr O'Brien, the minister has heard your question, and he is attempting to answer it. You do not need to keep repeating yourself to allow the minister to answer your question; you just need to afford him that opportunity.

Mr D O'BRIEN: Chair, if the minister—

The CHAIR: Mr O'Brien, your time has expired.

Mr D O'BRIEN: is going to deny what is there in black and white in the papers, I will cut him off.

The CHAIR: Mr O'Brien, you have not allowed the minister the opportunity to answer the question—

Mr D O'BRIEN: He says I am wrong. It is his budget papers that say it.

The CHAIR: and the minister may like to consider whether he needs to provide—

Mr D O'BRIEN: Explain it, Minister.

The CHAIR: Mr O'Brien, could you please control yourself? You are out of order—completely out of order. The minister was attempting to answer your question, and you cut him off to the detriment of your own time.

Mr D O'BRIEN: He was not. He was denying the facts.

The CHAIR: Mr O'Brien! The call is with Mr Maas.

Mr MAAS: Thank you, Chair. Thank you, Minister. Thank you, health team. I think it is an understatement to say the last few years have been extraordinarily difficult. Thank you for your very hard work, and indeed thank you to all healthcare professionals in this state. It has just been, as I said, an extraordinary time, and some very hard work has gone into keeping the state safe.

Minister, if I could take you to budget paper 3, page 54, I am interested in exploring the topic of elective surgery. I was hoping you would be able to explain the line item there that says, 'COVID catch-up plan'. What will that package mean for Victorians?

Mr FOLEY: Thank you, Mr Maas. In terms of your introductory comments, I join you in supporting this committee's support for our hardworking health professionals. But in terms of the elective surgery catch-up plan that was announced by the government, which is fully funded in this particular budget, we have seen at various points over the course of the pandemic both the category 2 and category 3 non-urgent surgery temporarily paused in both public and private hospitals—not just in Victoria but right across the country. As all restrictions were lifted earlier this year and as COVID hospitalisations then decreased and have now stabilised, and there now being no restrictions in place, we have sought to put in place a situation where we fund and support a recovery plan for elective surgery. We know that right across Victoria, indeed right across the country, these increases in deferred care throughout the course of the pandemic have seen waiting times for surgery increase to a point where significant trauma is being felt by many, many in our community.

In that regard earlier this year, earlier this month in fact, the Acting Premier at the time and myself went to Frankston Private Hospital to announce this catch-up plan. This is a plan that is designed to bring more resources and more effort into a sustained program to deliver more theatres for longer operating periods,

particularly around nights and weekends, bringing more nurses and trained clinicians over the course of the next few years into the system to lift the elective surgery capacity to some 125 per cent of our normal prepandemic effort. This, in terms of what is projected, means an extra 40 000 surgeries across the state every year.

As part of dealing with the issues associated with deferred care there will also be significant funding for the areas of cancer screening and allied health treatments to make sure that recovery happens faster and, wherever possible of course, avoid surgery altogether.

This is very much not a one-off funding package. It is a commitment to reform in partnership across the public and private systems how we deliver care for patients now and into the future. The funding will support levels of surgical activity to return and indeed exceed prepandemic levels and through that provide surgery to a targeted 240 000 Victorians per year as the capacity grows over the course of the forward projections by 2024.

In terms of specifics, this will include investment in a number of what we are calling rapid access hubs. It will include investment in the way operating theatres both operate and are configured so as to include safe but maximum efficiency. It will also have a particular focus on expanding same-day surgery models. It will also look to expanding the operation of those important assets of operating theatres in twilight and after-hours work, and it will also have a significant capacity to purchase additional private surgical capacity from the private sector. It will, as I have already indicated in the presentation, specifically go to an arrangement where Frankston Private Hospital will become a part of Peninsula Health and deliver a dedicated 9000 elective surgeries per annum to that wider south-east community.

But you have also got to have programs to equip and support those facilities, so there will also be significant investment in surgical equipment through the Surgical Equipment Innovation Fund, and we will also establish new units through our health services on the ground to deliver and coordinate patient support and non-surgical interventions so as to support patients through their journey.

So it is not just more of the same. It is more, but it is also about a different model of delivering surgery effectively and differently into the future so as to make sure that for Victorians who have gone through the global pandemic, deferred care is dealt with as expeditiously and as safely as possible. We will also do that in a way that prioritises those who are overdue and, on clinical advice, most pressing to be the first cabs off the rank, whilst indeed at the same time seeking to improve wider capacity across the related parts of both the public and private health system.

Really when it comes to elective surgery, in many ways that is a misnomer. No surgery is not important, but what this package will do is bring forward significant investment, significant capacity and significant infrastructure to address what is a major national issue as we deal with the consequences of the COVID-19 pandemic.

Mr MAAS: Thanks, Minister. Still on the COVID catch-up plan, I was hoping you could tell us more about the rapid access hubs that you referred to and the types of surgeries that they will be conducting. Maybe we will go to the Frankston Private Hospital; perhaps if you could explain the role of that hospital.

Mr FOLEY: Certainly, Mr Maas. So whilst delivering more elective surgery it is also about long-term improvements and system reforms that will build ongoing capacity to deal with these kinds of surgical needs for Victorians into the future. That is really what the public rapid access hubs are all about. These will exclusively deliver specific surgeries, all important but relatively high volume, in areas such as hernias, cataracts and joint replacements and a whole range of screening and other activities. These hubs will mean surgical theatres, equipment and staffing processes can all be brought together in a safe but streamlined manner that increases the number and effective delivery of these surgeries each and every day.

The hubs themselves, in terms of the health services that they will operate in, will effectively be quarantined from the impact of acute and emergency demands on them. Protected by those unpredictable emergency work arrangements, these hubs will have a much more predictable capacity to deliver low-complexity, high-volume but important procedures, whether it be cancer screening tests, gynaecological supports, hernias, gallbladder surgeries, joint replacements or a whole range of other important but, relatively speaking, increasingly uncomplex procedures.

They will be an important feature of how COVID has reformed our system, because what they will do is deliver higher public elective surgery throughput on an enduring basis. The rapid access hubs will seek to optimise capacity around building skills, processes and systems around sets of procedures that will limit equipment and staff changes safely but deliver effective surgeries around high-volume efficiencies, improved scheduling and utilisation of theatres, thereby increasing patient access with shorter waits, and improve the safety and quality, with procedures delivered where the best care is underpinning the whole approach. Each of the hubs will be informed by the disciplines and the particular areas in their community with the longest waitlists prioritised first—for example, this will include areas such as general surgery; urology; orthopaedics; ear, nose and throats; and gynaecological surgeries. The first eight hubs will be established through this budget in the next year at St Vincent's on the Park, Broadmeadows Hospital, Heidelberg repat, the Royal Women's, Werribee Mercy, Sandringham, the Peter Mac cancer centre and the University Hospital in Geelong.

In addition to that, as you asked about, in a Victorian if not Australian first, the Frankston Private Hospital—and I want to thank our partners in Healthscope here—will be transformed into a public surgery centre which will have the capacity to support up to 9000 public patients each year when fully operational in 2023. With no emergency departments as part of that facility and therefore its capacity to focus its healthcare workforce on these particular needs, this facility will focus on COVID catch-up care, meaning these patients will get their care faster. As part of that process two additional state-of-the-art theatres will be completed on site in Frankston by early next year to boost services at that dedicated centre and provide even more options than the current facility does.

It is the projections of our team, and funded through this budget, that by the 2023–24 year we will be running at 125 per cent of our prepandemic normal effort, as I indicated in my presentation, meaning some 40 000 extra surgeries within the next year, building up to that record level of sustained effort at some 240 000 surgeries every year in 2024. In addition to that we are in the process of purchasing more support from the private sector for public patients, and that will involve a $548 million investment building upon the collaborations that have been so central to getting us through the global pandemic. That will see 51 300 Victorians receive that kind of non-urgent but still very important surgery by June 2024.

My department has asked Peninsula Health, as the relevant local public health service, to work with our friends at Healthscope to transition that facility to public operations. We are working closely with Healthscope to make sure that the workforce, which we will need, will be supported to stay as part of the new public surgery centre. Healthscope are great partners and are committed to this project and to working through all of those details with Peninsula Health, and we thank them for their commitment. And of course this comes on top of previous investments to develop and expand Frankston Private Hospital to even higher levels than were originally planned when the initial $605 million investment was announced.

A key part of this elective surgery plan is to make sure that it drives long-term improvements and does so in a way that is sustainable. That is why I am very pleased that a highly renowned surgeon from the Royal Melbourne, Professor Benjamin Thomson, has agreed to become the department's chief surgical adviser, and he will work with the surgery recovery task force to provide the leadership in this clinical expertise and advice area. Currently at the RMH leading general surgical specialties in both the public and private areas, Professor Thomson is ideally placed to lead this important work, and I thank him in advance for the important work he will deliver on behalf of all Victorians.

Mr MAAS: Thank you, Minister. Partnerships with the private sector are critical as part of the recovery. Can I ask about what additional investments are being made within the public sector to maximise elective surgery activity in our hospitals?

Mr FOLEY: Whilst the partnership with the private sector is necessary to get us through, the core aspect of this plan is to expand the capability and the reach of the public health system as part of this process. As part of that plan opportunities across the public health services to improve the way surgical activity is dealt with will be at the heart of it. One of the key aspects is those highlighted eight rapid access hubs, and together with other measures there are a range of further opportunities. These go right across the state, well beyond those eight, increasing after-hours and twilight activity to optimise the use of the operating theatre capacity health services have, and we look forward to that process commencing in late 2022. Theatre hours will be extended particularly around twilight sessions and weekend activity. We will also consolidate low-complexity, high-volume surgeries where procedures around, as I have indicated, cataracts, tonsillectomies, hernias, hips, knees

and others, which account for some 19 per cent of all elective surgery, can be brought together in a more efficient delivery model. High-volume, same-day lists will also allow theatres to be delivered in an optimal way to increase the level of operations performed across the day, and indeed how theatres are effectively scheduled will also be a key part of how this project is funded in this budget.

Mr MAAS: Thanks, Minister. We are out of time. Thanks, Chair.

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

Mr BARTON: Thank you, Chair. Good morning, Minister and team. Budget paper 3, page 220: this year's budget results in an 11.2 per cent cut from the revised 2021–22 budget figures for alcohol and other drug treatment and prevention. I also note the government introduced a liquor reform Bill last year that made liquor far more accessible by enabling alcohol to be ordered online and delivered within minutes by untrained delivery drivers. Prior to this legislation being introduced the drug and alcohol treatment sector was already under immense pressure because between September 2020 and July 2021 the daily waitlist for treatment increased by 50.9 per cent from 2385 to 3599 Victorians. Minister, can you explain why, in a budget paper entitled *Putting Patients First*, the government felt it appropriate to cut 11.2 per cent from the revised 2021–22 budget figures for alcohol and other drug treatment prevention? I understand that this is the first cut to the sector in 17 years.

Mr FOLEY: Well, I understand your question, Mr Barton, but there has been no cut to the operational alcohol and other drug deliveries. What I can assure you is that there were significant cuts over the last 17 years, and they were most notably in the 2013–14 budget, which saw for the first time in the history of this state, as a result of those cuts, a reduction in the delivery of alcohol and other drug services and a mass exodus of workforce at the time, and that had a particular impact on regional and rural Victorians. So in regard to the assertion that there have been, firstly, cuts in this budget to alcohol and other drug services, I do not agree with that, but equally I do not agree with the assertion that there have not been historical cuts. There have been, and they were inherited by this government, which is why this government has invested over the course of the last eight years record amounts in alcohol and other drug support services, including in this budget the delivery of further residential rehabilitation and expansion of support through the investment of a facility in the northern Mallee in Mildura.

In regard to the particular matter that you draw attention to, it is very similar to the issue that Mr O'Brien highlighted in his question. What happened in the course of the global pandemic—which is still ongoing—across a range of services, including in alcohol and other drugs supports, was that the Victorian government put in substantial resources to ensure that, in the context of global pandemic restrictions, important support services could continue and indeed be delivered in a safe and particular manner. And in that regard, as we have come through that particular part of that phase of the pandemic, a whole range of investment areas have transitioned into ongoing support for not just alcohol and other drug support services but a range of mental health and other support services.

Whilst I am not the Minister for Mental Health, I do note that in the mental health portfolio—particularly when it comes to complex comorbidity areas specifically in mental health and other drug addiction, which is a complex interplay of circumstances as to which comes first—it is very hard to silo complex cases of addiction and mental health in the real world into budget papers and delivery of services. When you take into account the substantial funding that the Deputy Premier is delivering in the implementation of the royal commission's work in mental health; when you also take into account the substantial expansion that this government has delivered in residential rehabilitation and indeed in other day services; and when you take into account the coming to an end of the programs of specific, time-limited support to not just the alcohol and other drug sector but a range of areas in this and other portfolios to get sectors through that particular phase of the global pandemic, we will see ongoing and serious increased investment in how our alcohol and other drug service deliveries are performed in our state.

In regard to the issue of the delivery of alcohol and other alcohol services to Victorians through the other Act that you refer to, that falls beyond my portfolio but it certainly contributes to the wider issue of how we manage and deliver responsibly alcohol, which continues to be the most significant drug of addiction in our community.

Mr BARTON: Thank you, Minister. Certainly people who work in that area will have a different view to you about the funding. I will try this one: I note that this budget has discontinued the $25.62 million alcohol and

other drugs COVID-19 workforce initiative. This initiative provided an additional 100 full-time alcohol and drug treatment workers across Victoria as well as training and upskilling. Minister, can you explain why the government felt it appropriate to discontinue this funding investment in the alcohol and other drugs workforce initiative when there is a massive shortfall in the AOD and harm reduction workforce?

Mr FOLEY: Thank you, Mr Barton. That is one of the elements that I touched on in the first part of your question in terms of what was always understood by the sector as a time-limited set of measures which necessarily had to be constrained in how it operated in a remote and one-on-one delivery of support services during a particular phase of the global pandemic. The sector had always understood that that investment in services and people was time limited, and that particular investment program for that particular phase of the global pandemic is, as a consequence or as part of a consequence, coming to a conclusion.

That is not to say that investment in alcohol and other drugs supports is coming to a conclusion. What this government is doing, whether it be in residential rehab or whether it be in community-based or home-based services, is substantially broadening out how alcohol and other drugs services are delivered—I would hope increasingly in partnership with the specialist alcohol and other drugs service deliveries. One significant component that I have drawn the sector's attention to, and I think they welcome this measure, is how the Better at Home care program, which I touched on in my presentation, can bring together a range of service deliveries in a range of services, including in addiction services and rehabilitation, and can bring together allied health clinicians and community-based services in a new, exciting way that can bring the substantial resources that are currently, if you like, within the walls of a tertiary hospital into a more community-based supportive setting by the name of Hospital in the Home.

That is before you take into account the fact that this government has more than doubled the number of residential rehabilitation beds that we inherited, and has particularly done so in an appropriate therapeutic environment in regional Victoria—whether that be in Bairnsdale, in Traralgon, in Wangaratta, in Corio, in Ballarat and now with a program to expand that into Mildura. There have also been substantial expansions in the metropolitan Melbourne area of services.

So whilst I understand that the specialist AOD component of the delivery of this wider range of services is important, we know that the expansion and the reach through mental health, through the specialist delivery of services and through our investment in residential rehab and our investment in community rehab will see a substantial expansion of alcohol and drug services as part of a much wider set of service delivery programs right across the state. At least from my discussions with the peak body in the alcohol and other drug sector, they recognise and look forward to partnering with us in that important work.

Mr BARTON: Important work it is. Minister, Victoria currently has 0.74 residential rehab beds per 10 000 head of population, leaving us second last across the country. Victorian families are desperately resorting to private, for-profit rehabs, which can charge up to $30 000 per month and have little clinical treatment support or regulation. Minister, can you outline how this budget puts patients seeking assistance with risky addiction first?

Mr FOLEY: Certainly. Let me deal, firstly, with—you have made an excellent point in your question around this—the unregulated nature of the private rehabilitation providers. Whilst I will concede that there are, no doubt, reputable private providers, there are sadly too many disreputable private providers. The Abbott-Turnbull-Morrison government have been sitting on since 2014 a report that calls for the national, consistent regulation of those private providers. They are unregulated, and some of them take advantage of that unregulated status. I have been calling on successive commonwealth health ministers since 2015 to act on that report and to bring those private rehab operators into the same regulatory framework as the public sector operators right across the country. Sadly, after nine years, in government at a commonwealth level there has been no action at all in that regard, and that is a great disappointment and puts many people at risk, as you outlined in your question.

In regard to this government's investment in residential rehabilitation services, this is a government that has more than doubled its investment in resi rehabilitation services and has done so particularly when it comes to regional and rural Victoria. As I outlined, whether it has been outside of Bairnsdale, the youth facility that recently opened in Traralgon, the service that the Premier opened in Wangaratta, the services that have been opened in Ballarat and in Corio or the service that has been funded in Mildura in this budget, this is a

government that has more than doubled its capacity in this area. In addition to that, we have also worked to expand the community rehabilitation side of investment, because of course not everyone is in a position where either the detox in other circumstances or the rehabilitation support in resi rehab is appropriate. Community-based support is in many, many cases both preferred and desirable. We have also expanded support for those programs right across the community, and as I indicated in my earlier answer about the evolution of how rehabilitation services are delivered, we actually think there is a huge prospect for better outcomes and reform and closer partnerships between the specialist alcohol and drug sector, the mental health community sector and our hospital services, as outlined in the royal commission into mental health's report and as set out in partial support in our Better at Home care.

So taking all of those factors into account, I agree with you that the private sector non-regulation of rehabilitation services is nothing short of scandalous and needs urgent national attention by whoever is the next commonwealth health minister. Whilst of course we can always do more in rehabilitation services, I think this is a government that has a significant record of achievement in resi rehab, community rehab and broadening out the rehab capacity of the wider health service.

Mr BARTON: Thank you, Minister. Thank you, Chair.

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

Ms RICHARDS: Thank you, Minister and officials as well, not just for appearing here today but again for the service that you provide the Victorian community. I would like to explore Better at Home—and it is actually a good segue from Mr Barton's questions as well, I think. Budget paper 3, page 54, outlines the government's significant investment in the Better at Home initiative. Could you please provide some additional detail for the committee on this funding and the benefits it will provide to the Victorian community?

Mr FOLEY: Thank you, Ms Richards. I am more than happy to detail the important and continuing work that Better at Home is delivering, which will be a significant learning from the global pandemic about how we can deliver better health services right across our state. The investment of $698 million over four years to expand the home-based and virtual care components of the Better at Home initiative will mean that, in the security of people's own homes, they will get access to the best clinicians, allied health professionals, nurses and community and other supports. What this investment does is extend the Hospital in the Home beds that were initially established in response to the global pandemic and increase that capacity to the equivalent of 358 virtual beds. That will mean that those Victorians will not have to go to hospital for treatment. From July 2021 to the end of the 2021–22 year some 12 800 patients will have been supported by the Better at Home package, and this investment will expand that program to help more than 15 000 Victorians access those home-based care opportunities every year—and that is in addition to the increasingly normalised telehealth checks that both primary care and indeed the state systems of check-ups are using, including interestingly and in a very important way through our virtual emergency departments.

We are learning from the impact that COVID-19 has had on our system that there can be better and different ways of delivering a model of care that in so doing can improve that level of care to thousands of Victorians. This funding of $698 million will in particular deliver support for embedding and expanding home-based services and the virtual model of care to, as I have indicated, some 15 000 Victorians. That indeed will also have as a component of it investment to reform home-based and virtual care for particularly at-risk Victorians. As I indicated in my presentation, it will pilot and scale a virtual clinical model providing Aboriginal Victorians, in partnership with the Victorian Aboriginal community controlled health organisations, access to culturally safe specialist appointments and support on country—particularly important given that Indigenous Victorians tend to be over-represented in non-engagement with more traditional health services. It will also include a $3.6 million investment to, as I pointed out in my presentation, bring forward and scale up transition accommodation models between health services and disability providers in an attempt to, in a way, pay twice for the services that the Victorian government are already paying for, as we pay for the national disability insurance scheme as part of its operation but still see hundreds of Victorians who are medically able to be released from hospital but, because of the failings of the commonwealth and the NDIS, are stuck in our health services for many, many days, if not, in some extreme cases, years. The combination of these measures will not just provide better service delivery to these Victorians in a safer and more accessible and supported home environment—always determined by clinical risk decisions—but will also free up what would otherwise be beds that those Victorians would use in our hospital services. The initial work that we have seen at Better at

Home reflects that the program is improving access to a range of care at home, including everything from chemotherapy, post-surgical care, rehabilitation and other services, and it will also mean that the particular model of care can be increasingly individually tailored to the needs of individuals and their family, cultural and particular services.

Reports that we have had done also reflect that recovery in familiar surroundings is quicker and reduces the risk of complications, particularly in older and frail Victorians when it comes to falls, which are a major risk still in our tertiary hospital settings. And we have seen in the targeted areas—it is not for everything, but it is for an increasing number of things—that Better at Home is associated with better outcomes. It improves the progressive functional work of particularly elderly Victorians who have accessed the service, and it shows some positive signs in perhaps addressing some of the cognitive decline that we see with overly long stays in hospital with some people. It will, through the home-based and virtual care improvements, strengthen the position that we in Australia have, if not, I would argue, perhaps more significantly on a global level, from the improvements that home-based care enables us to have. The range of services that Better at Home is increasingly looking at and delivering includes home-based chemotherapy, and that is particularly important given the impact that that can have on people's immediate sense of feeling unwell; and peri-operative care—patients recovering from surgery. We have also seen, particularly for communities that have been over-represented in poor maternal health and antenatal outcomes, some really important initial benefits of targeted support through community supports, particularly for CALD communities, in maternity and antenatal care. It will also have an increasing rollout for infections and diabetic wounds. Importantly it has now also been expanded into a series of ongoing chronic illnesses such as cystic fibrosis. Geriatric care for people with medical conditions related to ageing will also be an increasing part of the focus.

We know that this will be an important contributor in dealing with the ongoing and unrelenting pressures that our healthcare system is under. New models that take advantage of technology but bring the models of care with them are really important. As we have indicated, this is the equivalent of 358 virtual beds. That is the equivalent of the old Footscray Hospital, and it will no doubt, I would like to think, add a valuable further tool to our healthcare system. I want to particularly thank the clinicians, the allied health practitioners, the nurses and those many thousands of Victorians who have come forward to build and deliver this important model of care, which I think will become an important part of our ongoing model of care well into the future.

Ms RICHARDS: Thank you, Minister. It is well known that the pandemic has placed significant pressure on hospitals and obviously the ability to undertake elective surgery, so I am interested in perhaps exploring and understanding what this investment will do to assist with safely increasing elective surgery activity.

Mr FOLEY: Thank you. The impact on elective surgery by the global pandemic has been significant. We know that this particular approach to Better at Home will be one factor, but an important one, in how we respond to it. The provision of home-based and other virtual care supports in this initiative will really release capacity to assist in these performance measures, which will enable healthcare services to perform more elective surgeries by freeing up bed capacity in those health services. The advice that I have received from my health agencies points to that in 2021–22 that is the equivalent of some 204 beds. The projections for the 2022–23 year are that that will be the equivalent of some 236 beds freed up, and by 25–26, as I have indicated, that will be some 358 beds essentially freed up for other uses in our hospitals and health networks. So, 1262 hospital beds will be freed up through home-based care, including 236 from the Better at Home care and the 100 beds that are forecasted from transitional care for people with disabilities that I touched on.

The Better at Home initiative will of course need additional staff capacity, and it will increase the hours that staff, as well as new staff, are able to deliver services. I know that that will be a demand on them, but what we have seen over the course of the global pandemic and the rollout of this program is that staff have enthusiastically taken to this new model because it delivers better outcomes.

Ms RICHARDS: Thank you. Of course there is always great interest in the impact on regional and rural Victoria, so could you outline perhaps how regional Victorians will be able to access Better at Home and the benefits that this new model will have for those living in regional and rural areas?

Mr FOLEY: Of course. Making sure that patients can have the choice to recover in familiar and supported environments rather than in a hospital environment is something we want to make available right across the state. Improving patient outcomes and experiences is at the heart of that, and we want to make sure that home-

based care providers get that opportunity to support families in their rest, recovery and their mobility at home. It can also need supports around how infection can be a greater risk the more you travel, and regional Victorians disproportionately have to travel for access to their hospital care and support services. If we can improve that physical side of their recovery and reduce the amount of travel they have to do, then everything—their physical deterioration, sleep disruption and social isolation—is capable of being improved, and we do have some positive indications that that is the case. When it comes to making sure that those important services are available to regional Victorians, who would otherwise have to face the need to spend disproportionately long periods away from their families and communities, this program can have particular benefits for our regions. Our local health services are working in collaboration with other health services right across the new partnerships models that have also evolved from the global pandemic, and I am pleased that some 25 regional health services across Victoria are now receiving direct Better at Home care funding to deliver that support right across our regional and rural communities. We know that all of our eight healthcare partnerships across the state, which is that coming together of the geographic areas of the public health services to deliver better care, will now have access to this. These services will deliver, particularly in our five regional health service partnerships, this model in the Barwon south-west, in the Grampians, in the Loddon-Mallee, in the Hume and in the Gippsland regions, so I look forward very much to regional Victorians perhaps increasingly and at growing levels taking opportunities from Better at Home and sharing the benefits that that will bring in models of care to their communities.

Ms RICHARDS: I do not have long left, so perhaps we could just very lightly touch on support for Aboriginal Victorians. In budget paper 3, page 56, there is discussion of piloting a virtual specialist clinic to enable Aboriginal Victorians to access care on country. Just in that short time, I am wondering if you can provide some details on how that will provide culturally safe and appropriate care?

Mr FOLEY: In important discussions that we have had with the Victorian Aboriginal community controlled health organisations we have allocated $2.1 million to invest in a pilot model of what a virtual specialist care clinic would look like for our community-controlled health organisations, all designed to deliver culturally appropriate, safe care in a regional setting. This model was codesigned with the VACCHOs, and it puts Aboriginal Victorians at the centre of that care. It will seek to ensure that special advice is maximised and appropriate care is provided through Aboriginal healthcare workers attending appointments to support, coordinate and get Victorian Indigenous communities increasingly into this system. This gives me an opportunity to particularly thank VACCHOs right across the state for their efforts over the last two years. They have, other than the ACT, delivered the highest levels of Indigenous vaccinations and amongst the best outcomes of health protection over the course of the global pandemic in the nation to their communities, and this program will seek to build on that.

Ms RICHARDS: Thank you, Minister.

The CHAIR: Thank you, Minister. Mr Newbury.

Mr NEWBURY: Thank you. Mr Hotham, a number of your team have spoken to me about having a target of preparing two to three events for the minister each week. How was that target agreed-upon?

The CHAIR: Mr Newbury, could I remind you that your questions need to relate to the budget estimates, please?

Mr NEWBURY: They absolutely do. The use of departmental staff is entirely within scope.

The CHAIR: Mr Newbury, we are here to consider the budget estimates. I would appreciate it if you could relate your questions to the estimates process for the benefit of this inquiry and the benefit of the report this inquiry will deliver.

Mr NEWBURY: Chair, they absolutely do, and Mr Hotham's use of departmental staff—do not try and cover it up—is entirely within scope. Mr Hotham, how was that target agreed upon?

Mr MAAS: On a point of order, Chair.

The CHAIR: Mr Maas.

Mr MAAS: I was just after a budget paper reference.

Mr NEWBURY: There is no budget paper reference. The use of departmental finances—

Mr MAAS: Is there a reference? Is there a reference in the presentation, Chair?

The CHAIR: Mr Newbury, I would appreciate if you could provide a relevant reference.

Mr NEWBURY: There does not have to be a reference.

The CHAIR: Mr Newbury—

Mr NEWBURY: There does not have to be a reference.

The CHAIR: Mr Newbury—

Mr NEWBURY: Chair, this is a Labor protection racket. Do not use your position to protect the minister.

The CHAIR: Mr Newbury, please do not speak to me in that fashion.

Mr NEWBURY: Well, that is what you are doing.

The CHAIR: Mr Newbury, I would appreciate it if you could allow me to chair this meeting, rather than aggressively speak over the top of me and point at me in the way that you are.

Mr NEWBURY: I am not speaking aggressively. Do not use words that are inappropriate.

The CHAIR: Mr Newbury, you are out of order and your question is being ruled—

Mr NEWBURY: Just because you say it does not make it true.

The CHAIR: Mr Newbury, could you please stop interrupting the Chair as I am attempting to make a ruling? You are out of order and your question is out of order, and I ask you to move on to a question that would assist this inquiry into the estimates process, please.

Mr NEWBURY: Well, I will note that department staff have made complaints about being forced to prepare—

The CHAIR: Mr Newbury!

Mr NEWBURY: You can say all you want—being forced to prepare photo opportunities for the minister.

The CHAIR: Mr Newbury, you are out of order.

Mr NEWBURY: Well, I am sure the media are going to be chasing this one up, Martin.

The CHAIR: Mr Newbury, you are out of order. I would ask that you please provide a question to the witnesses that is within the scope of this inquiry and would assist this inquiry in its consideration of the estimates.

Mr NEWBURY: Professor Wainer, have you received advice from the public health team in relation to the reintroduction of mask wearing?

Prof. WAINER: I would probably defer that to the minister given the decision-making that goes with it.

Mr NEWBURY: No, I asked if you had received the advice.

The CHAIR: Mr Newbury, it is not for you to determine who is the most appropriate witness to answer the question. The witness has advised you that that is an answer that will be provided by the minister, and the minister should have the opportunity to respond to your question as is appropriate.

Mr FOLEY: Thank you, Chair. As colleagues will be aware, the legislation that passed the Victorian Parliament for the *Public Health and Wellbeing Act* reframes the processes whereby what are now called pandemic orders are determined by the minister. The minister is obliged to seek the advice on all orders from the chief health officer and by extension the public health team, and the minister also has the opportunity to take into account other factors—economic, social, mental health and other arrangements. We know that over the course of the global pandemic there have been a range of orders in place around the use of masks. They are all tabled in this Parliament. They are all published on the internet.

Mr NEWBURY: Minister, I asked if advice been received on the reintroduction of masks. I did not ask for a history lesson or filibustering.

The CHAIR: Mr Newbury, could you please—

Mr NEWBURY: Has advice been received—yes or no?

Mr FOLEY: In regard to all advice that has been received, it is all published, it is all on the record and it is all tabled on the website of the Parliament of Victoria and the department's website, and in regard to any advice that I have received, it is obliged to be tabled within seven days. It is all there on the record. If your question relates to whether there is advice to reintroduce mask mandates, I would just point out that there are currently obligations in high-risk settings to wear masks, particularly in regard to health care and other at-risk settings. In regard to the important role that masks play in those settings, we know that they play an important role. What we also know is that we are moving from one set of arrangements of the global pandemic and one phase of the global pandemic to one that the public health advice rightly calls out where responsibility and opportunities to manage—

Mr NEWBURY: Minister, have you requested advice on the reintroduction of masks—yes or no?

Mr FOLEY: Well, that was not the original question that you asked.

Mr NEWBURY: Well, I am asking you another one now.

Mr FOLEY: Well, I have yet to finish answering the first one, and I am happy to answer—

Mr NEWBURY: Because you are filibustering on purpose. I mean, you are using the time to filibuster on purpose.

The CHAIR: Mr Newbury, you are the person who is wasting your time.

Mr NEWBURY: No, Labor Chair. I mean, sit there as a Labor Chair if you want, but I mean, you are being ignored.

The CHAIR: Mr Newbury, please. You have just said that you are ignoring the Chair, and I would ask you—

Mr NEWBURY: I am ignoring the Labor Chair, absolutely, because you are using your job as a card-carrying Labor member. I mean, it is clear for all to see.

The CHAIR: Mr Newbury, I would ask that like all members of this committee and any other parliamentary committee, you give the due respect to all committee members, witnesses and the Chair as is appropriate.

Mr NEWBURY: But when you use your role in a partisan position—

The CHAIR: Mr Newbury, please do not interrupt me. When you ask a question or put a proposition to those who are before us, you need to allow them the opportunity to answer it. And as I have said on a number of—

Mr NEWBURY: The minister would take 18 minutes if he could to answer the question.

The CHAIR: Mr Newbury.

Mr NEWBURY: It is a tactic; he does it in question time every day. Sitting there and saying otherwise does not make it so; it means you just delay the Chair.

The CHAIR: Mr Newbury, please do not yell over the top of me.

Mr NEWBURY: I am not yelling over the top; I am using my voice.

The CHAIR: Mr Newbury, you were yelling over the top of the Chair, while the Chair was attempting to control this committee.

Mr NEWBURY: No; just using words does not make them so.

The CHAIR: Mr Newbury, you asked a question; the minister is entitled to answer it. As I have said on a number of occasions this week, you do not have to like or agree with the answer, but you do have to give those who are—

Mr NEWBURY: I do not like the fact that you are a Labor Chair, but here we are.

The CHAIR: Mr Newbury, you do have to give the witnesses an opportunity to respond to your questions and propositions, without interruption, please.

Mr NEWBURY: Have you requested advice, Minister, on the reintroduction of mask wearing?

Mr FOLEY: As I was answering before I was interrupted, the process of advice being presented, and not only advice but reasons for decisions and not only reasons for decisions but the impact on the human rights of Victorians of those decisions, are all tabled and are there for all Victorians to see, making the Victorian government's approach to the ongoing management of the pandemic the most transparent and accountable in the country, I would argue, if not the world. So in terms of the specifics that Mr Newbury raises in regard to proposals or mandates or advice, to be clear, there are no proposals to extend the wearing of masks before the Victorian government or me as a minister.

Mr NEWBURY: Thank you.

Mr FOLEY: There are no proposals.

Mr NEWBURY: You have answered the question, Minister.

The CHAIR: Mr Newbury.

Mr NEWBURY: Stop using your position inappropriately, Chair. It is embarrassing.

Mr FOLEY: But there continue to be recommendations around safe social distancing, and in circumstances where you are required to wear masks to continue to do so. Where Victorians increasingly take into their own control—

Mr NEWBURY: Okay, you have filibustered enough now. Come on.

Mr FOLEY: be they individuals, workplaces, sectors or communities, to transition from one set of arrangements of COVID management to this set of arrangements, where responsibility is devolved to communities—

Members interjecting.

The CHAIR: Mr Newbury and Mr O'Brien, you asked a question; the minister is entitled to answer it.

Mr NEWBURY: Okay. Secretary, for the last reporting year how many Victorians were removed from the elective surgery waiting list?

Prof. WALLACE: I will get those numbers for you. In 2020–21 there were 163 628 surgical admissions from the elective surgical waiting list, and the estimate for the current year, 2021–22—obviously those numbers will be reconciled subsequently—is about 164 168.

Mr NEWBURY: Thank you. And how many of those people were removed because they had passed?

Prof. WALLACE: Apologies. The numbers I have given you—the 163 628 for 2020–21 and the 164 168 for 2021–22—are the numbers of patients admitted to our hospitals for elective surgery, and they then come off the list for that reason.

Mr NEWBURY: Yes.

Prof. WALLACE: These are admissions. We do not have reported to us from hospitals the numbers that you have asked for.

Mr NEWBURY: You do not have any record of how many are removed for reasons of passing?

Prof. WALLACE: No.

Mr NEWBURY: Can I take you to page 220 of budget paper 3, Secretary: funding for outpatient clinics and the $160 million cut in that line item—can you see that?

Prof. WALLACE: It says 'Non-Admitted Services'.

Mr NEWBURY: Yes. Why has there been a cut in that funding?

Prof. WALLACE: There are no cuts to outpatients. Obviously the 'Non-Admitted Services' is a capture of a whole list of activities—community, palliative care episodes, specialist outpatients. To go to outpatients specifically, the target for the actual number of specialist outpatient clinic appointments in this coming financial year, 2022–23, is 1.975 million, exactly the same as was the target for the current financial year—1.975 million outpatient episodes. So there has been no cut to outpatient services funding in the current budget.

Mr NEWBURY: Other than the fact that it is stated in black and white in the budget.

Prof. WALLACE: No. As you know, that is the total output funding for non-admitted services that include outpatient services, community palliative care services and post-acute care et cetera, et cetera. As the minister touched upon in his introduction, and actually across a number of the questions already, our health system is in flux so we are moving to a system that is providing care—we hope and intend—more meeting the needs of individual Victorians. So Hospital in the Home and the Better at Home package are about providing virtual care, in replacing care that would be in outpatient. For example, during the pandemic—and I think we have actually discussed this at this committee in the past—our colleagues at Monash Health moved 70 per cent of their antenatal appointments to virtual care. Women had 70 per cent of their pregnancy care appointments actually at home or in the office rather than attending the hospital, so that has changes to funding. I think if you are to look at the total funding for specialist outpatients, it is not just the non-admitted services, it is also Better at Home and other funding lines, because it is the total approach to funding both admitted and non-admitted services in a system that is in transition.

Mr NEWBURY: Thank you. Has the department got any modelling around the numbers of what they call the hidden waiting lists? The people who have gone to a doctor and they have an issue—they have got a problem—and they are waiting for a specialist appointment before they are put on to the elective surgery waiting list. Is there any departmental understanding of how many people are in that wait, for want of a better term?

Prof. WALLACE: Just so I understand your question, these are patients who have attended the general practitioner and then have been referred from the GP to a public hospital specialist clinic and then are waiting for that appointment?

Mr NEWBURY: Yes, that is right, and they are not yet on the elective surgery waiting list because that appointment has not occurred. It is called the 'hidden waiting list'—some people refer to it as such. Has the department got any modelling around that?

Prof. WALLACE: No, we do not. We do not have oversight of the numbers of patients waiting for an outpatient appointment. I would say, though—and again it was touched upon by the minister earlier—that the approach that we have taken to the recovery and reform program for elective surgery fundamentally addresses

some of those questions. I think there are opportunities for us, as there are in other jurisdictions, to ensure that patients receive the best possible care. If I use musculoskeletal as an example, traditionally GPs would refer patients to our orthopaedic clinics and they would see an orthopaedic surgeon and then, where appropriate, be listed for a knee replacement, a hip replacement or whatever. We now know that about 40 per cent of those individuals actually, if they had access to very high quality physiotherapy, would avoid surgery altogether. So one of the—

Mr NEWBURY: So the answer was: no, you do not have any.

Prof. WALLACE: One of the packages of the program is to realign care to better meet the needs of Victorians so that actually the referrals will come into a continuum of care program rather than necessarily seeing a surge in the first instance, if that makes sense. But we do not hold waiting list numbers for clinics—

Mr NEWBURY: I asked about modelling, but the answer was no. Can I take you to budget paper 3, page 54, Secretary? I note the secretary of the Police Association, Wayne Gatt, finding that around North Richmond, crime, including theft and property offences, has increased as addicts flood to the safe injecting room in Richmond. In the budget reference I just referred to you have listed 'Investing in a thriving North Richmond'. Is increased drug use the reason behind the word 'thriving'?

Prof. WALLACE: Oh, no, I think that is a mischaracterisation. As you know, the North Richmond service has been a highly successful medically supervised injecting service, and this is an investment—

Mr NEWBURY: When I went outside there it was like a war zone.

The CHAIR: Mr Newbury, could you allow the Secretary the opportunity to answer your question without interruption, please.

Prof. WALLACE: There are almost 5000 overdoses that have been well managed by that service. There are hundreds of Victorians alive today that would not be alive today had it not been for that service. I think by anyone's measure that is a highly successful service in North Richmond. We now have people diagnosed with hepatitis C on antivirals for genuine treatment. This will eradicate hepatitis C from those individuals, and many of those individuals will avoid getting liver cancer because of that and will live. This is a highly successful program. I think the continued investment from government is a reflection of just how successful that program has been.

Mr NEWBURY: Thriving, it seems.

Prof. WALLACE: Well, it is an investment. To go to some of the questions and anxieties that you and others have had around the environments of the facility—to make sure that those environments not only meet the needs of the clients of the service but also of the local population—I think there has been significant investment there to improve the environs.

Mr NEWBURY: On that point, has there been any recent investment around the Yooralla building in Flinders Street in that soon-to-be-thriving part of the city?

Prof. WALLACE: No. We have not undertaken any further investment in that building to date.

Mr NEWBURY: Thank you. Can I take you also to page 54 in relation to 'Equitable cancer care and prevention'? Obviously I think we would all agree that early detection and prevention is critical. Are you concerned about the rapid drop-off of cancer screenings due to the COVID restrictions?

Prof. WALLACE: Did you have any particular cancer screening in mind?

Mr NEWBURY: Well, I know that there have been issues with things like bowel cancer.

Prof. WALLACE: The three most significant cancer screening programs that we have are for bowel cancer, breast cancer and cervical cancer. Cancer Council Australia have expressed anxieties that people have not been coming forward. In terms of cancer screening provision, BreastScreen Victoria will screen more women this year than they screened last year and in the coming year will screen more women again, so there has not been a fall-off in breast cancer screening.

Mr NEWBURY: Thank you.

The CHAIR: Thank you. Mr Newbury's time has expired. We might take this opportunity between members to have a 15-minute break and resume at 10.27 am.

I will reopen this hearing of the Public Accounts and Estimates Committee with the health minister and the portfolio of health, and I will give the call to Ms Taylor.

Ms TAYLOR: Morning, Minister and officials. Thank you for your time today. I also echo the sentiments of my colleagues in expressing gratitude for your service to community, particularly noting the extenuating circumstances of the pandemic. If we could explore the pilot program for patients awaiting NDIS packages, I understand that many hospital patients with a disability experience delays to being discharged while they wait for accommodation and care arrangements to be formalised under the federal government's national disability insurance scheme. How does the pilot model between health services funded as part of this initiative support these patients?

Mr FOLEY: Thank you, Ms Taylor. In answering that, just let me say how fundamentally disappointed we are that we have to deliver this scheme, because of course these are patients that have been cleared to leave our health system. These are patients that should be cared for in the community. These are patients that the Victorian community and the Victorian government have already paid for more than twice. We are paying for their care in the health system, and we have already made significant contributions to the national disability insurance scheme. But as a result of the commonwealth's mismanagement of the national disability scheme both here and in other states, these are people who are stuck in our healthcare system because they are yet to have either a care or a housing package approved by the NDIS. This is a significant problem. I did note that it got some media coverage this morning. Indeed we are talking about, from the most recent survey, 208 people in our health services who should be cared for in the community through the NDIS. I know that that has got as high as 260. This is not just for a day or two. The average stay for acute patients is 118 days. These are people who have been cleared and, on average, for 118 days are stuck in hospital because of the commonwealth's mismanagement of the NDIS.

In mental health it is even longer. There are cases of mental health patients approved for the NDIS support—eligible—who have been in the system for years, stuck in our healthcare system when the NDIS's failings mean that families and carers have no choice but to continue to have them looked after in our health system. Really it is a matter of concern that all states have repeatedly raised with the commonwealth, with the NDIS and with the relevant commonwealth health and disability ministers to no avail. So faced with this, the Victorian government has had to step in yet again to clean up the commonwealth's mismanagement of their responsibilities. As a result, this particular scheme is around building that capacity for those people who are really looking at how they can deal with the chronically underfunded NDIS from the federal government to nonetheless partner with disability providers and healthcare services to get them into more appropriate supports. We have had to do this despite all states having written to the commonwealth and raised with successive disability and health ministers this important need to fix the NDIS. As I have indicated, the current 208 figure is spread across 21 health services across the state, and those 208 are ready for discharge but have no NDIS pathway out of the health services.

What this transitional care program for people with disability will do is build, in addition to the care that they have received in the state health system, a new model of care—that should be the responsibility of the national disability insurance scheme—to get those clinically well patients discharged but, in partnership between health services and disability providers, deal with particular circumstances of their care. It will seek to address the extended hospital stays and to minimise those by ensuring that through the partnership with specialist disability providers we bring the level of person-centred care that they are entitled to. In effect we are having to deliver on the promise of the NDIS for the commonwealth again. It is making sure that addresses practical things like permanent accommodation, like care and life support for them in partnership to transition into the community.

So far this pilot program has supported 34 patients to transition out of hospital. That itself, given those averages, has freed up some 1300 bed days in the system, but given the level of demand from NDIS-eligible patients we sadly see this as having some way to go. Whilst I am hopeful that this program will free up more beds and that our health services will continue to support NDIS-eligible patients into the community, what we really need is a solution to this at source. A solution to this at source is not our healthcare system having to do

the job for the commonwealth. It is not Victorian taxpayers having to pay twice for both the healthcare service and our substantial investment in the NDIS. It is in fact the commonwealth stepping up and delivering on the promise of the NDIS and stopping its cuts to that service and that system, thereby addressing at source the problems that the NDIS is beset with, one of the expressions of which is these current 208 Victorians eligible for support, ready to go into the community but unable to do so.

Ms TAYLOR: Thank you. I think it would be helpful to now move to budget matters associated with our health workforce, so if I could refer you to budget paper 3, pages 54 and 56, and also to some of the references you made in your presentation. Could you please take the committee through some of the initiatives the government has invested in with respect to expanding the Victorian health workforce?

Mr FOLEY: Certainly. So in regard to the important work that our healthcare workforce does, as you mentioned in your introductory comments, they have done an outstanding job, and I join with you in acknowledging and thanking our healthcare workforce. Everyone—our nurses, our midwives, our patient service attendants, our allied health professionals, our ambos, the doctors, the ward clerks, the executives, the entire rich array of our healthcare services—has been under strain, and they continue to be under strain like never before. Really in the evolving marathon that has been the COVID-19 global pandemic they have again and again under the most trying of circumstances risen to every challenge, and they continue to provide outstanding care to Victorians through those challenges. We know that our hospitals and healthcare workers increasingly have to continually manage the evolving COVID-19 pandemic's impact and now the return to, if there is such a thing, a business-as-usual environment as Victoria is opened again, with the impact that that is having on our health services—the increasing complexity in care of cases; the ongoing impact of still furloughing, on average, around about 1500 healthcare workers across our system each and every day who are unable through COVID-related reasons to attend work. And now as we enter a challenging winter, having had two previous flu seasons essentially with very little if any flu, we are seeing every indication that flu is returning with a vengeance right throughout the Victorian and indeed Australian community. All of these put sustained and enduring pressures on our fatigued workforce. Not only is it fatiguing them and having those impacts that I have touched on, but it has also disrupted the normal recruitment and training pipelines of staff and has increased the demands of the acute health system on our workforce. So in terms of the investment that you have pointed to in this budget in backing our healthcare workforce, it is always important but it has perhaps never been more important. How we build the capacity of our workforce is a key priority of this budget and of this government. It always has been, but it is now more so than ever.

As I touched on in my presentation, since 2014 we have grown every area of our healthcare workforce. As of June we will have an additional 9464 full-time equivalent nursing and midwifery staff compared to June 2014. That is a 27 per cent increase in our nursing and midwifery workforce, and that is before we then include the projections that you have touched on for further enhancements of our workforce this year. In regard to just the public hospital component of our medical workforce, that has increased by nearly 4000 full-time equivalents. That is a 44 per cent increase, overwhelmingly in clinical and care positions, compared to June 2014.

Growing the workforce is critical but so too is the support, training and development of that workforce, which is why this budget continues this trajectory of growth but also looks to how recruitment, training and support for that workforce can continue to be delivered. As the Premier has touched on I think in his presentation to this committee, a key part of the budget process will support the recruitment and training of up to a further 7000 healthcare workers in this budget, including a $59 million contribution to see more than 1125 registered undergraduate students of nursing enter the workforce for each of the next two years. In addition there will be a $9.8 million investment to deliver 75 registered undergraduate students of midwifery each year over the next two years. These are undergraduate nursing positions that we have seen in success stories of the pandemic as having been essential to supporting patient care and easing the burden on our stretched healthcare professional workforce. These two measures in particular dealing with our nursing workforce will facilitate their early employment and bring quicker the invaluable support they will bring, as undergraduate nurses will learn valuable skills on the job and will facilitate their transition into a postgraduate training and employment environment. It will have the dual impact of both improving workforce readiness and, we are confident, addressing retention issues for that fatigued workforce.

This model of employment was first developed as an arrangement for employing student nurses in our healthcare services under this government. A small pilot was run in 2018 and has shown itself to be particularly important in rural and regional Victoria as it provides benefits to students, staff and our health services. Further,

for those health services that have employed this model, the budget's expansion of it here will provide improved working environments for staff and, we are confident from the work to date, improve the quality and care for patients.

But of course there is always more to do when it comes to improving the position of our clinical workforce, and this budget is funding a series of other measures to particularly expand that clinical and nursing workforce. There is an investment that you touched on your reference of $5.6 million to allow an additional 288 enrolled graduate nurses to hit the ground in health services and in hospitals with the support that they need over the course of the coming years. There is a further $4.6 million when it comes to allied health professionals as they transition to advanced practice roles, and there is a further $1.5 million to support Aboriginal health students in cadets, scholarships, and training and support.

As part of our wider COVID catch-up plan, which you referenced at page 54 there, we are investing a further $80 million to support our healthcare workforce as we recover from COVID and deal with the issues of the deferred catch-up care. This involves, particularly in those elective surgery catch-up areas, additional training of more than 1000 nurses and theatre sterilisation technicians so as to make sure that that increased theatre capacity can be delivered. It will also support a further 400 nurses in their postgraduate studies in that peri-operative nursing area. And it will also be an important part of the recruiting, now that international borders are open and increasingly the traditional pipelines of recruitment of caring workforce are being re-established, some 2000 skilled both expat and international healthcare workers.

This is all about making sure that we are investing in supply, in capability and in our workforce right across the state. We know there are shortages and demands on that fatigued workforce in metropolitan, regional centres and rural locations, and we will make sure that these important investments are delivered in this budget.

The CHAIR: Thank you, Minister. Mrs McArthur.

Mrs McARTHUR: Thank you, Chair. Secretary, I refer to emails received through FOI from your department, and I ask: was Operation Mocha Extra Hot successful?

The CHAIR: Sorry, Mrs McArthur, this is not an inquiry into FOIs you may have received but the budget estimates. Could you please relate your question to the budget estimates, please.

Mrs McARTHUR: Well, surely they spent money on this program.

The CHAIR: Mrs McArthur—

Mrs McARTHUR: We are here to look at how the taxpayers money was spent, aren't we?

The CHAIR: Mrs McArthur, the terms of reference—

Mrs McARTHUR: Aren't we here to assess how taxpayers money is spent?

The CHAIR: Mrs McArthur, I am giving you an opportunity to rephrase your question before I rule it out of order. But we are here to consider the budget estimates.

Mrs McARTHUR: Budget paper 3, page 54.

Mr NEWBURY: In order? Is it all right—in order? Are we okay now?

The CHAIR: Mr Newbury, could you please refrain. You are extremely rude.

Mr NEWBURY: You are just a Labor hack.

The CHAIR: Mr Newbury, you are being extremely disrespectful and offensive. Could you please control yourself.

Mrs McARTHUR: Thank you, Chair. Professor Wallace, is that helpful?

Prof. WALLACE: Whereabouts on page 54?

The CHAIR: Mrs McArthur, the Secretary has asked for a clarification. Whereabouts, the page and the budget reference, are you are referring to?

Mrs McARTHUR: Well, that is the information I have got.

Mr D O'BRIEN: It is in relation to the vaccination question that I asked you earlier on the 2021–22—

The CHAIR: Mr O'Brien, you do not have the call. The Secretary has asked Mrs McArthur to point to the budget reference, and Mrs McArthur does seem unable to point to her budget reference. Mrs McArthur, do you have a budget reference for the witness's information?

Mrs McARTHUR: Look, we have just given you the reference: budget paper 3, page 54.

The CHAIR: And the Secretary has asked whereabouts on page 54 you might be referring to, Mrs McArthur. It is not an unreasonable question to be prepared for.

Mr D O'BRIEN: Well, Chair, it is not unreasonable for me to assist, which I just did. It is budget paper 3, page 54, referring to vaccinations. That is the question. That is what I just did. Mrs McArthur is asking a question about vaccination programs, one of them titled—what was it, Mrs McArthur?

Mrs McARTHUR: Operation Mocha Extra Hot.

Mr D O'BRIEN: That is it.

Prof. WALLACE: Thank you. The state-led COVID vaccination program has probably been one of the most successful programs not just in Australia but worldwide. One of the key things around the program, one of the driving principles of the program, from the outset was to ensure that all Victorians—no matter who they are, no matter where they live—had equitable access to vaccines. The commonwealth's reporting on equitable access for Victoria shows equal access to vaccines across our state and across all of our LGAs in a manner that is actually not reflected anywhere else in our sister states and territories. The program that you referred to was one of the very bespoke, community-based vaccine delivery access opportunities for locals to get access. It was about reaching in, particularly to our culturally and linguistically diverse communities, to provide access. If the question, as I understand it, Mrs McArthur, is around 'Were our community-based, small pop-up components of the vaccine program successful?', they were really successful.

Mrs McARTHUR: So how many jabs were administered in that?

Prof. WALLACE: I will take that on notice. I mean, we have numbers for the total program if you are interested.

Mrs McARTHUR: For Operation Mocha Extra Hot, we would like that information if possible. Also, while you are on it, what was the cost per vaccination?

Prof. WALLACE: I do not have those numbers in front of me. We will be able to provide those once the current financial year has finished. Of course the vaccination program is ongoing, so we will reconcile costs at the end of the financial year, but we will not have those costs per dose for individual components of the vaccine program until our books are closed.

Mrs McARTHUR: Documents from the education department, Secretary, detail that grants of $12 000 were paid to providers to do zero jabs. In other words, they sat at schools to do zero jabs. Is this good use of taxpayer money?

Prof. WALLACE: Well, I think—

The CHAIR: Sorry, Secretary. Mrs McArthur, we have had the secretary of the department of education here previously. We are currently here with the witnesses before us, being the Minister for Health and the Secretary of the Department of Health. If you could relate your questions to the health estimates—not outcomes, the health estimates—and the relevant portfolio, that would be appreciated.

Mrs McARTHUR: What is more of a health issue than giving a vaccination, Chair?

The CHAIR: Mrs McArthur—

Mrs McARTHUR: Secretary, do you think vaccinations are important?

The CHAIR: Mrs McArthur, while your question went to vaccination, it went to an issue that is an issue for the department of education, not the Department of Health.

Mrs McARTHUR: Well, the Department of Health is organising the vaccinations.

Mr FOLEY: Not in that instance, Mrs McArthur.

The CHAIR: Mrs McArthur, you can use your time to argue with me, but I am ruling your question out of order.

Mrs McARTHUR: Well, you are trying to get outcomes of vaccinations—

The CHAIR: Mrs McArthur, could you please not speak over me and could you please relate your questions both to the estimates and the relevant department before us.

Mrs McARTHUR: Secretary, on Friday night a senior doctor tweeted:

HOSPITAL IN THE HOME … IN VICTORIA IS IN A STATE OF COLLAPSE

The department had an emergency meeting, we understand, on Friday. What was the outcome of that meeting?

Prof. WALLACE: I am not familiar with the tweet. What was the doctor's name?

Mrs McARTHUR: I am not providing the doctor's name. You must be familiar with the problem.

The CHAIR: Mrs McArthur, again, we are here to discuss the estimates, not Twitter, and if you are going to propose a question that relates to a tweet that the witnesses before us may not have even seen and yet not advise them who that tweet might be from, it makes it very difficult for anyone to assist you.

Mrs McARTHUR: Okay, Chair. Is there an issue with the Hospital in the Home program in Victoria?

Prof. WALLACE: No, there is not.

Mrs McARTHUR: Oh, it is going perfectly?

Prof. WALLACE: There are now two components of the Hospital in the Home, so-called HITH, program. There is our standard HITH program that has been in place for many, many, many years. Again, it is part of the transition of hospital-based care out into the community. As a specific response to the pandemic, the COVID response division worked with our acute hospitals division to create an expanded HITH program for COVID. It is part of the COVID Positive Pathways. As you would be familiar with, the COVID Positive Pathways take individuals from self-care all the way through to HITH and then admission, and there are some 75 000 Victorians on the COVID Positive Pathways this morning, today. So the HITH program for COVID, yesterday—I do not have today's numbers, apologies—I think had 178 people in the program. It is working extremely well. It is one of the reasons that Victorians with COVID have by and large managed to avoid hospitalisation at the rates that we see in our sister states. The rates of hospitalisation in Victoria are significantly lower than in New South Wales and in Queensland, for example, partly because of our highly successful program. The senior doctor that you refer to—presumably the tweet is in the public domain—if you can tell me his or her name, then I can perhaps answer more precisely the anxieties that they might be having.

Mrs McARTHUR: Can you confirm the department had a meeting about this on Friday?

Prof. WALLACE: I cannot, but let me take that on notice. I mean, we have meetings clearly every day, and particularly around our HITH program, our COVID Positive Pathways. If there was a meeting on Friday on our COVID Positive Pathways and our HITH program, that would not be a surprise to me. I would be surprised if we were having a meeting specifically in response to a tweet.

Mrs McARTHUR: Dr David Berger was the doctor, so do you have context about that?

Prof. WALLACE: David Berger is a Queensland infectious diseases physician, so he does not work in Victoria.

Mrs McARTHUR: Okay, Secretary. Let us go to a question Mr Newbury has touched on. The Yooralla building at 244 Flinders Street was bought by the government for $40.3 million and has been sitting empty doing nothing since June 2021. Why?

Prof. WALLACE: Sorry, is that question for me or for the Minister?

Mrs McARTHUR: Secretary, thank you very much.

Prof. WALLACE: Thank you. You are quite right: we bought the Yooralla building early last year—

Mr NEWBURY: The dipping birds down there.

The CHAIR: Sorry, Mr Newbury, I cannot hear the Secretary.

Mr NEWBURY: Well, neither can I, over your dipping birds down the other end of the table.

The CHAIR: Mr Newbury, could you please allow us all to hear the answer?

Prof. WALLACE: We bought the building last year with the intent of it being a future site for provision of a variety of community-based health care. Clearly our community partners, the providers of such care, the individuals or the organisations who would provide such care, have been deeply engaged in our pandemic response. Our community health providers have been a core component of the pandemic response from the very beginning, hence why we have undertaken no further work.

Mrs McARTHUR: The Lay report is well overdue. Is it your advice to the Minister, Secretary, that this report not be released?

Prof. WALLACE: Well, it is a matter for Mr Lay. Mr Lay has not provided the report to us yet, but it is a matter for Mr Lay. Clearly in due course when the report is provided it will inform decisions of government.

Mrs McARTHUR: So are you concerned about the delay? Does this report affect the project's credibility?

Prof. WALLACE: No, I do not think it does. Clearly the whole environment and the needs of the community-based health care that we envisaged for this facility have changed dramatically in the last two years. Again, the minister this morning in his introduction talked about the Better at Home program. We are significantly changing the way that healthcare provision is structured. So I think it is quite appropriate that we wait until we get better clarity about what the future needs for our community are going to be for those vulnerable communities that this facility might serve. I do not think it undermines the credibility of the facility or the program at all. Actually rather, once the report is provided it will inform decisions in an environment that perhaps we could not have envisaged two years ago.

Mrs McARTHUR: Secretary, in December the waitlists for dental care were 151 500. What is the latest figure today?

Prof. WALLACE: I will ask Ms Geissler to go to some specific figures about dental services. Again, I think, as has been reported before, lots of our services have been interrupted by the different phases of the pandemic. But Ms Geissler might have some specific numbers.

Ms GEISSLER: I will just start by saying that the relevant reference in the budget papers is we are investing $327.7 million in dental services this budget. The public dental waiting times for the full year to 30 June for general care went from 19.4 months to 22.7 months, and denture care from 17.8 months to 21.6 months. I think it is really important to say, however, that none of our emergency clients, none of the priority clients that require immediate care—urgent care—go onto the dental waiting list.

Mrs McARTHUR: So 151 500 in December—how many now on the waitlist?

Ms GEISSLER: I will have to get back to you on that.

Mrs McARTHUR: Thank you very much. Secretary, on 7 April the chief health officer, Professor Sutton—who we wish well, because he is not here today, and neither is the deputy chief health officer, for some reason—said vaccine mandates could be removed in most workplaces at the earliest reasonable juncture so that they become at the discretion of industry and individual workplaces. Will the department and the health sector be following that particular piece of science?

Prof. WALLACE: Well, again, as the minister described earlier, the current structure we have around the pandemic declaration and the pandemic orders have the pandemic orders as a ministerial instrument, as opposed to the CHO direction that was in place prior to December last year. So those are matters for the minister to consider, and as the minister described earlier, he is required under legislation to take advice from the chief health officer.

Mrs McARTHUR: So what is the written advice, can we ask, from the chief health officer on this matter?

Prof. WALLACE: Well, again, as the minister said earlier, all written advice to the minister is published and is required to be published within seven days. So all advice provided by the chief health officer to date—

Mrs McARTHUR: So that advice was given. Where are we up to with it?

Prof. WALLACE: Again, all advice provided by the chief health officer is published.

Mrs McARTHUR: Well, Minister, are you accepting the advice of the chief health officer on this matter?

Mr FOLEY: On which particular matter, Mrs McArthur?

Mrs McARTHUR: The removal of vaccine mandates.

Mr FOLEY: As the Secretary indicated, the current process, which I will not go through again—I will take it as understood—

Mrs McARTHUR: Thank you.

Mr FOLEY: given that it went through the Parliament—is that the arrangements that are in place at the moment are that in a very narrow group of areas, including aged care, disability settings and our healthcare systems, there are requirements for people to be up to date with their vaccinations. That is because vaccinations save lives.

Mrs McARTHUR: So have you requested the advice from the chief health officer?

Mr FOLEY: As the Secretary indicated, every piece of advice that I have both requested and responded to with reasons is set out in this Parliament, is set out on the internet, is set out in transparent—

Mrs McARTHUR: And the last date of that advice, Minister—could you provide that?

Mr FOLEY: As per the most recent changes of orders, which were some weeks ago, which you will find on the department's website as well as the Parliament's website, the current arrangements are in place until 12 July, 11.59 pm, and I have no advice to change those arrangements, which continue to protect Victorians in those high-risk settings.

Mrs McARTHUR: Okay. I will go to Professor Wainer now if possible. Professor, can you confirm the recent award of a contract to record and analyse highly sensitive personal data of Victorians, including health information, namely the Victorian public health survey?

Prof. WAINER: Thank you very much for the question, Mrs McArthur. That is a matter for VAHI, and I would be happy to take it on notice, unless the Secretary had—

Prof. WALLACE: Yes, Mrs McArthur, I can answer that. The Victorian Population Health Survey is a survey that, as Professor Wainer says, is oversighted by the Victorian Agency for Health Information—VAHI—part of the department now, since the machinery-of-government changes last year. It is a survey that has been running since I think the late 1990s under VAHI's stewardship. It is an annual survey, a telephone survey, and previously it was a survey of about 7500 Victorians. Under VAHI's stewardship every three years

now it will be for 34 500 Victorians—so 7500, 7500, 34 500—as part of that rescoped work to make a more comprehensive survey to inform not just the population but also the department and government. Quite appropriately, VAHI went out for tender.

Mrs McARTHUR: Well, yes, and Secretary, do you think it is appropriate in this current security environment that that contract be awarded to a wholly owned subsidiary of a Chinese research firm?

Prof. WALLACE: Can I reassure you that the procurement processes followed are consistent with best practice. The company that won the contract to undertake a telephone survey with de-identified information, DBM—

Mrs McARTHUR: Yes, but having been given the entire list of telephone numbers in Victoria—

The CHAIR: Mrs McArthur, your time has expired. I am allowing the Secretary to complete his answer to your question, but I would appreciate it if there were no interruptions.

Prof. WALLACE: It is an Australian private company. It has been registered in Australia for some 20 years, and the procurement aligns with local jobs procurement policy. This is an Australian company.

The CHAIR: Thank you, Secretary. Mr Richardson.

Mr RICHARDSON: Thank you, Chair. Thank you, Minister and department representatives, for your time and for joining us. We are nearly on the home stretch. I might take my questions from the budget papers rather than TikTok and Twitter late-night scrolls and go to budget paper 3, page 220, and go further into some of the health workforce expansion that you went through. Minister, building on some of the information that you provided in your substantive response, are you able to outline for the committee the recruitment initiatives being used to expand Victoria's health workforces and how the Victorian government will ensure newly recruited workers will have the skills to provide top-quality care?

Mr FOLEY: Thank you, Mr Richardson. Making sure that our workforce has the skills and the retention that it needs is critical to that support for building the numbers, the capacity, and dealing with the fatigue issues that we have dealt with. The budget does have a range of initiatives centred around health workforce supply, capability and wellbeing, and in regard to particularly those capability and skills issues we want to make sure that we support the current professionals we have to stay in the public health system while at the same time attracting new workers from the Victorian community as well as interstate and international professionals to join us in our public healthcare system. That is why we invest, as the papers set out, some $240 million in the education, training and development of that workforce to make sure that it is sustainable in every sense of the word and capable of delivering better health outcomes as a result. We want to make sure that we build clinical placements through this program, that we transition to practice programs, that we support postgraduate economic education opportunities and that we help ensure the highest quality health professionals as a result of those combined efforts. Since coming to office this government has invested more than $2 billion in the training and development of our workforce—in nurses, doctors and allied health and right across the spectrum of that professional workforce. The last 2½ years have certainly been extraordinarily challenging for that training and skills development, particularly as so much of not just the state system but indeed the primary healthcare system of the nation was built on a workforce pipeline of international workers.

That area in particular has become highly competitive in the global market—it always was but is even more so now. So part of the strategy, in addition to having the key focus on our domestic and local workforce, is to launch a new strategy for the recruitment of international healthcare workers. As part of our COVID catch-up plan the goal is to make sure that we boost healthcare professional workforce numbers, including in the critical professions of medicine, midwifery and nursing, and to attract some 2000 international and expat healthcare workers to come to Victoria over the coming years. In this highly competitive field, which becomes more competitive seemingly every month as packages are made more attractive—comprising relocation packages, healthcare support packages and targeted campaigns in those international communities that have traditionally been the source of so much of this workforce—what that does is seek to actively build those healthcare workforces here whilst we rebuild on the back of the changing nature of the global pandemic. That does include an international travel allowance that was introduced last year and that has been one important component of attractions. It includes covering costs associated with visa applications, flights, professional registration and indeed short-term accommodation, all of which are important components of that support.

The health services that are leading this will also receive financial support for visa sponsorship and transition-to-practice expenses to assist those professionals to smooth their transition, and I know the healthcare services, particularly the specialist ones, are active in that international recruitment strategy right now. This support over the next financial year, both in our domestic and international efforts—building the skills, bringing in the ready-made skills—is an important part of a much wider recovery plan, and I look forward to its progressive and continual rollout.

Mr RICHARDSON: Minister, going on to workforce support and retention—you covered off a few of those points there—we know that our healthcare workers in Victoria and indeed across Australia have faced significant challenges over the course of the pandemic. For the committee's benefit I am wondering if you could provide an overview of the investments that the Victorian government is making in terms of worker wellbeing and ensuring that healthcare workers are supported to remain in the workforce.

Mr FOLEY: As I think all members of this committee have acknowledged on many occasions, our workforce in the healthcare sector have been extraordinary over the last 2½ years as they have responded to the global pandemic. Their monumental effort is one that I think we all rightly applaud and that we all rightly need to build on in ways that go well beyond simple applause. I want to acknowledge that work, but I also want to reinforce the additional measures that we are developing, funding and rolling out through these programs that are set out in the budget.

It is important that while we recruit international healthcare workers and build the new domestic workforce we at the same time retain those highly skilled staff—particularly those that are facing significant fatigue in our public health services—through the support that they need. The challenges of the last 2½ years have seen a real impact on the mental and physical wellbeing of those that carry out this important work, and in that regard there is a $4.8 million contribution for all our publicly funded healthcare services to deliver access and support through Safer Care Victoria.

I want to acknowledge the great work that the Safer Care Victoria team have done in partnership with the healthcare services through the healthcare worker wellbeing centre, which was the first of its type rolled out in 2020 and has built and continued to deliver impressive results every year since.

That centre provides staff in clinical and non-clinical roles in community health support, aged care and primary care settings—it offers across the board of healthcare professions—critical support in the most accessible ways possible. The funding in this budget will extend that support for a further two years and will expand coverage from 21 to now 100 health and indeed community health centres. It will bring a level of physical and mental health and wellbeing supports that is desperately needed by those new organisations that will come into its purview. Led by the office of clinical chiefs at Safer Care Victoria, this service will deliver a range of digital resources, opportunities for leadership in those healthcare services and community health services and improvements in initiatives that will address worker wellbeing and the individual, the managerial, the executive and the systems processes that make sure that those services are available and readily accessible in each workplace covered.

The centre has drawn on the work of the reputable Institute for Healthcare Improvements in 21 health services from all regions across the state, and it will build a further $32 million through this program for statewide packages that were to be delivered in 2021 to provide even more practical wellbeing supports, such as the provision of psychologists and counsellors on site to provide proactive support and coaching for staff, particularly in leadership roles. There has been additional workplace rest and recovery in safe places for staff—simple things that have had to be changed during the course of the pandemic to make them safe for meal delivery, convenient healthy eating spaces and the actual provision of healthy eating resources for both at work and after work. And it extends beyond the healthcare professionals themselves, because healthcare professionals' families are also directly impacted by the extraordinary efforts that they have put in. The program is deliberately now going to be substantially rolled out to support, where appropriate, those families of our healthcare workforce.

Learning to live safely alongside COVID is no easy task. The importance of making sure that the wellbeing of our workforce is at the heart of that is central, and I know that our healthcare workforce has—like many workforces across the state—suffered when it comes to the direct catching of COVID-19 in a way that has been really demanding on them and their colleagues. At the height of the omicron wave earlier this year we saw

some 5900 furloughed staff for extended periods of time. Those workers' wellbeing, the impact that had on their colleagues as they dealt with record numbers of infections at that time, as they come out of that particular phase of the pandemic and as we are now moving to the traditional challenging respiratory illness periods of winter—we know that their wellbeing is critical. As we led in 2020 and 2021 in the infection prevention control for our workforce—the fit testing and other measures to keep that workforce safe in the prevaccination period—we now continue to see the 153 000 healthcare workers who have had that testing and support for COVID at the front line and now extending that support for them to be ongoing with their families, with their colleagues is really important.

The best thing that the rest of us can do to deliver support for these frontline champions of our public health system is to back their wellbeing by continuing to do what we can to bring demand on our health services down. The best thing we can do as a government to support them is build around their capacity and wellbeing, and this significant investment will do precisely that.

Mr RICHARDSON: Taking you back to budget paper 3 and page 56, Minister, it refers to funding for a nursing and midwifery health program. For the committee's benefit, are you able to outline how this program is expected to provide benefits and will help the Victorian nursing and midwifery workforce?

Mr FOLEY: Thank you. There are specific programs of support, be it for medical practitioners, who have their own separate program, but this particular program, the Nursing and Midwifery Health Program Victoria, is a critical component of that broader support to nurses, midwives and students in this area, many of whom are facing those issues of fatigue relating to the demands of their job and the impact on their health and wellbeing. Investments in this program in this part of the budget are all about employing more counsellors to provide additional support to nurses, midwives and students to make sure that at the time of significant need they get the support they really require.

This program was first established in 2006. It provides confidential and independent, one-on-one psychological support services to nurses and midwives right across the state. The program seeks to support some 75 per cent of participants to return well to their workplace within 12 months of engaging that program, and they are very successful in their efforts. The profession-specific health and wellbeing guidance is a highlight of that program. It extends to screening programs for at-risk issues and individuals. It assesses particular individuals' needs, it has a referral support position in place, it has individual support sessions and indeed extends to peer supports where appropriate to manage everything from stress to alcohol and other drugs, mental health and, increasingly, the family violence and security issues that have been brought to its attention. It is targeted to focus on the unique and particular aspects of the workforce in these areas, and it does so in a particularly successful way. It is designed and led by nurses and midwives, and that builds the confidence of peers in that program, where it has particularly high rates of referral. That is why together with its, if you like, partner program in the Victorian doctors health program, which I was very pleased to announce at the recent AMA awards dinner, it is being more than increased in its historical investments over the next two years by bringing some further $400 000 to its not dissimilar program delivered by the AMA. All of these services, whether they be for doctors, for nurses or for other health professionals, go to making sure that, for this critical workforce, which at the best of times has been under significant pressure and is now coming out of the most significant health crisis certainly in our lived experience, their wellbeing, their issues and their health are at the forefront of sustaining our efforts. Only through that will we come out the other side of this global pandemic.

Mr RICHARDSON: Thank you.

The CHAIR: Thank you, Minister. Mr Hibbins.

Mr HIBBINS: Thank you, Chair. Thank you, Minister and team, for appearing this morning. Can I ask about, obviously the budget papers—and it is pretty obvious that the hospital system and staff are really under pressure. My understanding is that COVID hospital inpatient numbers have increased steadily from fewer than 200 to more than 500 in the past couple of months. Is there any planning for future measures to reduce COVID transmission in the community to protect hospitals and staff?

Mr FOLEY: To me? I was not sure who you were asking.

Mr HIBBINS: Whoever is best suited to answer the question.

Mr FOLEY: I am happy to perhaps share that around the community. When you say 'COVID transmission in the community', there are many, many approaches to how COVID is best dealt with in this phase of the pandemic where we learn to live safely alongside COVID given its patterns of transmission and its evolution. As the virus has evolved so too has our response. As we have dealt with on a number of occasions in this hearing, there are key components at a high level. This is not exhaustive, but obviously the key program is vaccination, and the vaccination program will continue to evolve as the technology behind that globally seeks to evolve—and this government's investment in mRNA technology and the partnership with Moderna and others is a key part of our sovereign capacity to deal with that.

The fact that we have one of the world's highest vaccination levels has allowed us to move to a new part of really a social compact with the Victorian community about how that response is dealt with, whereas lockdowns are a thing of the past and we now move to an arrangement where social measures are built on a local, workplace, community, individual level of how we comply with that.

Mr HIBBINS: Can I ask about that social compact? Particularly with mask use obviously being very good at preventing COVID but also the flu as well, which is a serious issue, are you looking at steps that might not be enforcing mask use but actually encouraging or incentives or awareness of the benefits of mask use inside?

Mr FOLEY: As we move to a phase of the pandemic that I think Mrs McArthur touched on, where the chief health officer was reflecting a broader public health view that we are now in a part of the pandemic response where responses are devolved to community, workplace and indeed individual levels and where guidance is increasingly the direction as opposed to mandates, mandates are a thing of the past when it comes to many of the areas of COVID response that we have had over 2020–21. 2022 and beyond is about living safely with and alongside COVID and indeed other respiratory illnesses.

Taking the example that you touched on—mask wearing—mask wearing will continue to have a limited role in those high-risk, targeted areas for those workplaces and communities that they are a part of, where it is currently in place. We have seen, for instance, aged care facilities extend well beyond what the pandemic orders are in that regard to that application in their workplaces. The same thing can apply to—and this is only one, for instance—immunocompromised Victorians who, rightly, look to mask wearing as one of the opportunities that will allow them to more fully participate in the community as we continue our recovery strategy. We know that masks work. We know, as a result of the last 2½ years, that they are part of the armoury of our response to respiratory illnesses on a range of fronts, but how they are applied and how they are encouraged are all now part of a much broader strategy of living alongside, of educating and of participating for all of government and all of the community to share in. For instance, I was on the tram the other day, and whilst I had my mask on I have to say that perhaps there were a number of citizens who did not.

Mr HIBBINS: That is an ongoing issue.

Mr FOLEY: And the tram inspectors got on and shared masks with the Victorians on that tram and gave them some information about the important role that masks play in confined environments that did not involve those Victorians being fined. I am not the Minister for Public Transport, but I commend the Minister for Public Transport for his educative role in making sure that mask wearing in appropriate circumstances is delivered with a much more voluntary compliance method as we continue down this path.

Mr HIBBINS: Yes. It is a good example. There has been a bit of discussion about the advice that you receive and then the publishing of that advice, but my understanding is that under the *Public Health and Wellbeing Act* you are actually not required to release health advice when you do not subsequently make an order. Is that correct? And can you provide the most recent advice from the CHO in regard to what should be done, if anything, to minimise the pandemic's increasing effects on the hospital system?

Mr FOLEY: Sorry, could you say that first part of the question again?

Mr HIBBINS: If you are provided with advice and you do not subsequently make an order, do you still table or publish that advice?

Mr FOLEY: Yes—any advice. But fortunately I have not been in the position of not acting on the advice. Every piece of advice has led to orders since this part of the Act came into place in December. Whilst dozens and dozens and dozens of orders have been made, mostly to ease restrictions, I am not aware of—I might take

this on notice, and if I am wrong, I will certainly get back to the committee—any piece of advice that the chief health officer and the public health team have provided not being published.

Mr HIBBINS: Okay. All right. Thank you, Minister. The national data through the ABS showed that deaths nationally were about 22 per cent higher than expected for that month, with the increase attributed to COVID. Is there any Victorian data on excess mortality during the 2022 summer omicron wave, and if so, can we have that data on notice?

Mr FOLEY: I think there is. I might seek assistance from my colleagues—whether that is Victorian or national. Excess deaths, which is done per population, is the accepted international model that talks about how you measure the impact of deaths being attributable to various particular circumstances. You are right—there is that ABS data that shows that by international comparisons Australia has been extraordinarily successful in keeping excess death levels down to amongst the lowest globally. In regard to whether that data is then able to be deconstructed to a state level, I might take advice perhaps from Professor—

Prof. WALLACE: I can answer, Minister. We have been tracking the so-called excess deaths through the pandemic. As you probably know, Mr Hibbins, in 2020–21 we had negative excess deaths, so deaths prevented. It is a complex story, but just as a simple example—it is just a very small example—less traffic on the road, less traffic accidents, so less traffic deaths. But also we have had zero flu seasons for the last two years—one of the particular things we were worried about obviously for this year—and so no deaths from flu, or very few, over the last two years. So we have had negative deaths. Your question was about the omicron wave in December and January. Obviously we have got ongoing data analysis—and we can certainly provide you the data that we have got—but we do look like we have, like everywhere else with omicron, excess deaths. So we have gone from negative excess deaths to positive during the omicron wave.

Mr HIBBINS: Yes, okay. Thank you. I want to ask now about staff retention within the health system. Obviously with a lot of nurses and health workers and what have you quite exhausted and leaving the health system, experienced staff members are difficult to replace. Do you have any data on the number of doctors, nurses and allied health that are leaving the hospital system?

Mr FOLEY: Again, I might seek the assistance of the departmental officials, but what we have seen is at that global level people come and people go for a whole range of reasons, but undoubtedly fatigue is a major part of that, not only in departing the system but in changing the way in which they stay in the system. The number of people who, particularly over the last six months, have gone from full time to part time or part time to casual has been quite high and has been a consistent feature right across the state. As that becomes an expression of how the fatigued workforce member seeks to manage their fatigue, so too have there been in addition—it got up to many, many thousands at the height of the omicron wave in January—an average of about 1500 a day furloughed. In addition to that, the number of no-shows has also increased. So whether it is the resignations—and I look to my colleagues here—or changing how you manage your relationship if you are staying in the system or your relationship with when you come to work and do not come to work, all expressions of that fatigue issue have been an issue of significant concern to our healthcare services. But I might just see if any of my colleagues at the table have that data, and if not, I will undertake to provide it to you. Ms Geissler.

Ms GEISSLER: We have the data that we shared on the presentation in terms of the numbers of staff and the increase over time from 2015 across the workforce—doctors, nurses, medical support and ancillary staff. But in terms of attrition, we would have to get back to you.

Mr HIBBINS: Okay.

Prof. WALLACE: We do an annual census in June. So the data the minister showed in the slides obviously related to June 2021, and we will have an updated set shortly. I think the minister is right that there are certainly people who have left the workforce, but probably the bigger contributor is staff choosing to work fewer sessions than previously. I think, again, the minister has commented on the healthcare worker wellbeing centre run by Safer Care, a very purposeful response to recognising those challenges.

Mr HIBBINS: Well, that was my next question in terms of what is actually in the budget for current health staff and to assist with their retention. What is the government's plan to make sure hospital staff are not leaving the system right now?

Mr FOLEY: As I responded to some of the earlier questions, it is on a range of levels. In the wellbeing response area, it is building on the work that the Safer Care Victoria healthcare worker wellbeing centre has delivered since it was established in 2020, at that time with a focus around infection prevention and control, fit testing and other arrangements as its primary focus in dealing with those kinds of issues. What it has now rolled out into, now that we are getting around to the second, if not third, annual fit-test arrangements for IPC and PPE efforts to keep people safe at work from not just coronavirus but particularly coronavirus, is to continue to expand that issue around psychological, mental health and personal support for both the worker and, increasingly, their family. We have now rolled that program out from beyond the initial number of health services it had to not just health services but community health providers, because what we are finding is that one of the lessons of COVID has been the partnerships that we have been able to create across health services but increasingly with community service providers. The workforces are essentially, for practical purposes, the same, and the issues around how that is applied are the same. I responded to, I think, Mr Richardson's questions about the funding increases in those services and I would refer to those earlier answers, but it is probably, together with the skill retention and skill development, one of the top-level issues that unions, health services and individual healthcare workers raise with me on a regular basis.

Mr HIBBINS: Okay, thank you. I want to raise some issues now about non-COVID effects on the health system. There are a lot of preventable non-infectious diseases that are impacting on hospital demand—obesity, diabetes. Why isn't the government investing some significant amounts in actually reducing the future demand burden on our hospitals and tackling those non-COVID-related diseases and disease prevention?

Mr FOLEY: Given the time left, I will perhaps defer to Professor Wallace. Long COVID is still an emerging issue for us. COVID, whilst it might be a respiratory illness, gets into the bloodstream—it gets into every single organ in the body—and its impact on people is still being understood. In the remaining time I might ask someone who knows a lot more about it than me.

Prof. WALLACE: It is a really important question. I think, as you know and as we have discussed at this committee in the past, one of the responses in 2020 was to establish our local public health units—very purposely contract tracing, very purposefully COVID facing. But of course—and we have discussed it before—it is this foundation piece to a much stronger preventative footprint, and in this current budget there is funding specifically for the continued establishment and evolution of those. Professor Wainer oversights our local public health unit, so maybe she wants to talk to that—the continued increasing focus on prevention, not just for the health of Victorians but for the very reasons that actually you reduce hospitalisations.

Prof. WAINER: Thank you, Professor Wallace, and thank you for the question. I think we certainly learned through the COVID-19 pandemic in the early days about just the value and importance of that local and regional presence of public health, not just acute health services, so that they can both support the COVID-19 response, but now we have a significant investment for them to be able to actually support our regions at that regional and local level across the range of prevention activities, including critical areas in child obesity, which are also a challenge, so the full spectrum of both health protection and prevention.

Mr HIBBINS: Terrific. Thank you.

The CHAIR: Thank you, Mr Hibbins. Thank you to the minister and all of the witnesses for appearing before the committee today. That concludes the time we have set aside for the health estimates. The committee will follow up on any questions taken on notice in writing, and responses will be required within five working days.

The committee will take a lunch break. I declare this hearing adjourned.

Witnesses withdrew.