ATTACHMENT: **QUESTIONS TAKEN ON NOTICE AND FURTHER INFORMATION AGREED TO BE SUPPLIED AT THE HEARINGS**

HEALTH

1. Please provide any additional speaking notes from the Minister's presentation.

   (Page 4 of the Health portfolio transcript)

   The Minister did not use speaking notes during the presentation.

2. Please explain the decline in funding for the Small Rural Services output group, including a description of the proposed new funding model.

   (Page 6 of the Health portfolio transcript)

   The reduction in funding for the Small Rural Services output group in the 2016-17 budget papers is primarily due to the transfer of the responsibility to the Commonwealth Government for funding of Home and Community Care Program services for clients aged over 65 and for planned entry of clients into the National Disability Insurance Scheme.

   The Commonwealth Government will provide funding directly to services in 2016-17 with no net loss of funding to individual services. Overall Small Rural Health Services will receive additional funding in 2016-17.

   The department has reviewed the 2003-04 block-funding model to ensure continued support for the work of small hospitals in flexibly delivering safe and effective health care to rural communities across Victoria. The proposed new model is underpinned by the development of a small rural activity unit, a weighted measure based on actual costs, which will enable equitable funding of services with differing service streams. The model consists of a number of components:

   - An availability component: a fixed sum payable to all services. This contributes to the fixed costs of providing a service to a small rural community.
   - An activity-linked payment: an amount based on three-year historical activity across service streams.
   - Supplementary payments for additional services where the cost data indicates additional support is required. These include: multi-campuses; dialysis and high volume urgent care supplementary payments.

   The new model will increase transparency, equity and accountability whilst maintaining flexibility for services. The model will be gradually implemented over the next few years.

3. With respect to the health complaints system, please provide any available details on groups that are more at risk of being exploited, such as regional clients, metropolitan clients, a specific gender, age group or ethnic group.

(Page 12 of the Health portfolio transcript)

There is no reliable comprehensive source of data about particular groups at risk. It is expected that many such instances of exploitation go unreported.

Research published by Consumer Affairs Victoria in 2004 ("Discussion Paper: What do we mean by 'vulnerable' and 'disadvantaged' consumers?") identified that consumer vulnerability is a complex mix of personal factors and nature of the transaction involved.

This is consistent with anecdotal evidence which would suggest that those most vulnerable to exploitation by unscrupulous health service providers depends on the nature of the service being offered and the promises being made. Those offering cheaper alternatives to conventional services aimed at improving appearance or general well-being seem more likely to appeal to those who are disadvantaged in terms of income or labour force status, educational attainment or mental capacity. In contrast, vulnerability to those pedalling 'miracle cures' cuts across all sectors of the community and appears to be more closely linked to experience of hopelessness, for example in the face of incurable illness or a child with serious developmental delays.

The commencement of the *Health Complaints Act 2016* will provide a capacity to take action against unethical health service providers, including those who seek to exploit vulnerable members of the community. These new powers, along with the introduction of powers to accept third party complaints, are expected to lead to improved levels of reporting of such issues. The Commissioner will have powers and functions related to the collection and analysis of data and, over time, this should enable the Commissioner to identify any particular 'at risk' groups and support the health service system to respond appropriately.

4. How long is the arrangement whereby the Epworth Hospital leases space at the Box Hill Hospital expected to last?

(Page 13 of the Health portfolio transcript)

Eastern Health and Epworth HealthCare signed an agreement to lease a ward in the Box Hill Hospital until June 2017.

The Department has been formally notified that the Eastern Health/Epworth licence agreement will terminate early on 30 June 2016.

5. What is the anticipated completion date of urgent infrastructure works at the Western Health Footscray site?

(Pages 16-17 of the Health portfolio transcript)

The $15 million package to support urgent works for Footscray Hosptial's South Block will allow its continued operation in the short term up to 2021. The work is in two

components: engineering services and building fabric repair. The services component includes limited upgrading of lighting, fire services, security and communication systems with repair of internal piping and electrical system. Building fabric works includes rectification of leaking roof, protective work to building brickwork and capping, repairs to floors and limited asbestos removal. Works will begin in coming months and all funds will be fully expended by up to 2021.

6. Please advise:
    a. the level of staffing anticipated at Better Care Victoria; and
    b. how this compares with the Health Innovation Reform Council.

(Page 26 of the Health portfolio transcript)

a) Better Care Victoria is supported by a team of 10 Equivalent Full Time staff: a Project Director, three Principal Project Managers, three Senior Project Officers and three Project Officers. The Better Care Victoria team provides secretariat support to the Board but in addition coordinates a range of Better Care Victoria functions to support sector-led innovation including:

- funding of innovation projects
- analytical and evaluation support
- delivery support for innovation projects
- knowledge sharing of best practice innovation and "how-to" guides
- innovation engagement and networking
- leadership and innovation capability building.

b) The Health Innovation Reform Council was provided with secretariat support by on average 1.5 Equivalent Full Time staff who prepared issues papers for Council consideration and developed materials for publication arising from the Council's recommendations.

7. Please advise the number of days that Dr Douglas Travis is anticipated to work between 10 February 2016 and 9 February 2017.

(Pages 27 of the Health portfolio transcript)

Dr Douglas Travis will work a minimum of 104 days as Better Care Victoria's expert adviser between 10 February 2016 and 9 February 2017. In addition, he will work approximately a further 12 days in his capacity of Chairperson of the Better Care Victoria Board.

Dr Travis was appointed Chairperson of the Better Care Victoria Board from 18 December 2015 to 30 June 2018.

The Better Care Victoria Board was established under part 6A of the *Health Services Act 1988* (the provisions for the Health Innovation Reform Council) and is categorised as a Group B, Band 1 organisation under the Victorian Government's Appointment and Remuneration Guidelines for Victorian Government Boards, Statutory Bodies and Advisory Committees.

In accordance with these guidelines Dr Travis is remunerated $48,958 per annum for his role as Chairperson.

Remunerating Dr Travis at the top of the band for this categorisation is appropriate given the responsibilities placed on the board and Chairperson including:

- extensive sector stakeholder engagement and communication
- advice on the expenditure of the $10 million dollar Better Care Victoria Innovation Fund
- monthly Board meetings and additional out of session teleconferences.

In addition to the role of Chairperson, Dr Travis has been engaged by the Department of Health and Human Services, working two days per week for a period of one year, to provide expert advice on the establishment and design of Better Care Victoria, including:

- supporting the development of a strategic plan for Better Care Victoria
- supporting the identification and definition of Better Care Victoria focus areas based on sector views gathered during the Travis Review and informed by clinical improvement expertise
- supporting the successful implementation of Better Care Victoria and development of its service offerings.

This response clarifies the response provided by the Secretary at the Public Accounts and Estimates Committee hearing.

8. Please provide details on what comprised the $17 million of urgent infrastructure works at the Western Health Footscray site.

(Page 28 of the Health portfolio transcript)

$15 million is allocated for Footscray Hospital (south block) urgent works while $2m is for planning for a potential Footscray Hospital Redevelopment. The works for South Block relates to critical infrastructure as required to allow its continued operation in the short term up to 2021. The work is in two components: engineering services and building fabric repair. The services component includes limited upgrading of lighting, fire services, security and communication systems with repair of internal piping and electrical system. Building fabric works includes rectification of leaking roof, protective work to building brickwork and capping, repairs to floors and limited asbestos removal.

9. Please advise how many children accessed dental services during 2015-16, and how many are anticipated to access these services during 2016-17.

(Page 31 of the Health portfolio transcript)

2015-16 data will not be finalised until the end of July 2016.

In 2014-15, the Victorian public dental system treated approximately 223,500 children, including 67,389 under the Commonwealth's Child Dental Benefits Schedule (CDBS). Additional children will have received treatment in the private sector through the Commonwealth Child Dental Benefits Schedule.

There is uncertainty regarding the future of the Child Dental Benefits Schedule in 2016-17 which means it is not possible to provide reliable estimates for 2016-17.

10. Regarding the $25 million funded under the Meeting Hospital Demand initiative for 2015-16, please advise what this funding was for and who the recipients were.

(Page 32 of the Health portfolio transcript)

The $25 million allocated for this current financial year includes:

- $21 million to support the delivery of additional hospital activity. These funds have been provided to 22 health services based on their capacity to deliver additional activity and the current level of demand for services at each site.
- $4 million to support improvement in specialist clinics waiting list management. Funding has been provided to 41 health services to undertake this work in 2015-16.

11. Regarding the Access to Medical Cannabis initiative please advise what the money provided under this initiative funds.

(Page 36 of the Health portfolio transcript)

The Budget initiative includes $21.3 million for the Health portfolio to implement the medicinal cannabis scheme in Victoria. The 2016-17 Budget also provides $7.3 million to the Agriculture portfolio which will fund cultivation and extraction of a quality-controlled non-smokeable medicinal cannabis product for children with intractable epilepsy. The funding for the Agriculture portfolio is overseen by the Minister for Agriculture, the Hon Jaala Pulford MP.

Funding will support the creation of a significant hardship fund to ensure medicinal cannabis products are affordable for these families. Eligibility criteria for the hardship fund will be developed and make publicly available to ensure transparency in decisions for financial assistance.

Funding will also support the establishment of the Office of Medicinal Cannabis and an Independent Medical Advisory Committee to implement the Victorian medicinal cannabis scheme and oversee it once it is established. A number of critical programs will be established within the Office of Medicinal Cannabis to operate the framework including research facilitation, secretariat, licensing, auditing and clinical approvals. A key task for both the Office of Medicinal Cannabis and the Independent Medical Advisory Committee will be the development of clinical guidance and standards to support the medical profession. The Independent Medical Advisory Committee will provide advice about further patient groups that might be able to access medicinal cannabis and the suitability of medicinal cannabis products for approval.

12. Please explain the decline in the cost of the 'Acute training and development' output, including explaining the alignment of the Victorian State budget descriptions and classifications with the national health reform.

(Page 38 of the Health portfolio transcript)

Training and development research grants were consolidated into the relevant Weighted Inlier Equivalent Separation peer group price for 2015-16 after budgets were established. These grants were introduced to recognise the costs of teaching and training activities of health services that are not directly related to measurable activity, such as the involvement of clinical staff in research relevant to their professional development and academic positions. As teaching and training activities form part of the core business of Victorian health services these costs are now factored into the price of delivering health services and will appear as a cost of 'acute admitted' output. There is no net reduction in ongoing acute training and development grants.

13. Which areas had rural generalist GP procedural positions in 2014 but do not have them now?

(Page 38 of the Health portfolio transcript)

The Government's budget commitment is for 11 rural generalist posts per annum. Where there are more doctors who wish to undertake training, and the training hospitals have capacity to provide further training, the department may reprioritise funding from other budget sources to fund additional posts. While posts in 2015-16 were located in the same health services that had the posts in 2014-15, some may have had fewer posts in 2015-16.

14. When is the target of 2,600 participants in the PrEP trial anticipated to be reached?

(Pages 38-9 of the Health portfolio transcript)

The study is expected to be fully enrolled with 2,600 participants by April 2017 or earlier.