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

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Budget Estimates 2017–18

Melbourne — 17 May 2017

Members

Mr Danny Pearson — Chair
Mr David Morris — Deputy Chair
Mr Steve Dimopoulos
Mr Danny O'Brien
Ms Fiona Patten
Ms Sue Pennicuik
Ms Harriet Shing
Mr Tim Smith
Ms Vicki Ward

Witnesses

Ms Jill Hennessy, Minister for Health,
Ms Kym Peake, Secretary,
Mr Terry Symonds, Deputy Secretary, Health Service Policy and Commissioning, and
Mr Greg Stenton, Chief Finance Officer, Department of Health and Human Services.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2017–18 Budget Estimates. All mobile telephones should now be turned to silent.

I would like to welcome the Minister for Health, the Honourable Jill Hennessy, MP; Ms Kym Peake, Secretary, Department of Health and Human Services; Mr Terry Symonds, Deputy Secretary, Health Service Policy and Commissioning; and Greg Stenton, Chief Finance Officer.

Witnesses in the gallery are Ms Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management; Ms Anne Congleton, Deputy Secretary, Community Participation, Sport and Recreation, Health and Wellbeing; Mr Euan Wallace, Chief Executive Officer, Safer Care Victoria; and Mr Nick Foa, Deputy Secretary, Finance and Infrastructure, and Director of Housing.

All evidence is taken by the committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Comments made outside the hearing, including on social media, are not afforded such privilege.

Witnesses will not be sworn but are requested to answer all questions succinctly, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

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

All written communication to witnesses must be provided via officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way and cannot photograph, audio record or videorecord any part of these proceedings.

Members of the media must remain focused only on the persons speaking. Any filming and recording must cease immediately at the completion of the hearing.

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

Ms HENNESSY — Thank you very much, Chair, and a big, happy PAEC morning to other members of the committee. Can I also pass on my regards to Mr O'Brien for a speedy recovery; I hope that he is not listening and is focused on his own wellbeing.

Ms SHING — No, we assure you he is listening attentively, Minister.

Visual presentation.

Ms HENNESSY — I will just go to the slide. The $2.4 billion in additional funding that is being delivered in this year's budget continues our very strong investment in health, and will mean better hospitals, better equipment and better, faster and safer care for Victorian patients. It builds on the $1.9 billion of additional funding that was provided in the 2015 budget and the $2.3 billion of additional funding provided in last year's budget. We are providing more services and more surgeries for Victorian patients, new medical equipment and modern facilities to ensure our doctors and nurses and healthcare workers have the safe and modern facilities and the equipment that they need to do their job. All of this is in line with our reform agenda which has been designed in consultation with experts and health professionals right across the system.

As you can see from this next slide, the investment in the 2017–18 budget represents a 10.5 per cent increase on the funding provided for in the 2016–17 budget for acute health services, which in itself provided an additional 8.2 per cent on the 2015–16 budget. The total funding in the output is over 13.1 billion which is around $2.9 billion higher than what it was when our government came to office. These investments are paying significant dividends in a number of ways, including that last year we delivered the lowest elective surgery waitlist on record and last quarter we delivered the best emergency department four-hour performance for a first quarter on record.

But of course there is always more to do, so in this year's budget we are delivering 1.67 billion to support hospitals. That could equate to more than 200 000 patients getting the surgery that they need sooner, and that is possible due to the largest ever one-off elective surgery boost of 174.3 million in 2017–18 alone, which is equal to 12 000 hip replacements or more than 51 000 eye surgeries. We are also delivering on our cancer action plan to save 100 000 Victorian lives by increasing cancer screening and expanding the hepatitis B vaccination program. And we will ensure more rural and regional Victorians have the transport and accommodation that they require to access the care they need when they are away from home.

To cater for the health needs of Victorians now and into the future we do need to continue to invest and create a modern health system by embracing technology, medical research and innovation. Our $34.2 million investment in medical research will see that the operational infrastructure support program receives the biggest boost in its history, and this is of an ongoing nature indexed each year. We are backing our world-leading medical researchers, scientists and institutions to develop new treatments and to find cures for diseases. We will invest $11.6 million to partner with the commonwealth to improve care for patients with multiple, complex and chronic conditions. We are doing what we can to better utilise the capacity within our hospitals by sharing best practice across the system, supported by another $10 million for the Better Care Victoria Innovation Fund. And we are ensuring that more Victorians with rare diseases get access to genomic sequencing to get the diagnosis and the treatment sooner through an $8.4 million investment to expand our genomic sequencing program.

In line with our commitment to accept in principle all of the recommendations from Dr Stephen Duckett's report on quality and safety in Victoria's hospitals, we are investing a very large $215 million to implement recommendations and to deliver on the blueprint of this reform.

To maximise the safety of Victorians experiencing or at risk of family violence there is a $38.4 million package to ensure that health workers are trained to identify indicators of family violence and to get vulnerable Victorians the support when they need it where they need it. We are investing to ensure that every health service in Victoria provides training for those most often on the front line to better identify and support victims of family violence.

We are focused on better preparing against extreme and unpredictable events such as thunderstorm asthma with a $15.6 million package.

Our legislative reform to bolster the powers of the new health complaints commissioner is being supported with a significant $7.9 million boost, ensuring that complaints are investigated more quickly.

We have invested $1.8 million in additional funding for the Victorian Assisted Reproductive Treatment Authority to give it the resources that it needs to undertake its work in line with the legislative change that will give all donor-conceived people equal access to their genetic information.

We are determined to continue to eradicate occupational violence and aggression against our healthcare workers, and bullying and harassment across the health system with a $3 million investment.

Finally, we continue to invest in building hospitals to give the best possible care to Victorians. This year we are expanding the Northern Hospital to meet the healthcare needs of Melbourne's growing outer-northern suburbs. We know families in Melbourne's west need and deserve a new hospital, so we are investing towards a new Footscray hospital, with funding to support the identification of a suitable site nearby if required and urgent works at that site. Our sickest kids will get the emergency care that they need sooner and separate from adult patients at Monash with a $63.2 million expansion that will also deliver better access on that site to ambulances. And we are investing $40 million for key upgrades to the Royal Melbourne Hospital. Infrastructure works worth almost $30 million will also be delivered at the Austin.

In support of hospital infrastructure, the government is providing $60 million for the purchase and upgrade of medical equipment and $2.2 million for more intensive care and neonatal beds. In addition, almost $12 million is to be spent on cybersecurity works.

To support growing communities in rural Victoria, $7.5 million is to be spent on the planning for the Warrnambool hospital as part of the rollout of Victoria's largest ever, one of its kind Regional Health Infrastructure Fund. We have set aside for the first time an allocation of funding to undertake planning work on

future capital projects so we can continue to pipeline, and the next slide does map out where we currently have capital investment going on across rural and regional Victoria.

In conclusion, these investments are ultimately aimed at patients. Their ultimate aim is to provide better hospitals, better equipment and better and faster care for Victorian patients and to provide our hardworking doctors, nurses, healthcare workers, paramedics and other health professionals the world-class services that they need. I think we are making very important progress in turning our health system around. I am proud that our capital investments that we have made in three budgets outstrip by 14 per cent the investments made by the previous government in its four state budgets. There are of course many challenges within our health system. We are very focused on addressing those challenges, and I look forward to, in the course of this hearing, talking about some of the strengths, successes and challenges in the year to come.

The CHAIR — Thank you, Minister. I might commence. We will have government questions until 9.53 a.m. At the outset I wish to disclose that I am the ambassador for children's health as well as the chair of the public housing renewal advisory group. Minister, if I could raise with you the question about medical research. The budget paper reference is budget paper 3, page 89. Can you outline to the committee what is in this year's budget in relation to medical research, please?

Ms HENNESSY — I would be delighted to. Often when people are talking about how we are going to manage the growing demand on health systems and health services, we look at not just the fact that we have an ageing demography, significant challenges around chronic disease and cancer prevalence, medical research is absolutely critical to addressing some of those challenges, and we are very blessed and lucky here in Victoria. It must continue to work to ensure that we continue to be the jewel in the crown when it comes to medical research and we are able to attract and retain some of the many brilliant minds that exist both here in Victoria and overseas.

To that end, last year we released the first ever health and medical research strategy, and that is supported by $20 million in last year's budget. That included new fellowships, a medical research acceleration fund and greater coordination for clinical trials. This year we are investing a further $34.2 million to further cement our home as the leading health and medical research state and a further $8.4 million over four years to expand genomic testing, particularly out of research settings and into public health services. The great ambition of much of our medical research is that we are able to translate the practice of research in everyday clinical care settings.

There are extraordinary discoveries that are occurring in our state, and this year's budget includes $1 million for planning work for a national centre of drug discovery for the Walter and Eliza Hall Institute. Just to reinforce the great capability of that institute, they, along with the Olivia Newton-John, the Austin and RMH, have had some significant breakthroughs, and an example of that is a drug called venetoclax. It has just been listed on the FDA, but the early clinical trials have literally melted tumours away for people who had been told to go home and prepare for death, so there are some incredibly significant breakthroughs that are being made there.

The CHAIR — You mentioned the national drug discovery centre. Can you outline to the committee in a little bit more detail about what that proposal might look like?

Ms HENNESSY — Look, essentially the Walter and Eliza Hall Institute wants to explore the opportunity to be able to establish such a centre. Essentially it would be a technology platform that has the potential to very rapidly unlock breakthrough new treatments for cancers and another serious illnesses. So in simple terms, it is a cutting-edge technology that literally tests millions of molecules, each with a potential new drug, against target disease cells to try and identify new research and drug development pathways.

As I said, they are achieving quite extraordinary things at that centre. They, along with many of our other independent medical research institutes in Victoria — again, we receive about 40 per cent of the national health and medical research funding from the federal body as well, which I think is a testament to the brilliance of many of our medical research institutes. But one of their great challenges and one of the significant issues around the funding model for medical research has been that you are funded for the research but you are not funded for the operational overhead. Whilst the state has for a significant period of time provided some such funding, it has remained stagnant for a significant period of time, so not being able to use the funding that you get for research to turn the lights on has a significant impact on the sustainability and the ability for those wonderful medical research institutes to put their hands up for either state, national or international grants.

The CHAIR — Minister, what has been the feedback or the response from the sector in relation to these initiatives or these investments?

Ms HENNESSY — Look, they are delighted. For a long period of time they have been advocating for an increase in the operational infrastructure support, so for the first time in 10 years we are boosting our support for that research sector to $34 million to help with those things that they are not ordinarily eligible for in their medical research grants. I have a pretty strong conviction around medical research. We are not going to be able to sustain the kind of demands over the forthcoming decades on our health system unless we actually start to get some of these really significant breakthroughs.

Genomics is another incredible success story. We have also, through the brilliant work again at the ONJ centre, and with people like Professor Jonathan Cebon with Grant MacArthur, identified a new way to, for example, test for things like melanoma with a simple blood test. The role of immunotherapy is now seeking to be an incredibly important model in how we treat particular illnesses and diseases. It is broadly referred to as personalised medicine within the medical research sector, but that also brings lots of other dilemmas. It is very expensive to deliver personalised medicine, but people often talk about when and where do you get the great cure for cancer. It is what occurs every single day that helps us better understand, that helps us through things like immunotherapy, to be able to fight cells and to make sure that you have got a person-specific approach to those many illnesses and diseases.

We are very highly respected internationally, which also means that many of the great international research institutes do want to partner with us and our institutes here in Victoria. Data is obviously an incredibly important part of that, and so sharing data around research and patient results is another really significant input as well. They are absolutely delighted to receive this investment. It is kind of humbling, their appreciation, but they absolutely deserve this investment. The contribution that medical research already makes and we need it to make in the future means that this is a very important and worthwhile investment.

The CHAIR — Yes, and I just think it is fantastic that you look at the last 15 to 20 years when these early investments were made by the former state government, and it is starting to pay those dividends now. It is terrific.

Ms WARD — Good morning, everyone, thanks for coming along. Minister, you just mentioned the Olivia Newton John centre, which is terrific. We know that in the north-east we have a fantastic hospital with the Austin, and it is thanks to investments by Labor governments that we kept the Austin in the north-east. In the northern corridor though of Melbourne we have seen that there has been some what I would call a bit of neglect in terms of that corridor. We had PANCH removed under the Kennett government, and the north has never really recovered since in terms of health provision. You have got in your presentation that $162.7 million has been allocated in the budget for the expansion of the Northern Hospital. Can you talk us through what this is going to mean and how this is going to address that deficit that the north has experienced for some time?

Ms HENNESSY — I would be delighted to, Ms Ward. Thank you very much for your question. As you have rightly identified, the northern corridor is the site of incredible population growth. There are different demographies within that community that have specific healthcare needs as well. To say that Northern Hospital has been groaning for a significant period of time is not an understatement.

Ms WARD — Ever since it was built.

Ms HENNESSY — So we are really delighted that in this year's budget we are making an investment of $162.7 million to expand the Northern. What that expansion will do is it will see the completion of a seven-storey tower that will include 96 new inpatient beds, three new operating theatres and more treatment rooms. When we build hospitals it is always important that you try and futureproof them to as great an extent possible so you are not then having to go back and the cost of your capital investment for future expansions is then somewhat inhibited, so we will also be making sure that we put futureproofing within that model. We estimate that the additional beds will have the capacity to treat more than 10 000 new patients per year. Building works are expected to start late next year, in 2018, and they are due to be completed in 2021.

Ms WARD — I understand that there was in the pipeline a few years ago some work to be done on the Northern. Is this less than, is this more than, does this improve what was being planned under the previous government; do you know?

Ms HENNESSY — Look, I do not come here to be too unnecessarily punchy about matters, but — —

Ms SHING — Others will take care of that for you.

Ms HENNESSY — I have every confidence that you will, Ms Shing. However, in the four years there was not work done on the Northern Hospital. It is true to say that there was an election commitment made by the previous government, but that was of a much smaller scale — that was a $98 million commitment compared to a $162.7 million commitment that we have made. Theirs was a three-storey infill on the inpatient tower and 64 inpatient beds, so significantly different. The growth, as I said, is extraordinary, and again that is a health service that is overjoyed with this announcement because they have been waiting for too long. You would probably also recall in last year's budget we made a commitment to fund the Broadmeadows elective surgery centre as well. I am happy to ask Mr Foa to provide you with an update on where that is at.

Ms WARD — That would be great, thank you.

Ms HENNESSY — He has obviously been keeping a very strong eye on things.

Ms WARD — While we are waiting for Mr Foa, it must be significant also — obviously as the parliamentary secretary for employment I am interested in jobs — the amount of jobs that will be created through being able to treat 10 000 patients a year, and three theatres and a seven-storey tower must also be phenomenal.

Ms HENNESSY — There are a significant amount of jobs that will be created, particularly, as you would be aware, our particular procurement policy position as well, and I will ask Mr Foa to speak to that as well.

Mr FOA — Broadmeadows is under construction and will be completed later this year.

Ms WARD — We can come back to this when it is next our turn if you like, Mr Foa. That would be okay, because I think we have got 20 seconds.

Mr FOA — Broadmeadows is under construction. Sorry, I missed the second question.

Ms HENNESSY — The number of jobs that Northern will generate.

Mr FOA — I will take that on notice, if I can, thank you.

Ms WARD — Okay, terrific. Thank you.

Mr MORRIS — The Victorian Heart Hospital — in last year's capital program there was $135 million. That was page 50 of the capital program from last year — 135 million with a footnote saying:

> Final project TEI and completion date will be determined following completion of business planning and development, and confirmation of funding contributions from project partners.

Yet when we look at this year's 'State capital program', the facility is mentioned but that TEI has dropped from 135 down to 15, and it is now spread out over a much longer period. What has changed from last year? Why are those figures no longer there? Why is 135 no longer there?

Ms HENNESSY — The Treasurer has confirmed that the $135 million is in contingency, that planning works continue, and again I am happy to ask Mr Foa to take you through those if you would like.

Mr MORRIS — Please.

Mr FOA — Through you, Chair, the Victorian Heart Hospital is a dedicated 195-bed standalone facility that in its completion will also include 22 emergency department beds, 10 catheter labs and will complete 2000 surgeries a year. There are 55 dedicated heart hospitals around the world, but none in Victoria, none in Australia, the most famous of those being the Mayo Clinic, the Cleveland Clinic, Massachusetts General et cetera. The idea is to bring clusters of cardiologists and surgeons and specialists together, creating a centre of excellence and including our project partners Monash University — that is one of the largest universities for cardiac research and education — and Monash Health is doing now the largest number of cardiac care services in Victoria. So with those two partners at the table we are working very, very closely with them, drawing down

on the first $15 million that has been made available to do the planning works, and we are well advanced with site master planning, working with the university around an early works package. We are designing the information system architecture, and the next steps will be around a functional design brief. We will then seek the approvals to put to market.

Mr MORRIS — Thank you, Mr Foa. I am not sure that that added to the sum total of our knowledge, but I appreciate the response.

Minister, on budget night the ABC reported the Treasurer as saying of that $135 million:

> It's one of only two or three election commitments that we can't deliver …

In light of the Treasurer's comments, is it your position that you will no longer deliver the hospital — —

Mr DIMOPOULOS — On a point of order, Chair, is it possible to have an actual direct accurate quote from the Treasurer? Is that exactly what he said?

Mr MORRIS — It was:

> It's one of only two or three election commitments that we can't deliver …

Mr DIMOPOULOS — And there was no context before, either?

Mr MORRIS — ABC TV news, 2 May 2017, at 7.01.

Mr DIMOPOULOS — Before or after, or just that line?

Ms HENNESSY — I am happy to address the point, Chair. Our government is committed to delivering the Victorian Heart Hospital. The only other election commitment is Aikenhead, where both St Vincent's and our contribution is awaiting the commonwealth contribution. Of course we will seek commonwealth support for the Victorian Heart Hospital, but it is our intention to deliver on that commitment.

Mr MORRIS — Okay. What will it cost and when will it be built?

Ms HENNESSY — We currently have only recently completed a business case that contains a number of options, and so the ultimate cost of the Victorian Heart Hospital will be determined ultimately by which option is supported. We are working very well with our partners in both Monash Health and Monash University and the philanthropic sector. There are other project partners with whom we are working. We are also going to be seeking a commonwealth contribution, but the value of this project particularly lies in not just the clinical care model, it is actually the alignment with Monash University to be able to have the research and education — —

Mr MORRIS — You must have a sort of a minimum and maximum.

Ms HENNESSY — Well, ultimately it will depend, as we now focus on securing funding support from other project partners.

Mr MORRIS — So you do not have a sort of minimum and maximum depending on the configuration as yet?

Ms HENNESSY — All I can tell you, Mr Morris, is the focus of our work now is on attracting support from other project partners. There is that work occurring. Again I am happy to ask Mr Foa to update you if you would so like.

Mr MORRIS — So the answer to that is no, effectively. Could I ask the secretary: have any project partners actually signed up to funding commitments?

Ms PEAKE — Certainly, Mr Morris, I can advise the committee that there has been very positive discussions with both Monash University and Monash Health about their contributions to this project. Obviously they have their own governance processes that they need to work through in terms of the final confirmation of the nature of those commitments. They can speak for themselves but are very committed to this project.

Mr MORRIS — But at this stage there are no actual commitments.

Ms PEAKE — Well, Monash University has certainly indicated its contribution both in kind in terms of the education and, as the minister has indicated, a research contribution.

Mr MORRIS — We heard in February that everything was positive, and we are now, what, three months down the track. I am just wondering whether in fact anything has changed, whether anyone has signed up to it.

Ms PEAKE — I think, Mr Morris, what has changed is the progress of the work on the business case, which enables the board of Monash University to now consider those options and confirm their funding contribution.

Mr MORRIS — So it is under consideration but nothing has been — —

Ms PEAKE — Correct.

Ms HENNESSY — We are confident in our project partners contribution, but as the secretary just said, because the options in the business case have only recently been completed the focus on those matters are now the main work being done. Like many of the other great health services that have been built with a specific focus, whether that is the VCCC or the Monash Children's, they often are 10 years in the planning and the making, and it is important that we get this right given it will be the first standalone cardiac hospital in this country.

Mr MORRIS — Do you have any idea — again to Ms Peake — of the scale of contribution you are expecting from Monash?

Ms PEAKE — I think I updated the committee in February that already Monash University has contributed in kind in terms of land for the project. They have also been talking to us about the nature of the cash contribution they would make, but I am deeply aware that they need to work that through their governance processes so I am not in a position to give you a sense of scale today.

Mr MORRIS — Just coming back to a question I asked the minister, secretary, are you able to on notice give us the minimum and maximum costs of the business case?

Ms PEAKE — I am really not in a position to do that, because it needs to go through the governance processes of the university before those parameters are available to us.

Mr MORRIS — So when it has, can we have that information?

Ms PEAKE — Certainly. As the project unfolds, the options are considered and the funding sources are confirmed there will be more information available to the committee.

Mr MORRIS — In as timely a manner as possible would be helpful. Just one final question on this, again to the secretary: obviously risk management is an important part of what you do. What are the risks of having a specialist hospital co-located with a university rather than with another major health service?

Ms PEAKE — I think really, as Mr Foa outlined, Mr Morris, the great benefits of the translation of clinical research through to practice and the connection to education is one of the great benefits of a specialist clinic. There has been a lot of research done looking at these sorts of specialist health services right around the world. And I think if you look at the analogy of our trauma hospital, the Alfred, and the great benefit that has brought in the support to other health services around raising their capability, providing secondary consultation, the proof is in the pudding of the value of specialist services.

Mr T. SMITH — My question is also to Ms Peake. BP 4, page 59, lists the Victorian Comprehensive Cancer Centre as a completed project. Is the 13th floor still empty?

Ms PEAKE — I think when we discussed this in February I indicated to the committee that the fit-out of the 13th floor was scheduled to be completed by the end of this calendar year. That work is still on track for that completion date.

Mr T. SMITH — But it is still empty?

Ms PEAKE — The fit-out work is underway in line with the time frames that I have provided to the committee before.

Mr T. SMITH — No, Ms Peake, I am asking a very simple question.

Ms WARD — And she just gave you the answer, Mr Smith.

Mr T. SMITH — No, she did not give me a straight answer.

Ms WARD — Can you stop berating people.

The CHAIR — Order! Ms Ward!

Mr T. SMITH — Ms Ward, be quiet please. I have not received an answer to my question. Is the 13th floor empty?

Ms PEAKE — The 13th floor is not empty. It is being fitted out in line with the time frames that I have provided to the committee previously.

Mr T. SMITH — Is there anyone working on the 13th floor?

Ms WARD — Who is fitting it out?

Mr T. SMITH — Is anyone physically undertaking — —

Ms SHING — Asked and answered, Mr Smith.

Mr T. SMITH — There may well be people putting whatever in it — —

Ms SHING — Putting whatever in it?

Ms WARD — That would be called working.

Ms PEAKE — That is work, Mr Smith.

Mr T. SMITH — Seriously, I am sick of getting bureaucratic doublespeak.

Ms PENNICUIK — Good morning, Minister, secretary, deputy secretaries and all the other staff that you have. Thanks for coming today. I want to raise a couple of questions in the short time I have on some of the capital works and asset initiatives you have, and one of them, I think we have talked about it before, is the Footscray Hospital. I know that $50 million or so went in to plan the new Footscray Hospital development, in the budget. On page 92 of budget paper 3 it mentions that planning will commence for the Footscray Hospital and there will be options for land acquisition of a suitable site if required. Certainly many people believe it is required and that it would be less expensive to actually rebuild the hospital than to upgrade the current hospital. But also on page 58 of budget paper 4, the state capital program, it mentions 'Western Health urgent infrastructure works (Footscray and Sunshine)', with a TEI of $61 million-odd and estimated expenditure of around 8 to the end of this financial year, and another 26. Could you explain how all of that is working? What is going to Sunshine, what is going to Footscray, and whether or not the government is thinking of rebuilding Footscray Hospital — whether Footscray Hospital will be actually rebuilt?

Ms HENNESSY — If I can go to the Footscray Hospital issue, a topic very dear to my heart, as well as I know your colleague's heart, as well.

Ms PENNICUIK — And mine; I grew up in the western suburbs.

Ms HENNESSY — Wonderful. I think it is beyond contest that the infrastructure at Footscray Hospital has reached its use-by date.

Ms PENNICUIK — Quite a while ago.

Ms HENNESSY — So we have a couple of dilemmas. As you rightly pointed out, the debate around what a future Footscray Hospital might look like requires us to do both a business case that looks at the brownfield site

as well as the greenfield site. The great challenge around doing a brownfield site is having the capability and the capacity to decamp patients whilst you are doing that construction, and the flip side is obviously that you have got to find another alternate site where there is good access, given the acute component of Footscray remains incredibly important. But whilst we do those business cases — and we are very committed and I am very personally committed to ensuring that Footscray gets a new hospital — we also need to address some of the challenging infrastructure within Footscray. So the figures that you refer to — there is $17 million worth of work that has been undertaken around south block, which was a particular challenge, so a construction manager has been appointed and the work to fix up those areas will start soon. We also need to do some other infrastructure work at Footscray, so some of that funding is included within the 50 million, but the other figure that you referred to is infrastructure works that is required at Sunshine Hospital.

Ms PENNICUIK — How much of that is actually going to Sunshine? What is the figure going to Sunshine?

Ms HENNESSY — Could you just clarify which TEI and which budget page you were referring to?

Ms PENNICUIK — Page 58, budget paper 4. It says, 'Western Health urgent infrastructure works (Footscray and Sunshine)', and it does not separate them.

Ms HENNESSY — I might ask Mr Foa to see if he can provide you with any other insight. I do not want to simply say it is minus 17, because I know that is the cost of the works at south block, and if we are unable to furnish that accurately to you here today, I am absolutely happy to follow up on notice. But Mr Foa, I am not sure if you have anything you can add to Ms Pennicuik?

Mr FOA — The 17 was for Footscray and so the balance is for Sunshine.

Ms PENNICUIK — So the balance of the 50 is for Sunshine or the balance of the 20?

Ms HENNESSY — No; 50 is for Footscray in the current year. You are referring to a contribution that was made last year.

Ms PENNICUIK — Great, thank you. I do not think I have got that much time left, but I wondered if I could go to your presentation — page 7, '$60 million for new medical equipment and upgrade infrastructure across the state'. I am just wondering is there any breakdown of that? What is involved in the new medical equipment and where is it going et cetera. I saw the little map. Is that where it is all going? Is that how we work that out, the little map at the end with the big symbols on it?

Ms HENNESSY — We do have a disaggregation, because some of that is around high-value medical equipment, some of that is around other small infrastructure grants that people require. Mr Foa, if you would like to? To the extent that we can disaggregate it for you, to the extent we cannot, we are happy to furnish that on notice. It is disaggregated in the budget papers.

Ms PENNICUIK — We could be cut off at any moment, Minister, so if we do not hear it, could the committee be provided with that?

Ms HENNESSY — I am more than happy to provide the committee with that.

Mr DIMOPOULOS — Welcome, Minister and officers. Minister, I am going to ask you about the commitment to medical cannabis, but before I do, I am going to invite Mr Foa to conclude his answer to what Ms Ward asked in relation to the Broadmeadows surgery centre.

Mr FOA — It is under construction now, and completion later this year, the Broadmeadows.

Mr DIMOPOULOS — And how many patients will the centre treat?

Mr FOA — I do not have that detail with me at the moment, so I will take that on notice.

Mr DIMOPOULOS — Maybe take both of those on notice.

Minister, could I just say before asking I recently went with the member for Sunbury for a tour of the Walter and Eliza Hall Institute. It was absolutely incredible —

Ms HENNESSY — It is extraordinary.

Mr DIMOPOULOS — and they were really chuffed with the support. Exactly what we were told was it is about the general costs, their blights on cost that are increasingly putting pressure on their budgets. Your passion for medical research was very obvious in your presentation in answers to the Chair.

So medical cannabis. We have spoken about this before. I have got a number but at least one very engaged family in my electorate that would benefit greatly, so I am very proud of the achievement — the first in Australia, I think — to provide medical cannabis. Budget paper 3, page 249 references our commitment. I am just wanting to get a sense from you where it is at.

Ms HENNESSY — Thank you very much, Mr Dimopoulos, for your question and your interest in medicinal cannabis, and I will take you through where it is at. By way of preliminary observation, the horizons around medicinal cannabis have significantly changed and continue to change. I know from Ms Patten's perspective perhaps not far enough and perhaps not soon enough. But it is quite extraordinary, having gone from being the first mover in our country in a very, very complicated regulatory environment at a state, national and international level, to gradually seeing the growing appetite for states and jurisdictions, and largely driven by patient demand and people's legitimate commitment, to saying, 'Why are we not able to utilise this as an opportunity?'.

But I can tell you that development of our domestic product has been going very, very well. There has been some quite extraordinary work done, and Ms Pulford will be able to speak to the work that her department has been doing in relation to cultivating a range of suitable strains of the plant. Of course different strains and the composition of different strains will have different therapeutic effects. For the paediatric product we obviously need strains that are low THC, but for many other illnesses and diseases different strains will have a different impact, so whether that is around nausea related to cancer or HIV treatment, whether that is wasting associated with other treatments. One of the great opportunities that we have here is not just the medical research capability on those strains but also the agricultural capability, and that has been a matter that has been incredibly rewarding and interesting to watch unfold.

Certainly we obviously have our side of a confidential location for security purposes. We have established good manufacturing practice or GMP, and GMP is a certification requirement, a very intensive one. Having been to this location, I certainly have seen firsthand just how rigorous the certification processes are required to be. Of course this is the first such facility of its kind that has been licensed by the commonwealth for production of medicinal cannabis in Australia.

We are also involved in what I would describe as equally groundbreaking work to formulate extractor plant material into medicines suitable for ultimately different patient cohorts, but our focus is of course children with severe forms of epilepsy. We estimate that there may be up to 450 eligible patients in that first cohort. But when you are the first mover on these things, you are also the one that has to solve every problem and find a workaround for every issue. We expect that to be available to patients within a few months time later in the year. In parallel, we have established the office — —

Mr DIMOPOULOS — Minister, can I clarify what would be available?

Ms HENNESSY — Medicinal cannabis for eligible children with severe epilepsy, who meet the eligibility criteria.

Mr DIMOPOULOS — That was going to be my next question.

Ms HENNESSY — I just thought I would head that off at the pass, Mr Dimopoulos.

Mr DIMOPOULOS — And I mention her name because it has been in the paper, Ava, the young girl that I met in my community before the election. Her parents were so impressed that a political party, really, because we were not in government then, had the strength of mind to pursue something like this. I want to just commend you on your leadership and the Premier, because we are first movers on this. The old adage that when you do something bold like that, people will laugh at you first, then when they realise you are serious, they get angry with you, and then further down the track, you cannot find anyone who disagrees with you, that is the evolution of this, in a sense.

Ms HENNESSY — And the development of the right regulatory regime has been no small task at all. As I said we have — —

Mr DIMOPOULOS — We have pushed the commonwealth effectively, haven't we?

Ms HENNESSY — Yes, I am delighted with the changing position of the commonwealth, and whilst there are perhaps predictably many frustrating things that state and commonwealth governments have to say about each other in due course, I am delighted with the new minister's approach and attitude towards this issue. Having said that, I should also say that the Therapeutic Goods Administration and the Office of Drug Control at a commonwealth level have not been deliberately obstructionist — they have sought to be helpful. But again the development of a system for which a regulatory regime was not established has meant that we have just had to work through every issue step by step, and when you think you have solved every problem another 10 appear. But everyone is motivated to do the right thing.

Mr DIMOPOULOS — That would make it easier for other jurisdictions in Australia once the model is created.

Ms HENNESSY — Absolutely, and I am really aware that for many patients it cannot come soon enough. That is why we took the decision that we did, through the special access scheme, with the oversight of paediatric neurologists and the Office of Medicinal Cannabis that we have established — that has Professor James Angus as the chair, a very renowned and respected medical figure. In fact Malcolm Turnbull has appointed him as the head of the commonwealth committee as well. I think that is a really useful thing for Victoria, given that we need to try and have some degree of congruity in what is occurring. But we did, through the Office of Medicinal Cannabis, with the oversight and support of a range of paediatric neurologists, and through the special access scheme, get product for 29 young children. Again many of those are under care at Monash Children's, and there are many brilliant clinicians there that are doing the right thing. And so it is caution — slowly but surely.

The great risk I suppose that I am always attendant to is making sure that we have got the clinical safety — that with our testing regime we are not in breach of the regulatory regime. Having said that, and our focus is on the paediatric cohort to begin with, every day I am contacted by people with very painful and enduring diseases who are seeking some form of access to medicinal cannabis, and it is very frustrating to, I suppose, have to identify that there will still be some time before those patients can get access.

Mr DIMOPOULOS — Absolutely. That is the sentiment of Ava's family and Ava herself and others — that it cannot come soon enough for some. With the 29 kids, I think you said —

Ms HENNESSY — Yes.

Mr DIMOPOULOS — did we import medical cannabis?

Ms HENNESSY — We did, and obviously for families with very severely ill children going every day without a medicine that might be life changing when nothing else is working, it cannot come soon enough. So we made a decision that we would fast-track access particularly for 29 extremely unwell children, who due to the severity of their symptoms, were unable to wait for the broader access scheme.

In order to do that, to enable early compassionate access, a limited number of cannabidiol oral solutions were purchased by the government from a Canadian company called Tilray. They are a good manufacturing practice-certified leader. They are a Canadian company. They are a leader in medicinal cannabis at both a research and a production level. And paediatric neurologists nominated the children that they thought would most benefit from early access. The Independent Medical Advisory Committee established very strict criteria about who would be able to access those, and I am pleased to say that that product is to hand. I watched and identified when that plane left Canada and when it was going to land in Melbourne for us to be able to get through our symptoms, because I know that for these parents, as I said, every second really counts with the severity of the illness of these children. We need a more sustainable solution, and that is what our reforms are targeted at doing.

Mr DIMOPOULOS — And we look forward to those, Minister, very much. Thank you for your leadership again and for your answers.

Ms HENNESSY — Thank you, Mr Dimopoulos.

Mr T. SMITH — Again on the VCCC, how long will it be before the Ian Potter Centre for New Cancer Treatments occupies the 13th floor space and is functioning?

Ms PEAKE — I might actually ask Mr Foa just to give you some more detail on the progress of that fit-out, which is obviously on the half of level 13 that the department is assisting with the fit-out of.

Ms SHING — Mr Foa, if you could also speak up, as there are some ventilation fans that are making it difficult for some of us on this side of the room to hear.

Mr FOA — Certainly, thank you. And, Mr Chair, I have the answer for Broadmeadows if you also wish to know that.

The CHAIR — Save that for government time, please, Mr Foa.

Mr FOA — Thank you. So with the level 13 space, as the secretary has pointed out, there is an element of it that is within the arrangements with Plenary Health, so that is not an area of the facility that is being sublet. The sublet areas of the facility will be housing the new international cancer research centre. The works are progressing there at the moment. We are leaving the fit-out to the tenants themselves, so we are not actually controlling the direct works for the tenants to fit out that space. They can fit it out to their specification. We are providing a warm shell for that space. So the designated expansion space from Plenary is leased by the department and then sublet to the tenants, and we have rental commitments for that space that covers the rental payments that we pay to Plenary, but the fit-out will be their responsibility.

Mr T. SMITH — Which organisations are you referring to?

Ms PEAKE — I think I might, Mr Foa — the part of the 13th floor, Mr Smith, that you were referring to I think was specifically that for the international cancer research centre, is that correct?

Mr T. SMITH — Yes.

Ms PEAKE — That part of the floor I think we talked about in February, we have provided about $12 million to assist with the fit-out for that part of the floor, and again the intention is that that work will be done by the end of this year.

Mr MORRIS — Calendar year or financial year?

Ms PEAKE — Calendar year.

Mr T. SMITH — So this designated expansion space, which organisations will be renting that space?

Ms PEAKE — There are two organisations that have been successful in managing that part of the space: the Australian Genome Research Facility — so they have signed on for an initial term of 10 years with a further two options of five years each; and then the second is the Victorian Cytology Service, and, again, they have signed a lease for five years with an option for a further five years. They are then going through the sort of commercial processes of looking at who they will sublease, in agreements with Peter MacCallum, and it is those commercial processes which will then lead to the actual fit-out happening by the end of the year, to your earlier question about the timing.

Mr T. SMITH — So they will start paying rent next year — next calendar year?

Ms PEAKE — I might defer to Mr Foa on the timing of their rental payments.

Mr FOA — Yes, upon their occupation, the start date of which is still being negotiated with them.

Mr T. SMITH — Ball park?

Ms SHING — Of occupation, or?

Mr T. SMITH — Rent being paid, the start date.

Mr FOA — Upon their occupation. We would hope that the warm shell can be fitted out by the tenants and started this calendar year.

Ms HENNESSY — Calendar year.

Mr T. SMITH — This calendar year?

Mr FOA — Yes.

Mr T. SMITH — How much are they going to pay?

Mr FOA — So they cover the costs of the rental from Plenary, so it will not be a net cost to government.

Ms PEAKE — I can give you those figures for each of the tenants.

Mr T. SMITH — Yes.

Ms PEAKE — For the Australian Genome Research Facility, they have committed to subleasing 700 square metres, a commencing annual rent of $400 per square metre plus GST and outgoings. So based on the 700 square metres, this equates to an annual rental of $280 000. In terms of the Victorian Cytology Service, they have committed to subleasing 1500 square metres, again as I said for an initial term of five years, at a commencing annual rental of $360 per square metre plus GST and outgoings. So based on the 1500 square metres, that equates to an annual rental of $540 000.

Mr T. SMITH — Thank you very much. Moving on, with Peter MacCallum's move to the VCCC there has been a significant increase in utility costs, a high usage of contract staff, changed casemix attracting reduced funding and a loss of some of the sources of income, all resulting in a very difficult financial position for Peter Mac. Will Peter Mac run a deficit this year, and if not, how much funding will DHHS need to provide them to keep them in the black? —

Ms WARD — A point of order, Chair, can I ask Mr Smith to explain to let us know where he has got that advice from?

Ms SHING — Just a budget paper reference, to start, would be nice.

Mr T. SMITH — Budget paper 4, page 59.

Ms WARD — And your source for the claims regarding the increases?

Mr T. SMITH — PAEC, DHHS, February 2017.

Mr MORRIS — There was a very straightforward question about whether Peter Mac will run at a deficit, and if so, how much funding would be provided to keep them in the black.

Ms WARD — Thank you; I appreciate that, Mr Morris.

Ms HENNESSY — If I can just provide Mr Smith with the assurance that they are expected to break even — operating result — by 30 June 2017, so that should address that issue. There has been a 5.1 per cent growth in their funding in the last year, so that addresses that issue. Was there any other outstanding issues you felt that I have not — —

Mr MORRIS — Just of that 5.1, is there any additional funding being provided over and above what was anticipated at the start of the budget year?

Ms HENNESSY — There is an additional 5.1 per cent of growth funding that was provided.

Mr MORRIS — Supplementary, I guess is what I am asking, Minister?

Ms HENNESSY — I will ask Mr Symonds. At different points of the year with different health services, some say, 'We are capable of more activity if you fund us'. There are others that request different sources of

funding, so where and when we can we supplement, as we have with emergency departments, for example, this year. I will just see if Mr Symonds wishes to make any comment on that to that end.

Mr SYMONDS — Just to reinforce your point, Minister, that the funding does not all go out at the same time. We publish a budget at the beginning of the financial year, but then during the year for elective surgery or additional emergency department capacity, to address operational issues for health services, there are frequent funding rounds during the year. It is all accounted for in the annual reports for those health services in the following financial year. So there is a range of things that might cause funding to flow during a financial year to health services across the state.

Mr MORRIS — Perhaps I can put it more directly. If Peter Mac is going to finish even for the year, is that as a result of extra money coming from DHHS that would have otherwise resulted in a deficit?

Mr SYMONDS — Well, all health services budgets primarily are based on revenue they get from the state government and the department. It is the overwhelming majority of the funding they receive, so they make their budgets up based on advice. They wait for the advice from us, and then they make up a budget and post that in the statement of priorities each year based on knowing the revenue they will get. So they have agreed — —

Mr MORRIS — So they have made their budget on the basis of their budget and the allocation they have received?

Mr SYMONDS — That is right.

Mr MORRIS — Is that sufficient for them to finish even for the year, or have they received supplementary funding?

Mr SYMONDS — If I just set out a sequence of events, we will publish a budget for each health service in the state. They will agree with the department a budget target. In the case of Peter Mac, that is a break-even target. The board chair and the minister will sign that target, and then many health services during the year will receive additional funding. As they will have additional cost pressures during the year, it is their job to manage the ins and outs and achieve the break-even result they have signed up to.

Mr MORRIS — Okay. So if they have received extra funding, how much?

Mr SYMONDS — I will take it on notice.

Mr MORRIS — If you could provide that on notice, that would be good.

Mr T. SMITH — To Ms Peake, I have got a number of questions about capital funding, so I will just sort of go through these — —

Ms HENNESSY — Sorry. Who was your question to, Mr Smith?

Mr T. SMITH — Ms Peake — sorry, Minister. Royal Melbourne Hospital has received 40 million for critical infrastructure work. Does any of that 40 million include funding for master planning for the RMH's much-needed redevelopment?

Ms PEAKE — In terms of Royal Melbourne Hospital, that funding is both to undertake the critical infrastructure works that you referred to but it will also support a master planning process as well.

Mr T. SMITH — Alfred Health: Infrastructure Victoria's 30-year infrastructure strategy identifies the aged condition of the Alfred, requiring major refurbishment or a new building to support the delivery of a complex statewide health service to the growing population. Why is there no funding for master planning for Alfred Health in this budget?

Ms PEAKE — I will defer to Mr Foa to give you a bit more detail here, but I can certainly reassure you, Mr Smith, that we are working assiduously as a department with Alfred Health to progress an update of their 2011 service plan really to take account of the recent projected catchment population increases, which are greater than what was predicted in 2011, changes in the model of service delivery and future developments in inner metropolitan Melbourne and Fishermans Bend. That work, the update of their 2011 service plan, will

really inform future planning around the works that are required for their service, but I will just ask Mr Foa to supplement that with any other information.

The CHAIR — We might want to hold that over. Ms Patten until 10.38 a.m.

Ms PATTEN — Thank you, Chair. Thank you Minister and team. I would like to follow on in regards to medicinal cannabis just briefly. While I note that you have a timeliness performance measure on page 248 of budget paper 3 of 95 per cent practitioner authorisations, I am assuming that that relates only to the access via TGA and most of this is for general access. When you say 95 per cent, what sort of numbers are you talking about?

Ms HENNESSY — Thank you very much for your question. It is not a very insightful performance measure, would probably be the commentary that I would make, because of course the scheme is not up and running at this point in time. I might just invite Ms Skilbeck, who is responsible for the scheme, to provide some more insight, but in fairness I do not think it is a very insightful output measure because it — —

Ms PATTEN — No. It does say that there is an expectation for 16–17, which I was — —

Ms HENNESSY — At this point in time.

Ms SKILBECK — Quite right, Ms Patten. It is particularly not insightful at the moment because the scheme has not yet commenced in terms of Victorian product, which is what it relates to. So no, it does not relate to TGA approval. That is a commonwealth responsibility. In developing our regulatory scheme we are trying to maximise how much we leverage from the commonwealth processes in order to minimise the additional red tape we create in any future processes. In practice, at the moment that particular measure is not operational because it relates to the product the minister was referring to in her answer to the earlier question on Victorian-grown product.

We have, however, received a number of permit applications, and that is via the commonwealth special access scheme. It still requires state-level approval because our responsibility is for the personal safety — —

Ms PATTEN — How many is that?

Ms SKILBECK — From practitioners, only two, and both — —

Ms PATTEN — Ninety-five per cent of two?

Ms HENNESSY — Which is my point.

Ms SKILBECK — I can report we have achieved 100 per cent of two.

Ms PATTEN — We could say 100 per cent of two, could we not?

Ms HENNESSY — We got there.

Ms SKILBECK — On the upside, we have achieved 100 per cent of two within the time lines of our usual schedule 8 drugs and poisons — —

Ms PATTEN — That is great. Fantastic.

Ms SKILBECK — In fact within one week each of them.

Ms PATTEN — Obviously we are all waiting for those 450 eligible patients to access the medicine that I was privileged enough to see being produced late last year. I note also in the debate about this that that product will be significantly subsidised given the expense of producing for such a small number of patients, but there is no budget for the medicinal cannabis office or for subsidising the production and access to that medicine.

Ms HENNESSY — I can address that issue for you, Ms Patten. I cannot recall if it was in last year's budget papers or the budget papers before, but there was an allocation in the order, I believe, of a guesstimate of $27 million. I will come back to you on that.

Ms PATTEN — Thank you.

Ms HENNESSY — But that was to fund the establishment of the Office of Medicinal Cannabis and the start-up costs around the manufacture. It is $28.5 million I have.

Ms PATTEN — And that money is still sitting there?

Ms HENNESSY — That money is in the base. That also includes money for a hardship scheme. By virtue of it being, at this stage, a state-produced product, we ultimately do see ourselves moving towards an industry licensing approach. Of course the commonwealth regulatory intersection there becomes important, but the money allocated from the health perspective as opposed to the Agriculture perspective flows from — the first-year budget or second-year budget?

Ms PEAKE — Second.

Ms HENNESSY — Last year's budget.

Ms PATTEN — Great. Just following on from that and looking at page 231 of budget paper 3, where you have got a performance objective of reducing deaths resulting from the misuse of prescription medicine, I wonder if you could briefly give me a date of when we are going to get the prescription monitoring scheme up and running? I am assuming none in the budget this year because the money was invested last.

Ms HENNESSY — That is correct; the money was invested last year. Melissa may be able to give us an estimate, but things are progressing well. As you would imagine, 11 coronial recommendations in the space of four years keeps us very focused. There is some debate amongst the expert advisory committee around what more than schedule 8 and of course debate since the feds have changed some of the regulation around codeine. But Melissa may be able to give us an estimated completion date.

Ms PATTEN — Even if you could give that to me on notice.

Ms SKILBECK — I can mention briefly now. We are still working to a 2018 delivery of the monitoring scheme. As the minister mentioned, there are a couple of key policy parameters to design, one being the scope in terms of the addictive drugs but particularly the need to mitigate forum shopping or chemist shopping. Also, very importantly, the response to what would be a working monitoring scheme means a lot more revelations of addiction issues as a result. So there is a significant amount of work going on with both those key issues.

Ms PATTEN — So when do you think it will be operational?

Ms SKILBECK — I think it will be late in 2018. While not the most expensive part of the project, at the core of it is a significant IT piece of work, and we are working very closely with the commonwealth government, who hold the database code against which we are seeking to have a national scheme.

Ms SHING — Thank you, Minister and witnesses, for the presentation and for answering the questions to date. Minister, I would like to turn to the issue of regional health. We have seen that there is a big distinction between the $400 million that we have invested, which you referred to in your opening presentation, over the three-year period in rural and regional capital and that map that was put up that shows very clearly a number of engineering, capital and ongoing works that are spread right across the state, and contrasting that with the $464.8 million that I think you said was over the four budgets of the previous government.

I would like to turn to regional hospital growth, and in that sense I note that population growth has been a key theme of many of the witnesses who have appeared before PAEC in this set of hearings. Accommodating that growth and making sure that we can meet the challenges associated with acute and ongoing care needs is a big part of making sure that we incentivise people to move to regions and to stay in regions and also give them equity and equality of opportunity for excellence in care.

I would like to take you to budget paper 3, table 1.18 at page 78, and to have you go through the elective surgery numbers and the way in which that 174.3 million will be allocated and what the process will be for individual hospital budget allocations in the course of this year along with policy and funding guidelines.

Ms HENNESSY — Thank you very much for your question, Ms Shing. Many of our regional health services will all benefit from both the $1.67 billion to meet demand and growth, particularly on elective surgery, as you correctly pointed out. There is $320 million for elective surgery. For many of those regional hospitals it is the same process as our metropolitan hospitals. We get our funding envelope. We then develop what are called policy and funding guidelines. That then enables the negotiation and discussion with health services around what activity they will perform that year. That then culminates in the signing of the statement of priorities, something that we now all publish, unlike times gone by. So the core investment will have a significant impact on our rural and regional hospitals, is probably the first important point to make.

The other issue is, I think, the very, very welcome investment from the rural infrastructure capital support, the largest of its kind. That started to flow from last year in the budget — $200 million. I would compare and contrast that with the 56 million that was invested by virtue of the previous government as well, and that map steps out where those investments are going, but there are really significant investments that are flowing from the benefit of that fund. Wangaratta will finally get a new critical care unit and a new emergency department. Mildura is getting an expansion of the intensive care unit and high-dependency unit. Djerriwarrh has $10 million to expand their theatre expansion, a maternity upgrade and more post-delivery beds. I am happy to furnish the committee will all of those specifics, but they have been welcomed with open arms by many of our rural and regional health services.

Many of our rural and regional health services are very good at adapting to the needs of their local demography, and so it may have been that 50 years ago maternity was their core business, but as their local community has aged things like aged care might be a more pressing need. Aged care has a significant commonwealth interface, and of course there has been a really significant cut in aged-care finding from the commonwealth government, which Mr Foley can talk to you about more insightfully than I. That has certainly led to some very challenging issues for many of our rural health services.

There will not be one rural or regional health service that will get less money than they got last year, Ms Shing. I can absolutely —

Ms SHING — I did want to pick up that particular point, Minister, because if we were to believe everything that we read, there would be — —

Ms HENNESSY — Always a dangerous proposition.

Ms SHING — Well, it is a dangerous proposition and a dangerous starting point, but there is a claim that has circulated in various parts of the popular media around cuts to hospitals and smaller rural hospitals. That is a claim that has been made. I am just looking at budget paper 3, page 228. I would like to get you to explain the extent to which that claim is or is not correct and also then to take us through the increase, as it appears to be at page 228, around small rural hospitals.

Ms HENNESSY — There is no cut at the behest of the state government by any stretch of the imagination. As I said, it will be to the contrary. The line item to which you refer indicates a decrease due to a reduction in federal aged-care funding. That is something that is certainly hurting many of our rural health services, but it is our position now and always will be going into the future to continue to invest in and support our rural and regional health services. That is evidenced by the fact that they will all be beneficiaries of the $1.67 billion, and we will be negotiating their funding and policy guidelines in the coming months as is the standard practice. But also they are and will continue to benefit from access to the $200 million regional infrastructure fund. This morning also we have announced an eligibility for palliative care services to also be able to apply for that fund, and it is quite extraordinary that someone would assert that we would cut funding to any of our rural health services. That is not factually correct, but they have suffered at the hands of a federal government cut in respect of aged care.

Ms SHING — So the only reduction that has occurred is as a consequence of commonwealth funding changes to aged care; is that a correct summary?

Ms HENNESSY — That is correct.

Ms SHING — Thank you. Minister, I would like to get your take on the tyranny of distance in rural and regional health care and meeting those needs. I represent an area which takes a lazy 7½ to 8 hours to drive

across, and for people who live and work in those communities, getting access to specialist services is often incredibly challenging. How have we addressed those challenges through telehealth and telemedicine, and to what extent does this budget enable regional hospitals to spread specialist services and better allocate care across large regions?

Ms HENNESSY — Thank you very much, Ms Shing. Through a number of ways: through our generalised $1.67 billion investment and through our ongoing capital investments and our infrastructure investments. And you are right to identify telehealth as being a platform that has enormous potential, and we have made and continue to make significant investments in telehealth. In fact — I cannot remember if it was this week or last week, the days all blend together — I was at Monash Health where a wonderful new surgery simulation centre has opened with generous philanthropic contributions, as well some funding from the state government. That of course is going to provide telehealth services to theatres down in the Gippsland region, but it also helps us be good global citizens. It serves not only in being able to provide platforms for people to be able to access services from telehealth in the Latrobe Valley, a place that I know is dear to your heart, we have invested in a number of telehealth projects to ensure, for example, that people are not required to travel significant distances.

Ms SHING — For training and specialist consultation.

Ms HENNESSY — For training and specialist consultations that they ordinarily would have to, and we will continue to use that as a platform by virtue of just the tyranny of distance but also access to clinicians with a particular specialty. We do it around dental. Another terrific one is in Shepparton, a relationship with the dental hospital down here. So kids who are requiring things like cleft palate surgeries are able to access those through telehealth locally as opposed to having to make the big trip to the big smoke.

Ms SHING — Thank you, Minister, and I would also just like to ask about another project dear to my heart in West Gippsland, an update on planning for a new hospital in more concrete terms than an amorphous opposition release might talk about. Where are we at with that?

Ms HENNESSY — We are very committed to all of our health services across the state, but we are especially committed to the health services to which you refer.

Ms SHING — We will probably end up coming back to that one because I think we are out of time.

Ms HENNESSY — I am happy to come back to that.

Mr T. SMITH — I will continue to Ms Peake. In 15–16 at BP 4, page 39, 106.3 million was allocated for expansion of Monash Health's Casey Hospital. An additional 28.61 million was announced in October 2016 making a total of 134.91 million; however, in the 17–18 budget, budget paper 4, page 56, shows TEI of 139.91 million for Casey Hospital. Why is there now an additional 5 million to deliver this project?

Ms PEAKE — Sorry, Mr Smith, could I just check whether you are talking about Monash Children's or Casey?

Mr T. SMITH — Casey Hospital.

Ms PEAKE — Thank you. I will just ask Mr Foa to outline the update on that project.

Mr FOA — Thank you. It is an increase in scope essentially, through you Mr Chair. The total scope will be 134 million. So a total commitment of 134.91 million will deliver an extra 64 beds, bringing the total number of beds to 160. It is also a significant increase in the floor area of the existing facility, including four additional operating theatres, a new intensive care unit and a new day surgery unit enabling the hospital to treat more patients and support more births. The expansion will enable the Casey Hospital to treat an extra 25 867 patients and perform an extra 8000 procedures.

Mr T. SMITH — I do not mean to catch you up, but the budget says 139 million; our question is why the extra 5 million.

Mr FOA — I might come back to that, if I may.

Mr T. SMITH — Will you come back today? Are you going to come back during the hearings on this?

Mr FOA — If possible.

Mr T. SMITH — Monash Medical Centre — the budget delivers 63.2 million for an upgrade with an estimated completion date of quarter 421–22. Can you confirm that this means that the separate emergency department paediatric space is not expected to be delivered for five years?

Ms HENNESSY — Thank you, Mr Smith, I am assuming that was a question for me.

Mr T. SMITH — It was actually to Ms Peake, but if you can answer it, Minister, that would be terrific.

Ms HENNESSY — That is a project where there is both a paediatric and an adult addition to the existing facility along with a mental health unit, and of course we inherited a project that did not have an emergency department scoped into it, that did not have a helipad scoped into it and where the adolescent mental health unit had been taken out of it, and we have sought one by one to address those.

Mr T. SMITH — My question was very, very specific.

Ms HENNESSY — Sorry, what reference — if you could just identify — —

Mr T. SMITH — The emergency department paediatric space is not expected to be delivered for five years. Is that correct?

Ms HENNESSY — Let me just clarify that. It is a project that will take a significant amount of time due to the scale — but I will get you the date — because it also involves reconstruction of the traffic access out the front.

Mr T. SMITH — Okay. Terrific. That is during the hearing today or on notice?

Ms HENNESSY — As soon as I can, I will provide you with that information, Mr Smith.

Mr T. SMITH — Okay, today; fantastic. I refer to budget paper 3, page 90, where for South West Healthcare it has a $7.5 million line item, but the footnote outlines it is already funded out of last year's budget allocation. Why has this hospital's planning funding been specifically identified in this year's budget as a recipient of the Regional Health Infrastructure Fund when it is clearly funded out of last year's allocation? To Ms Peake, if you do not mind, Minister.

Ms PEAKE — Again I will defer to Mr Foa. This is a question, Mr Foa, about the $7.5 million for planning at South West, that has been allocated from the regional infrastructure fund. I can start the answer — while you are just reflecting — to your question, Mr Smith, that it is a specific allocation from that regional infrastructure fund for that purpose.

Mr FOA — Through you, Chair. It is about the continued delivery of high-quality health services to the south-west area, and to support the planning, the 7.5 million will cover master planning, a feasibility study, schematic design, detailed design and documentation of the next stage of that project.

Mr T. SMITH — Yes, but I am just wondering why — it was funded last year — —

Ms PEAKE — The $200 million regional infrastructure fund was the source of funds. That was announced in last year's budget. It is now an allocation from that fund, which is why it is specifically identified in this year's budget as a specific project.

Mr T. SMITH — Okay. Moving on, Northern Hospital: budget paper 4, page 56, says that the estimated completion date for the Broadmeadows surgery centre is quarter 1 of 19–20; however, I understand it will be commissioned this year, which is a massive improvement in time. Will a similar approach be undertaken on the Northern Health expansion — BP 4, page 55 — to speed up the time frame again given the urgent needs in the north?

Ms HENNESSY — Sorry, I cannot hear your question, I am sorry, Mr Smith.

Mr T. SMITH — Sorry, the acoustics in here are shocking, Minister, but I will try.

Ms HENNESSY — Yes, sorry.

Mr T. SMITH — Do you want me to read it again?

Ms HENNESSY — Yes, please.

Mr T. SMITH — BP 4, page 49, estimates the completion date for the Broadmeadows surgery centre is quarter 1, 19–20. I understand it will be commissioned this year, which is a massive improvement in time. Will a similar approach be taken on the Northern Health expansion, budget paper 4, page 55, to speed up the time frame again given the urgent needs in the north?

Ms PEAKE — That is certainly our intent.

Mr T. SMITH — That is your intent?

Ms HENNESSY — And if I could just also make another point, the dates that are identified in the budget papers are around capital. They are sometimes financial completion as opposed to when a health service will be operational, which is often a significant time before then, so if you bear that in mind. People do want and need us to get cracking on the Northern Hospital, but it is important we get all of the right planning works done. We know some of the mistakes that are made when people rush out the door. The Eye and Ear Hospital is an example of that, but I absolutely concur that we absolutely need to get cracking on that capital redevelopment.

Mr T. SMITH — My final question: budget paper 4, page 56, Ballarat health cardiovascular services has an estimated completion date of quarter 2, 18–19. This is an 18-month blowout from the estimated completion date of quarter 4, 16–17 from last year's budget. Why is this project so significantly delayed?

Ms HENNESSY — Mr Smith, I will have to ask Mr Foa to address that issue, but again I would reiterate my point that the completion date as reported in the budget papers is financial completion and not necessarily construction. But to go to your point, I will ask Mr Foa to provide you with what insight he can.

Mr FOA — Through you, Chair, briefly it was a request by the health service to slow the project down by a couple of months — about four months — to allow for them to stage the works with the least amount of impact on the health service.

Ms HENNESSY — I have just been updated, Mr Smith. I am advised that we are due to open later this year.

Mr T. SMITH — The hospital front door — as in, this issue will be resolved at the end of this year?

Ms HENNESSY — The cardiac cath lab will be open, and the date to which you have referred and what was presumably the genesis of your question is because that budget paper includes the completion of cash flows for the project and not the operational date, as it does on many of those projects.

Mr FOA — I have the answer to the 5 million Ballarat question, through you, Chair, if that is appropriate. It does relate to a contribution from Monash University — the extra $5 million — for Casey Hospital.

Ms HENNESSY — That is because a nursing school is being built in the expanded scope of Casey Hospital.

Mr MORRIS — Can I just go back to Mr Foa on South West Healthcare. Did I understand correctly that you are saying that — the Regional Health Infrastructure Fund was announced in the 16–17 budget. Presumably it was funded at that time, but the allocation for South West Healthcare is funded from that fund in this year's budget.

Mr FOA — At 7.5 million.

Mr MORRIS — That is what you are saying?

Mr FOA — Yes.

Mr MORRIS — Okay. Another quick one on Ballarat. I understand Ballarat Health still has not been funded to fit out their empty space with operating theatres, and there is, I understand, a 59 per cent blowout in waiting lists up there — —

Ms HENNESSY — I am sorry, Chair. I just cannot hear the question.

Mr MORRIS — I was having that problem Friday. Ballarat Health, as I understand it, has not been funded to fit out their empty space with operating theatres despite elective surgery waiting lists having blown out by 59 per cent since 2014.

Ms HENNESSY — Thank you very much, Mr Morris, for your question. We are very committed from a capital perspective to Ballarat Health, as evidenced with a $10 million investment to open up a new cardiac catheterisation lab there. Loddon — a really significant issue with cardiovascular disease. We have made significant investments at Ballarat Health through the regional infrastructure fund, including $1 million in funding for the planning for the future expansion of those services. A pipeline upon coming to government would have been helpful, but we are gradually ensuring that we get — —

Mr MORRIS — We are two and half years in. We have had an almost 60 per cent increase in the waiting list and space there, and it is not funded.

Ms HENNESSY — No planning has been done, Mr Morris, for the fit-out. For four years of the previous government —

Mr MORRIS — You have had two and a half years, Minister. Come on. You cannot blame us.

Ms HENNESSY — no planning was done, and $1 million has been provided.

Members interjecting.

Ms HENNESSY — And $1 million has been provided to Ballarat for the purposes of doing the planning for that very project so we do not end up with a sick situation like the Eye and Ear under the previous government and a $30 million blowout.

Ms PENNICUIK — Minister, if I could refer you to budget paper 3, pages 24 and 25 with regard to drug rehabilitation services, on page 25 it says:

> Thirty new residential rehabilitation beds will be established within existing services …

On page 24 that looks like about 34 — nearly $35 million over the forward estimates. The submission by the Victorian Alcohol and Drug Association to the state budget points out that the number of residential rehabilitation beds in Victoria is half what it is in Queensland, one-third what it is in New South Wales and Tasmania and a quarter what it is in Western Australia, and they estimate about 300 more beds are needed to bring us up to par.

Ms HENNESSY — I did not want to interrupt you during your question, but this is Minister Foley's responsibility.

Ms PENNICUIK — Okay, sure. Okay, thank you.

Ms HENNESSY — So my apologies.

Ms PENNICUIK — I will raise that with him. You should have interrupted me, because it is just taking time.

Ms HENNESSY — I did not — you had a head of steam about you.

Ms PENNICUIK — No, no — you should have interrupted me. So my other question is: I asked you before about the medical equipment replacement program and the asset initiatives — that is budget paper 3, page 90 — and the committee was provided with a list of where those were. I wondered if you could provide a list of the metropolitan and rural health services that are selected for the 'engineering infrastructure replacement program' and also for the 'clinical technology refresh — cybersecurity and network connectivity' asset initiatives and some information as to what they actually are.

Ms HENNESSY — Absolutely. I am happy to do that. I might ask Mr Symonds to provide you with some greater insight in terms of discretely what those funds do. Obviously what occurred in the United Kingdom in

respect of cybersecurity just recently has had a pretty difficult and devastating impact. We, prior to that attack, had made a determination that we needed to do more around protecting our health services from cybersecurity. Mr Symonds, would you like to just briefly give an overview of what the various infrastructure technology capital refresh and cybersecurity funds will provide?

Ms PENNICUIK — In the short amount of time we have, if we could just have a description of that? The actual list, if we could just have that on notice for the committee.

Ms HENNESSY — Yes, absolutely.

Mr SYMONDS — So in general the funds go towards health service needs to maintain plant and equipment they have as part of running their facilities. In terms of specific cybersecurity investments, I will take that one on notice.

Ms PEAKE — I can certainly, Ms Pennicuik, give you some information. Over the last 12 months we have done a lot of work with our health services to really look at network security: patches — so antivirus and software patches as they become available — liaising with all of the vendors to ensure that their environments are secure and, again, that they have applied the patches that are necessary; and looking at scanning of active networks to make sure that the sorts of threats that we saw on the weekend we can detect, if we have got points of vulnerability, early.

Ms PENNICUIK — Thank you. Just on another issue going to your presentation, page 6, with regard to quality and safety across the health system and avoidable harm. I am wondering if that includes upgrades to security in hospitals with regard to safety for patients and staff in hospitals and whether that is part of that?

Ms HENNESSY — I am delighted to speak to that.

Ms PENNICUIK — And if we run out of time, if you could provide it on notice.

Ms HENNESSY — I will take it on notice. Very, very quickly: that funding for Safer Care Victoria and the new data agency is to what that financial allocation in my presentation speaks. You may or may not recall in our previous budgets a new occupational violence fund that we have been using as each health service has been identifying its risk around the safety of staff. It is a continuing challenge for us, and we have got a lot more work to do. Some of that has been about improving the capital facilities that staff are working in. Others have been for nurses that are providing at-home care having personal alarms — —

The CHAIR — Order.

Ms PENNICUIK — If you have any more details, if you could provide that to the committee.

Ms HENNESSY — I am happy to provide you with a list of that.

Ms WARD — Thanks, Minister. I just wanted to draw your attention to and ask you to have a bit of a conversation with us around end-of-life choices and end-of-life care. In budget paper 3, page 228, we have got the 'Output summary by departmental objectives' and we have got 'Victorians are healthy and well'. I understand that there is some work that has been planned over the next year in terms of end-of-life care. Can you please talk us through that?

Ms HENNESSY — Absolutely. Thank you very much for your question. As you would be aware, a new palliative care framework was developed last year, and in the course of the development of that framework there were a range of issues that became apparent. At a really high level about 14 per cent of people currently die at home, and we know from most research that about 75 to 80 per cent of people wish they could die at home. So we have got large amounts of people whose end-of-life care is in either a hospital, acute or an aged-care setting, and so that was a really significant issue.

More generally across the palliative care landscape we have got, very broadly, three forms of providers. We have health services that provide palliative care, we have community-based palliative care, and government provides funding support for both of those entities, but there is also a range of charities that provide palliative care, and they are not traditionally funded from government entities as well. More generally, the budget includes growth funding for both community and acute palliative care, and what we are very focused on in

terms of reforms of the model is transitioning from a hospital-based model into a home-based model. But that is not just a simple task. Depending upon where a person is, it has got different challenges.

One of the challenges, for example, and it is particularly acute in rural and regional Victoria as you would imagine, is for home-based palliative care and access to things like a 24-hour GP, if so required. Despite the expertise of many of our healthcare workers there are issues around the regulation of drugs that are required for different people at the end of their lives. So we are very focused on doing the workforce training to look at how you get the model of care to enable reform of the palliative care model to enable people to not just die in hospital settings.

So we have done a number of things to that end. As I said, we are going to be investing in growth funding this year for both community-based and our health services. We opened up a $5 million capital grants fund as well for our community-based palliative care services. The sorts of things they said they wanted were things like iPads so they are able to communicate with their other providers; attachments to cars; there is a whole range of — —

Ms WARD — These are grants that were announced today? Is that right?

Ms HENNESSY — Yes. We have — —

Ms WARD — I understand that you came out to Banksia Palliative Care in the north-east not so long ago.

Ms HENNESSY — I did. It is an extraordinary palliative care provider.

Ms WARD — And you met with Ardy's angels —

Ms HENNESSY — I did.

Ms WARD — some young kids who have raised about $3000 in memory of their friend who received palliative care at Banksia.

Ms HENNESSY — They are raising money by selling lanterns for a gentleman that lived down the road who died. They were with him, particularly during the end of his life, but very proudly talked about his wake. There were a number of stuffed animals — a bit of taxidermy going on. They were particularly delightful as well.

Ms WARD — They received nearly $100 000 today, I think. So the kinds of things they have are car leasing but also, as you said, other equipment that really helps them. Could you talk us through what that money is for in more detail?

Ms HENNESSY — Absolutely. Particularly if you are a community-based palliative care provider, things like the wear and tear on the car is not something that you have necessarily got a direct source of funding for — so things like transportation, and things like mobile phones for palliative care workers to be able to communicate back with their service provider. iPads was another really big issue, so technology has been a really, really important part of that particular issue as well.

Ms SHING — What about for regional palliative care in that space with grants, because that is a really challenging issue as well, not just distance but connectedness and dignity and assistance for people who are dying at home?

Ms HENNESSY — It is, and I think there is lots more we can do in that space. That is my general view. Today we have also opened up our regional infrastructure grants to community health palliative care providers as well. It is very similar to some of the investments that have supported that. Sometimes it is the simplest of things that can transform an organisation's or a service's ability to be able to deliver more care at home. But we do have to do I think the important work around reforming workforce training to get a model of care that is safe and secure, so it is not just the palliative care nurse or the volunteer that bears all of the responsibility around clinical issues and spiritual care. Getting the right model for people and their families is absolutely essential, and that is essentially the thrust of the palliative care reform work that we put out last year.

Ms WARD — The interim report from the ministerial advisory panel into voluntary assisted dying I think came out today, and there has been a bit of conversation already. What were the views of those who were making submissions into voluntary assisted dying?

Ms HENNESSY — Obviously this is an issue where there are many that are opposed a priori and many who have been supporters of law reform for a long period of time. The thing that I take great heart from is that so many parts of the health system are very engaged with the issue to say, 'How is it that we can ensure, if there is an assisted dying model that is supported by the Parliament, that that is anchored into the mainstream health services so it does not risk becoming a fringe issue?'. It ought be seen as part of palliative care, and more generally I think the really critical issue is that there is clarity and support, and that has absolutely been the experience of the panel.

Ms WARD — With that, where do you see that sitting within our health system?

Ms HENNESSY — At the centre of our health system with other services. It is important that it is mainstream. It is important that it is part of the palliative care system. It is important that it does not risk becoming one of the fringe issues. I think that is absolutely essential. It is a little bit like medicinal cannabis. Many people contact me on a regular basis, who are often in unbearable pain, asking about progress on this, and, as we all well know, the wheels of government and Parliament are clunky. Also it was a recommendation of the upper house inquiry that, should a model be supported, there be an 18-month time frame within which to ensure that all of the implementation issues are addressed as well.

There is an extreme, heightened community interest in this issue. I think it is important that we all become more comfortable talking about death, not just on the political platforms. I think traditionally some of these issues have been binary — you were for or against some form of assisted dying — but more generally, in a death-denying culture, trying to get the attention on the policy issues around how we die in the same way that we put great attention, and rightfully so, on how it is that we come into life, the maternity models of care, early intervention, all of those issues; it is just really not being given the focus that it deserves, and like taxes, Ms Ward, it is an inevitability for all of us. They are challenging policy issues, but I am hopeful around a mature discussion, and I have been incredibly heartened by the participation of all different arcs of the health sector to ensure that they do not ignore these critical and important issues, but there is still a significant amount of work to do.

Ms WARD — There are a lot of conversations that the department is going to have to engage on. Has the department got the support that they need to do that?

Ms HENNESSY — I would say absolutely, but perhaps that might be leading the witness to my left. I am happy to invite Ms Peake to make a — —

The CHAIR — Order! Opposition questions. I understand Ms Peake has an answer to some of questions from the opposition previously.

Ms PEAKE — Actually I am just going to ask Mr Symonds. This was just in relation to Mr Morris's question about additional funding support that had been provided to Peter MacCallum in the current financial year.

Mr SYMONDS — Mr Morris, I understand the question was how much additional funding has the department provided to Peter Mac since the statement of priorities and its budget were published, and the answer is $2 million. That is associated with unexpected increases in demand for services at Peter Mac. It is all for the treatment of patients.

Mr MORRIS — Thank you very much. Can I move to budget paper 3, page 228.

Ms HENNESSY — I am terribly sorry, Mr Morris. I seriously cannot hear you.

Mr MORRIS — First of all, I will say the question is for Ms Peake, rather than you, Minister.

Mr DIMOPOULOS — Still, the minister might want to hear.

Mr MORRIS — I am sure she will. Budget paper 3, page 228, which is the output summary, but according to the 2015–16 DHHS report, the most recent one, public health services spent $67.3 million on electricity for that year. The ABS released some stats recently showing that electricity prices had risen by 7.7 per cent in the March quarter of this year following the announcement of the Hazelwood closure and more price rises have been flagged. How much are public health services expected to pay in electricity costs in 16–17 and 17–18?

Ms PEAKE — If I just take a little bit of background before I come to your question, it is worth the committee noting that the public health system emits about a quarter of the state government sector carbon emissions and in 15–16 spent $88.1 million on 4658 terajoules of energy, which equates to about a 6 per cent increase in energy use since 2005–06. That is in the face of occupied bed days increasing by 22 per cent over that period and floor area by 27 per cent.

Mr MORRIS — Sorry, what year was that?

Ms PEAKE — That was over the period of 05–06 to 15–16 that we saw those increases. Energy costs over the same period have increased by 60 per cent generally, so the health system itself has benefited from very low energy prices over the past three years as Health Purchasing Victoria secured really favourable electricity rates well below the market norm. Due to those low rates it is expected that there will be a market correction in the new contract, which is due at the end of this year. So what we are working on as we head up to that new contract period of negotiation is a funding strategy to lessen the impact of rising energy costs for health services.

It is also worth noting that a number of our bigger services, in anticipation of the new contract coming, in recent years have really invested in the ability to co-generate so that they will not be impacted by new contract prices. In particular Alfred, Dandenong, Geelong, St Vincent's and Royal Melbourne Hospital generate the majority of their energy themselves on-site. As I mentioned it is the end of this year, 31 December, that the new contracts will need to be in place.

Mr MORRIS — So are the prices effectively fixed until 31 December?

Ms PEAKE — Correct, and the negotiation over that period.

Mr MORRIS — So whatever has happened in terms of prices in the last quarter or so, or previously, is not impacting on hospitals at this point?

Ms PEAKE — Sorry, Mr Morris?

Mr MORRIS — Is it correct to say that the 7 per cent that I referred to earlier and any other adjustments that have been made are not affecting the networks at the moment?

Ms PEAKE — Certainly the price is set until the end of the year. Obviously the level of consumption will affect total cost.

Mr MORRIS — Yes, but in terms of pricing?

Ms PEAKE — Correct.

Mr MORRIS — How many of the public hospitals are part of that contract? Are all of them part of that?

Ms PEAKE — I might need to take that one on notice.

Mr MORRIS — Okay, if you could. I am wondering whether you can actually tell us which retailer is currently contracted to provide both electricity and gas to the networks.

Ms PEAKE — Certainly. That is something I would need to go back through Health Purchasing Victoria to provide.

Mr MORRIS — Sure. So if we could have those on notice. If I could move to again budget paper 3, page 228, but a different subject, and that is the cost of employing nurses. The EBA, which was agreed last year — and again for Ms Peake — has average wage increases over the four years of, as you know, 3, 3, 3, 0.25 and 9. I understand that an annual adjustment of 2.5 per cent is built into the forward estimates, but I am wondering if

we can establish what is the full cost, including the 2.5 per cent adjustment for each year of 16–17, 17–18, 18–19 and 19–20?

Ms PEAKE — I will ask Mr Stenton to talk in a little bit more detail about this, but the overarching comment that I would make, Mr Morris, is that obviously we as the department are not the employers of nurses. The question that you are asking really is deeply affected by the level of nursing that is employed by individual health services, the rosters, the workforce models that they employ. We do not hold the information, hospital by hospital, about what their workforce looks like, and therefore the impact on an individual hospital. Obviously again just — —

Mr MORRIS — Having made the agreement, having signed the deal, so to speak, there must have been an idea of the cost though.

Ms PEAKE — Certainly facilitating the negotiations on that agreement. Again, just before I throw to Mr Stenton, as is always the case in complying with wages policy, in facilitating the negotiation of that deal, there were a number of offsets and productivity measures that were identified to contain overall cost. Just to give you a bit of an example of some of those, there was a reduction in the number of paid personal carers leave days accrued per annum, an improved discipline clause, removing ambiguities, streamlining processes, improved definitions around qualifying for paid study leave. But I will ask Mr Stenton to just elaborate.

Mr STENTON — Thank you, secretary. As Kym has rightly pointed out, there are a couple of points of clarification I think. The first is the department is not a party to the agreement. The agreement is signed by VHIA on behalf of employers. Whilst we are an interested party, we are not a formal party to the agreement. The costing of the agreement, if you like, as Kym also pointed out, there are a number of offsets in the negotiation process that make it particularly challenging to calculate the cost — the gross cost or net cost. The other moving part, if you like — and there are a number of moving parts — depending on when the previous agreement had ceased, there are sometimes retrospective payments or sign-up payments that relate to different periods. The size of the workforce and the general make-up of the workforce will vary across our 86 health services. Again over the course of an agreement you will have multiple moving parts, and generally the other major moving part is the part outlined in the budget papers. On average we have been attracting $300 to $500 million additional funding for health services. That is a moving part that builds year on year through the course of any agreement. Having said all of that, the average increase of the agreement over the full settlement of the nurse's award is about 3.4 per cent per annum.

Mr MORRIS — 3.4?

Mr STENTON — 3.4 per cent.

Mr MORRIS — Over?

Mr STENTON — Over an eight-year period, so that the agreement itself — there is the formal Fair Work Commission agreement, and then there is the deed that the parties have signed. Over the course of that there is an average 3.4 per cent increase per annum. The challenging part is, what is the base that you are working off? To calculate a cost you need to understand the base.

Mr MORRIS — You must have had some estimate for the cost. Can you tell us that?

Mr STENTON — Yes. Obviously we pick a point in time, so we look at the wages make-up across health services at a point in time. The cost base at that point in time was around $3.1 billion, so 3100 million, and we average that across the course of the agreement, so 3.45 per cent on that base.

Mr MORRIS — We are very tight for time I know, but I am just wondering whether the government has received any legal advice regarding the common-law deed covering the subsequent four-year period and its legality.

Ms HENNESSY — It might not surprise you to know, Mr Morris, that the government does not reveal its legal advice. Legal professional privilege exists for a purpose.

Mr MORRIS — I did not ask you for the advice; I asked you whether you had had it.

Ms HENNESSY — Yes.

Mr MORRIS — Yes you have?

Ms HENNESSY — We are legally confident in the enforceability of our arrangements.

Ms PATTEN — I would like to turn back again to palliative care, and I note in budget paper 3, page 231, we talk about palliative separations. As you mentioned earlier in your comments to Ms Ward, most palliative care does not occur in the hospital setting. The majority of it — in fact probably 70 per cent of it — happens out of care. I am just wondering, while this is a somewhat useful number for palliative care beds, is there any way that you are tracking palliative care numbers as a whole in the broader community?

Ms HENNESSY — Thank you, Ms Patten, for your question. I am going to have to rely upon the assistance of Mr Symonds, but if I could make some preliminary comments to you. You will note that the palliative care output measure has changed this year. That is an attempt to get a more meaningful measure to go to the very point that you canvassed at the commencement of your question. One of the other challenges in getting actuals around this is there are many, particularly in rural and regional health services, where a bed might not be a designated palliative care bed, but because this is a person known and loved in a local community — they are having treatment for presumably cancer or other illness or disease that is either part or co-related to the end of their life — that care is provided, often because when there are people that have got nowhere else to go or no other support at home; if they are widowed, for example. There is a lot of palliative care work that is done and exists. In terms of getting meaningful measures, we have sought to try to do that in this year's budget, but in terms of actuals, I do not know whether or not Mr Symonds has something else to add or whether or not we could take it on notice.

Ms PATTEN — I am happy to take that on notice.

Mr SYMONDS — I guess I would make the point that the measure we have got here is better than the previous measure.

Ms PATTEN — Yes: the 'no measure' — in the budget, anyway.

Mr SYMONDS — It replaces the previous measure of palliative care bed days, and that obviously could reflect very long lengths of stay. What we are trying to catch is the number of community members who are benefiting from palliative care. It still has the limitation, that it measures only in-patient palliative care, and that is the point of your question, I think.

Ms PATTEN — Exactly.

Mr SYMONDS — Roughly 40 per cent of the funding that we provide for palliative care — $46 million in the current year — goes towards home-based palliative care. That is increased in the current year by $6.2 million.

Ms PATTEN — I guess I was just actually looking for numbers and whether you could take that on notice, just because I have got a further question to follow through with that.

Mr SYMONDS — Sure, happy to take that on notice.

Ms PATTEN — I guess it was that lovely term you called 'death-denying society' which I will take on board. I love that. So we have been talking about this a lot in Parliament and we passed the medical treatment planning act last year which certainly again went towards giving patients more autonomy around their medical treatments, particularly quite often towards the end of life. I do not know of anything in the budget that is assisting or any money going into the budget to help roll that out, to help train doctors, to help train hospital staff around the advance care directives as well as the planning. I am wondering if I have missed it, or if it is something happening later.

Ms HENNESSY — I might stand to be corrected on this, Ms Patten, but I am aware in the recesses of my mind that there is money allocated around the training, particularly for advance care directives. I would be happy to take it on notice whether or not that sits within the Safer Care Victoria parcel of funding or whether

that sits somewhere else in the budget papers. But I am aware that there is funding identified for the purposes of that training. I do not know if Mr Symonds can add.

Mr SYMONDS — If I could add to that, of the $123.2 million in the current financial year for palliative care, $5.9 million is for regional consultancy, $1.1 million is for regional consortia that are collaboratives of palliative care providers working together to implement the policy and share resources across the region, $8.8 million is for statewide services such as the Victorian Paediatric Palliative Care Program, the Centre for Palliative Care for education training and research, Palliative Care Victoria as the peak body, and a range of other organisations, and they — —

Ms PATTEN — But none of that was specifically around the advance care directives or the changes to the medical treatment act?

Mr SYMONDS — I think it would be caught up in that and they would certainly be delivering training that is part of that.

Ms PATTEN — Right so it would just be broadly palliative care and — —

Ms HENNESSY — As I said, somewhere in the many papers that I have looked over in the prelude to the budget, there is an identification of a source around the training and it is obviously such a critical issue.

Ms PATTEN — I appreciate it.

Mr DIMOPOULOS — Minister, I want to ask you about cybersecurity and the events of the last couple of weeks. Those in the know who work in the IT sector see every event as it happens, but the general public I think just pays attention when a massive event happens, like the other day, in terms of breach of data privacy around the world.

Ms SHING — Ransomware.

Mr DIMOPOULOS — That's right, ransomware, as Ms Shing said. Australia was apparently relatively unscathed in that last episode. There are whole industries developed around penetration testing and a whole range of other things in relation to cybersecurity. I was interested to see, though, in BP3 on page 90 $12 million almost, committed to this area. The description on page 91 — as budget documents do — has just a couple of lines because there is so much information to tell. I have got a couple of questions but the first is: can you unpack that for us? What exactly will that $12 million be spent on, and what is the context of the problem as far as it relates to the department and health records specifically?

Ms HENNESSY — It is obviously a really significant risk and not one that we have just started to try and address this year. Obviously the massive global attack and the impact on the NHS specifically over in the UK in respect of the ransomware is a significant reminder to us. I know that there were really significant consequences in the UK in respect of that attack.

As at 16 May, which is the latest piece of advice, none of our health services were impacted. However, you may or may not be aware, some years ago there was an attack on Melbourne Health that was relatively quickly resolved, but obviously our minds have been very, very focused on that issue.

I should also just acknowledge and thank our health services who, during the era or the timing of that ransomware attack, were very good about making sure that they were as secure as they possibly could be. We are actually continuing in our work with the NHS in the UK in respect of some of the work and the lessons and the learnings that they are undertaking. But cyber attacks are becoming ever more sophisticated and, for all of the wonderful work that the black hats do in their attempts to understand where those risks are and what the next frontier in respect of cybersecurity may be, we have also got to continue to make sure that we are doing everything that we possibly can.

It goes a little bit to Ms Pennicuik's question that she asked earlier, but of the $10 million clinical refresh that we have had in last year's budget, some of that money was spent on cybersecurity issues, and we are making a specific additional allocation this year. The cold, hard reality is that no networked computer system is ever kind of guaranteed to be immune from cyber attacks. But we did initiate in March of last year a comprehensive cybersecurity program that was led by the digital health team to essentially look at digital clinical systems and

health information sharing as well as how you might respond to specific malware. A sector-wide review was conducted by external specialists who had a specialisation in cybersecurity. There is a working group of the Victorian health chief information officers, so we have a standing forum that looks at those issues. They have identified an agreed response, and the five areas that we are going to be focusing on are identification, protection, detection, response and recover. I think what we saw in the NHS was that their recovery was a relatively impressive one in my view, so I think that we have probably got more to learn from their response. In Victoria reasonably good progress is being made, but with this year's budget funding, that will enable us to advance further, particularly in respect of protection and detection.

Mr DIMOPOULOS — It is interesting you say 'recovery'. I know very little about this area, but you would imagine that it is almost impossible to prevent an attack. Of course you need to focus on some security around that but more so I would imagine in terms of what you do and how you pick up the pieces very quickly afterwards. Minister, just to unpack a bit more of the framework in terms of what you mentioned before, within the department. In my community, Monash Health for example — does it have its own cybersecurity arrangements? Maybe for the secretary or whoever you want it to be for: what role does the central DHHS play? Does it mandate certain levels of protection or cover? How does that work?

Ms HENNESSY — I might ask the secretary to take you through the general governance principles around IT and ICT policy, of which cybersecurity is one.

Ms PEAKE — Certainly. Thank you for the question. Obviously there are both. At a health service level there are dedicated people who are looking at the management of systems. On top of that we provide an overarching service, particularly on something like cybersecurity, where the impacts hit the system as a whole and the knowledge about how to respond is evolving at such a rapid rate. Our health CIO internally, Andrew Saunders, has been playing a very strong leadership role across the system, bringing, as the minister indicated, all of the health service CIOs together really to look at those important issues around making sure that patches are up to date so that vulnerabilities are closed off where they exist as well as at the business continuity planning, if there were such an incident, so that the response can be as quick and thorough as possible.

Some of the work that that group has been doing is specifically around operational control, so that in each of the risk plans and business continuity plans of individual health services there is a strong emphasis and plan around cybersecurity, and of course, as the minister mentioned, that is all backed by investment in last year's budget and this year's budget to support their work.

Mr DIMOPOULOS — Thank you. They were very comprehensive responses, both of them. The other side of it from my perspective is the layperson. It is an issue for service delivery, I understand that, but there is also the issue of the privacy breach for the average person. If I do not have to go to the doctor for another year or two, or the hospital, it may not impact me in a service delivery sense, but it impacts me in terms of my privacy. In this investment does any element of it go towards communication with patients — at the time or previous to the time, giving them a sense of comfort around whatever you can?

Ms PEAKE — You would be aware, Mr Dimopoulos, that at the start of this year we had a significant issue at Melbourne Health that did lead to privacy breaches. So it is something that we are acutely aware of and have built into our three-year program, with all the health services around that up-front prevention and protection work. Where there is an incident, absolutely part of the response is communication protocols with patients around the disclosure of what information, what impact. But obviously our core focus is on trying to make sure that does not happen in the first place.

Mr DIMOPOULOS — This is more of a comment to the minister and yourself — and I am sure this is covered by the CIO and others — I have had some very interesting conversations with members of my community who are from a non-English-speaking background, who struggle with the concept of the web. Basically, it is as immediate to me as my family. My 72-year-old father says, 'Can you send this document by email?'. He initially thought you would put something through the computer. They do not get how the world has changed in that way. So I think some of that communication has to happen in languages other than English, and it has to be very, very basic to really make them understand the concept.

Ms HENNESSY — I think that is a critical issue, and I think that there are parts of the health system where we do that very well and there are parts where we have got significant growth opportunities — that is the way in which I would probably politely describe it.

The CHAIR — Order!

Ms HENNESSY — A conversation for another day, Mr Dimopoulos.

Mr DIMOPOULOS — Thank you, Minister.

Mr MORRIS — If I could come back to Mr Stenton, just on the nurses EBA, you talked about an escalation of 3.4 over the period. I am keen to get the actual figures, because by my quick calculations, if you have an average of 3.4, if it escalates by 3.4 each year, while years 1, 2 and 3 are reasonably close to the same sorts of increases as we see in the enterprise agreement — working on 3, 3, 3.25 — when you get to the fourth year, there is a big hole. So I would like to know what the figures are, and are they in the forward estimates?

Mr STENTON — So the forward estimates run through to 2021. Can I just clarify: when you say 'a big hole', you mean — —

Mr MORRIS — Well, by my quick back-of-the-envelope calculation, if you escalate at 3.4 over four years, by the time you get to the fourth year, the fourth escalation comes to 3.54 billion, in rough terms. If you escalate on the basis of the agreement, you are looking for 3.7 billion, so you are missing $160 million. So could I have the figures that are being used, please?

Mr STENTON — Yes, so I have to understand your calculation.

Mr MORRIS — On notice, of course.

Mr STENTON — I can take that. Perhaps I will go back to where I was. So the compound effect that I think that you were talking about is a natural compound effect of any percentage increase. The point I was trying to make earlier is that the base is a moving base so — —

Mr MORRIS — I understand that, but given all those moving parts, if we could see the figures, if we could have the figures on notice?

Ms HENNESSY — To the extent that what we have exists, Mr Morris, we are happy to furnish — —

Mr MORRIS — On what has gone into the forwards basically.

Ms HENNESSY — We are happy to furnish you with what we are able to do with some of the qualifications that Mr Stenton — —

Mr MORRIS — But the point is in year 4 there is a 9 per cent increase.

Mr STENTON — Under the agreement?

Mr MORRIS — Under the agreement.

Mr STENTON — Correct.

Mr MORRIS — So I would like to see what the figures are, and are they in the forward estimates for that year?

Mr STENTON — Again, Mr Morris, I reiterate that the costs in 2021 will be affected by growth outcomes during the course of the budget.

Mr MORRIS — I understand all of that, but there is one particular increase that we know about that you must have taken into account when you did the figures, and I am asking you can you please provide that to the committee?

Mr STENTON — We can take that on notice.

Mr MORRIS — Thank you.

Ms HENNESSY — Just in respect of the energy question as well, we have just got a response to you for that as well, Mr Morris.

Ms PEAKE — I will be quick. I just wanted to confirm that all of the health services are in the contract. The five that I mentioned, the campuses that are co-generating are outside and the provider is Momentum Energy.

Mr MORRIS — Thank you.

Mr T. SMITH — My question is to Ms Peake. Referring to budget paper 3, page 78, where $2 million has been allocated for improving access to the Victorian Patient Transport Assistance Scheme in 2017–18, what specifically will this funding deliver for patients in 17–18?

Ms PEAKE — I might ask Mr Symonds to brief you on that.

Mr SYMONDS — That funding increase reflects increases in demand, but there is no significant change in what it will provide.

Mr T. SMITH — Sorry, what was that? I missed that.

Mr SYMONDS — It reflects increases in demand for the patient transport assistance scheme.

Ms HENNESSY — Growth.

Mr SYMONDS — Growth in demand, and that is growth that we have seen historically. It is simply the expected increase in demand we have from rural residents, giving coverage for their transport and accommodation costs beyond a certain kilometre threshold to access specialist care.

Mr T. SMITH — How many extra patients is that going to account for?

Mr SYMONDS — I will have to take that one on notice.

Mr T. SMITH — Okay.

Ms HENNESSY — You might also be interested, Mr Smith, the new building that the government in the last budget made a contribution to for leukaemia patients as well has now been completed.

Mr T. SMITH — Thank you, Minister. The improved access that you are talking about, do you intend to deliver these improvements in 18–19 as VPTAS has not been funded in the forward estimates but just for one year?

Mr SYMONDS — I am very sorry, I did not catch that.

Mr T. SMITH — This has only been funded for 18–19. In terms of the forward estimates, what is going on there with this initiative?

Mr SYMONDS — Sure. It has been provided for one year, but each year the costs of patient transport assistance have been met. There are some variables in the equation. One is the level of provision in rural Victoria. As we establish and grow regional centres for cancer care delivery, for instance, it reduces the need for travel. As we increase elective surgery in places like Albury-Wodonga and Warrnambool, now reported through our public elective surgery waiting lists, again it reduces the need for travel. The fact that it is not reflected in the forward estimates does not reflect a lack of commitment to funding — those commitments have always been met — but there are some variables in terms of regional care delivery that we need to monitor over time. That is all a good news story from the point of view of rural health care.

Mr T. SMITH — Forgive me, but I do not understand. You are funding it for 17–18, but that is it?

Mr SYMONDS — There is a single-year commitment in that budget; that is correct.

Mr T. SMITH — What I am asking is why is it not 18–19 and after that throughout the forward estimates?

Mr SYMONDS — Because we will need to monitor demand for transport assistance over time in the context of demand for local services in rural and regional Victoria, which do not require subsidisation of transport and accommodation to the same extent.

Mr T. SMITH — Okay. Budget paper 3, page 78, lists 392.2 million for meeting hospital services demand in 17–18, but a drop of 94 million in 18–19. What does the 94 million additional funding fund in 17–18?

Mr SYMONDS — I do not know whether Mr Stenton — —

Ms HENNESSY — Could you please repeat the budget reference paper, Mr Smith?

Mr T. SMITH — Budget paper 3, page 78.

The CHAIR — Which output were you after?

Mr T. SMITH — Lists 392.2 million for meeting hospital services demand in 17–18, but a drop of 94 million in 18–19. What does the 94 million additional funding fund in 17–18?

Ms HENNESSY — My instinct on that — and I am happy to take it on notice — is that it relates to the elective surgery boost in this year's budget, but I will take that on notice.

Mr T. SMITH — Okay. Referring again to budget paper 3, page 78, where 10 million has been allocated for Better Care Victoria Innovation Fund, why has BCV, charged with fostering innovation, again only been funded for one year?

Ms HENNESSY — Thank you very much, Mr Smith. I am delighted to be able to talk about Better Care Victoria. Many of the innovation projects that have come out of the funding that has been provided in years gone by have around an 18-month phase. Just to give you an insight into the purpose of those projects, we fund those projects and then identify whether they are successful or not and then identify whether or not we scale them. An example of some of those projects might be one of the ones that we are providing, a telephone service for women who have had miscarriages through the Royal Women's Hospital — lots of telehealth, different projects. Essentially it is about getting to that point in time when we will know which of those projects might be scalable, so that is why we look at the funding required on a year-by-year basis at this point, because they are 18-month projects.

Mr T. SMITH — Okay. Thank you, Minister. But I still do not quite get why you would not put such an important program over the forward estimates?

Ms HENNESSY — Simply because we will not be in a position to understand which of I think it is 22 pilots that we are running this financial year will be scalable and capable of expansion, so it genuinely does require a year-by-year monitoring in order to understand how big might your budget be in respect of funding for that innovation fund. But if your question is, are we committed to it, yes we are.

Mr T. SMITH — Does that mean you will not fund any more pilots? Is that what you are saying?

Ms HENNESSY — No, not at all. We will be finding another $10 million worth of pilots this year. The real quest ultimately is out of those pilots which are the ones that realised a change, and there is a slight difference between innovation and performance improvement.

Ms PENNICUIK — Minister, if I could ask you some questions about dental services. If we could go to budget paper 3, page 246, where it mentions dental services, the target for 17–18 is 226.1. That is around what the actual target was. You have increased the target just slightly. But if you look at the persons treated, that is actually less than the cost. So I wondered if you could talk about why we are expecting less people to be treated for more cost.

Ms HENNESSY — I would be delighted to talk to that because I think dental health is critically important. In the same way that we now think of Medicare as a very mainstream Australian value, I think getting dental care equally as valued —

Ms PENNICUIK — It is certainly we have been pushing for a long time.

Ms HENNESSY — is absolutely critical. I certainly share your enthusiasm for that, Ms Pennicuik. Just to talk you through those figures and to answer the question that you have raised, there is 226.1 million for dental services in 17–18. So from the perspective of the state contribution, that is $19.9 million more than last year —

an increase of 9.6. There is no commonwealth funding reflected in the forward budget for the dental output as arrangements with the commonwealth are yet to be finalised — I might stand to be corrected by Ms Peake — following the federal budget. But fundamentally we have had a grand tussle with the federal government in respect of dental funding and the national partnership agreements.

There has been some progress made in respect of the dental agreements in so far as they apply to children, but the adult public dental agreement — we are anticipating a 30 per cent cut. That cut seems to be confirmed in the most recent commonwealth budget papers, and therefore, given that was their position as we were attempting to negotiate with them as the national partnership agreement was coming to expiry — and, again, really challenging because many services need clarity around what their workforce is and how do they project their activity. So that has been an ongoing challenge. But essentially the drop in the output there reflects the 30 per cent cut from the commonwealth government in respect of the adult public dental agreement.

The other issue that is canvassed there in the footnotes goes to third-party revenue, and that is essentially third-party revenue that Dental Health Services Victoria contribute. That is about $9.1 million. That is essentially patient fees from co-payments and anything we get from the commonwealth in respect of the child dental scheme and sales of goods and services, so consumables, repair and maintenance of equipment.

Ms PENNICUIK — Thank you. Just a follow-up question, on that page the waiting times for dentures and for restorative dental care are expected to blow out quite significantly, from 14 months, which is already a very long time for dentures, and 15 months for restorative care up to 22 and 23 months. Obviously people waiting for those sorts of treatments have other subsequent health problems as well. Is that a consequence of what you were just saying?

Ms HENNESSY — Is a direct consequence of — —

Ms PENNICUIK — Is that where the most impact is? Because again I see that even though — —

Ms HENNESSY — You will note that they are in things for adult dental.

Ms PENNICUIK — You are saying that more patients are actually going to be treated but not in that area. Is that — —

Ms HENNESSY — Yes, correct. And there are obviously different levels of acuity required around dental care. The impact of these cuts, particularly on lower income people — their requirements for the sorts of procedures that you have just canvassed will be hit. A 30 per cent cut in adult public dental affects access and it affects wait times. We are very committed, as evidenced in our 9.6 per cent increase in funding that we are putting into dental, but we cannot continue to sustain the commonwealth cuts. There are real impacts on patients. I am grateful that we have managed to find some resolution, albeit not a perfect one, around child dental, but on adult dental, this will hurt people and it will hurt particularly low-income people.

Ms SHING — Thank you very much, Minister. I would like to take you to the record investment into family violence that has been made in this budget. Despite the fact that some are not able to or are unwilling to see this as a law and order issue, as a health issue and as a community issue, it is very much something which is now moving from the royal commission stage and the 227 recommendations into implementation of those recommendations.

I take you to budget paper 3, pages 5 and 7, and the responsibility that you have to certain initiatives that have come from the commission as part of making sure that we have better health outcomes for the, overwhelmingly, women and children who are impacted directly by family violence. I note that you are responsible for the enhanced role for universal service providers. Is that correct?

Ms HENNESSY — That is correct.

Ms SHING — The Premier has spoken a lot about the importance of our particular response to family violence tragedies and ongoing exposure that affect women and children. Often hospitals and health services are the first place that women go to get help. Can you tell us how these initiatives are able to better assist people in the health area to respond to recommendations from the family violence royal commission and what money hospitals are getting, in particular, to help resource a better response and also how this delivers on implementing

what we said we would implement as a government — namely, all the recommendations of the commission itself?

Ms HENNESSY — Thank you very much, Ms Shing, for your question. You have correctly identified that we are all responsible for doing everything we can in respect of the prevention and the response to family violence. Of particular note in respect of my responsibilities are the issues that were canvassed in the royal commission around healthcare services being a critical potential source of early indicators. Of course healthcare services are critically involved in the response to family violence as well. Anecdotally we were just talking about dental care before. One of the very interesting things that many community dental providers share with me is the early indicator of women who come in with their teeth smashed out, and obviously some of the evidence that has been given in the course of the royal commission is that this can be another early indicator that someone is experiencing family violence. Whether it be through the emergency department, irrespective of how people necessarily identify how their injuries were sustained, the health sector, I think, is a critical part of trying to better respond to family violence, to identify it early. Even in those very tragic circumstances where you might see a particular victim who may not have had any engagement with a refuge or other services, you can usually bet your bottom dollar that they have been in a hospital or a GP or a dentist having their injuries attended to, so we should never underestimate the power and possibilities of health services as a platform to be able to identify and support.

So to that end in this budget there is $38.4 million allocated for training of health sector staff in being able to identify the signs of family violence, and not just identify what might be patent or obvious injuries. We know the Royal Women's do extraordinary work as it is. They in fact developed the pilot that we funded last year with the Royal Women's and Bendigo Health. For example, women that are pregnant we know are at a higher risk of experiencing family violence, so the Royal Women's have developed a training module, and the women and the workforce there are very good at identifying indicators of family violence. What we need to do is to lift that capability right across the healthcare settings, and sometimes it is just in the practice of being able to get a patient alone to be able to ask them about their questions or in legal services that we provide very discreetly in some of our health services to support people that are victims of family violence and might need to plan for their removal as well.

Ms SHING — Thank you for that. How do we resource our workers in this frontline service delivery? Particularly, and again I come back to the regional issues because regional figures for L17s and family violence notifications are disproportionately much, much higher, and I know that throughout Gippsland there is a critical need for resourcing and support for workers to be able to identify and assist with family violence response to individuals. How do we actually roll that out in regional areas, in small communities where people are very close-knit and everybody has a tendency to know what everyone else is doing? How do we actually manage that to make sure that we are delivering on implementing the recommendation from the royal commission itself?

Ms HENNESSY — I might invite Ms Peake to make a couple of specific comments on the rollout, but there are just two issues that I would like to briefly comment on before I do so, and that is we should also never forget that given that the health workforce is a predominantly female workforce, many of the people delivering our health services are also people that have been exposed to family violence. Certainly some of the surveys that we have done in our health services have provided some shocking results as well. Having — we have talked a little bit about the nurses EBA — things like family violence leave, but also the practice of that in terms of a regional or rural setting where the local nurse, who might be a victim of family violence and whose husband might be well known to the surgeon that she works under, is not going to put her hand up to say, 'I'm going on family violence leave'. So I think we have got some industrial issues and some other training and capability issues to look around the practice of that, but I will ask Ms Peake to speak to the particular rollout.

Ms SHING — Thanks, that would be appreciated.

Ms PEAKE — And certainly one of the things that is going to be really valuable in rolling out this work is the relationship with hubs as they become available, so having more access to specialist services who are very adept at how you have those conversations to overcome people's anxiety around identification in a local community, stigma and risk. I have been doing a lot of work with the specialist family violence sector and the police around how they will engage with our health services, whether that is GPs or it is emergency departments, both to be known so there is somewhere visible to connect to but also so that there is a clear understanding from the health services about what that referral experience will look like, what it will involve

and the sort of confidence that you are referring to that the referrals will be dealt with appropriately and sensitively.

Ms SHING — And will that also monitor the way in which people can be assisted not to have to repeat their stories over and over again? That was definitely something that came out of the royal commission in relation to the need for victims and survivors of family violence not to have to tell their story to many, many people over and over again in order to get different pieces of a jigsaw in a response as they move through the system.

Ms PEAKE — That is right, and there is a really important piece of legislation in front of Parliament at the moment around information sharing to address that very issue. So even in advance of hubs being rolled out — because they will be progressively rolled out across the state — building those relationships and giving professionals confidence around their ability to share information is key to this.

Ms SHING — Fantastic, thank you. And with the 1 minute that I have remaining I would like to talk about women's health. Another area where again it is often challenging to access services is for sexual and reproductive health as well as for conditions like polycystic ovary syndrome and endometriosis. There is a strategy that has been involved in improving women's sexual and reproductive health. I would like to get an idea of how this will reduce stigma, expand education and increase services, please — budget paper 3, page 228.

Ms HENNESSY — Absolutely. We released our strategy last year. We have allocated, by recollection, I think it is around $8 million. I am conscious of the time. That will establish a new statewide pregnancy support phone line. There is some work being done around, as you said, polycystic ovary syndrome. There is a lot of work being done around endometriosis, which is often not diagnosed and is incredibly disabling for many women. I think the studies — —

Ms SHING — Further information in writing on notice would be great.

Mr T. SMITH — My question is to Ms Peake again. I refer to budget paper 3, page 78, 'Addressing occupational violence against health workers and workplace bullying'. Taking action on bullying is obviously a priority of your department. To give us context, how many cases of bullying, harassment or inappropriate behaviour in DHHS were reported in 2015 and 2016?

Ms PEAKE — I am going to ask Mr Stenton to address that. I can also come back to you, Mr Smith, on your previous question around the variation in the output coasts. So maybe after Mr Stenton has answered this question, if you would like us to come back on that, we are happy to.

Mr T. SMITH — Okay.

Mr STENTON — Like all things, national health funding is reasonably complicated.

Ms PEAKE — Sorry, before we do this, could we just answer Mr Smith's question on the corporate side on the allegations of bullying in the department.

Mr STENTON — My apologies.

Ms PEAKE — If you do not mind, if we answer the output question, and I will get the answer on bullying for you.

Mr T. SMITH — Yes, okay.

Mr STENTON — So the output question?

Ms PEAKE — Yes.

Mr STENTON — You queried the drop-off in the output costs for 17–18 to 18–19 for hospital demand. Under the national health formula, the department effectively has a matching arrangement with the commonwealth. So as the state puts in funding, the commonwealth matches those funds. In the 17–18 year we are expecting some additional revenue from the commonwealth to be reinvested in 17–18, and again the national health funding arrangement runs over a three-year period. So for additional activity that was delivered

by hospitals in the 15–16 year, the commonwealth owes us those funds. They will recycle into the 17–18 year. There is a component that is ongoing and there is a component that is a once-only repayment from the prior year, so the gap is primarily associated with that once-only payment owed by the commonwealth, which is built into the estimates.

Mr T. SMITH — Okay, thank you.

Ms PEAKE — In terms of your question, Mr Smith, in relation to bullying, I will need to take on notice the question about the number. I can come back to you on that, but I did just want to flag to the committee that one of the really important things that we have done in the last 12 months is hire someone as a conciliator in the department. We were really clear on the back of People Matter surveys that staff were concerned about who to go to where they had concerns about bullying, and this new appointment is providing a visible point of contact with deep expertise around how to respond to bullying claims. So it is something we take very seriously.

Mr T. SMITH — Could you provide on notice in detail the results of that survey?

Ms PEAKE — Sorry?

Mr T. SMITH — Can you provide in detail results from that survey to the committee, on notice?

Ms PEAKE — Sorry, which survey are you talking about? The People Matter survey?

Mr T. SMITH — Yes.

Ms PEAKE — Certainly.

Mr T. SMITH — How many staff have been counselled or fired as a result of bullying or inappropriate behaviour during the time frame I have previously mentioned?

Ms PEAKE — Again certainly I am very happy to take that on notice. We have released to staff a bullying and harassment strategy. Again I am happy to make that available to the committee.

Mr T. SMITH — Sure, thank you.

Mr MORRIS — I will just ask, if I may, to speak about the Ballarat issue — the phishing scam. BP 3, page 228, is the reference. As we, I am sure, are all aware, during the current financial year the Ballarat Health Services was the victim of a $2.7 million phishing scam. On 1 August last year the Acting Premier, Mr Merlino, confirmed that Ballarat Health Services was undertaking a review, that money lost in the incident would be covered by government insurance and in his view the moneys could be recovered. I am just wondering, has any of this money been recovered, and if so, how much?

Ms PEAKE — One of the things that was really important from my perspective on this was the Ballarat chair coming to me straightaway when this was identified, initiating as a board their own investigation into this matter, as well as the support we provided. I might have to take on notice the amount that has been recouped, but I know that there has been significant work done at Ballarat, both around the remediation of their controls to ensure that this vulnerability is not there in their procurement systems going forward as well as the investigation they did to track down what happened in this instance.

Mr MORRIS — Okay. If I could, how much of the money has been recovered, and I am also keen to know whether any additional funding was provided to plug that gap and indeed whether that money came from the department or from VMIA, so if you could take that on notice as well.

Ms HENNESSY — Mr Stenton has indicated he has got a contribution to make on that issue for you, Mr Morris.

Mr STENTON — Mr Morris, the secretary advised that the losses were covered by insurance, and they have been. My understanding is that any recoveries will flow back to VMIA. They will not go back to the health service. The impact on the health service was negligible.

Mr MORRIS — Right, so the 2.7 has come from VMIA?

Mr STENTON — That is my understanding.

Mr MORRIS — And you will be able to tell us how much has been recovered, understanding that it goes back to VMIA?

Mr STENTON — Sure.

Mr MORRIS — Have any other health services been subject to similar scams, Ms Peake?

Ms PEAKE — Again, I might just ask Mr Stenton to confirm.

Mr STENTON — Not that we are aware of. There were some attempts at some other health services and the department itself. It is a scam that seems to have been running in the capital area, so we have had a number of instances in the departments — small numbers — where people submit invoices with false information. We have picked those up. As far as I am aware, there are no others in health services, and we have also issued some guidance around that. We have highlighted the case of Ballarat and suggested to people that they improve their controls over the financial year.

Mr MORRIS — Just on that, has the review concluded?

Mr STENTON — Of Ballarat?

Mr MORRIS — Yes.

Mr STENTON — Yes, as far as I am aware.

Mr MORRIS — What were the findings?

Mr STENTON — Again, the findings were that with the financial controls, it was the checking of the invoice details. The case involved people effectively ringing accounts payable and saying, 'We've changed our address', providing details, emailing details with pretty authentic-looking information. That is what the review found. The advice that has gone back to health services — —

Mr MORRIS — So is it possible to get a copy of the review?

Ms PEAKE — It was actually a review to the Ballarat board, so it is not — —

Ms HENNESSY — A review commissioned by us.

Ms PEAKE — It would be something that I would need to take on notice, because it is not something that — —

Mr MORRIS — Sorry, are you saying Ballarat commissioned the review?

Ms PEAKE — The Ballarat board looked at the internal controls that were at play in this incident and then took the actions, as Greg has identified, to ameliorate — — .

Mr MORRIS — Well, can we get a copy of the review from — —

Ms HENNESSY — Because they bear the responsibilities under the Financial Management Act and the Health Services Act.

Mr T. SMITH — Can we have a copy of the review — —

Mr MORRIS — It is public money from the department that was scammed, so — —

Ms HENNESSY — Absolutely, Mr Morris. You will not find any quibble from me for having systems to ensure that shysters are not ripping off very valuable health resources.

Mr MORRIS — Yes, so can we get a copy of the review?

Ms HENNESSY — We are absolutely happy to take that on notice and provide you with what we can, but we make the point around the technicalities as to who commissioned it and therefore who has the permission to provide it.

Mr MORRIS — I understand, but effectively the department is the funding source for the network, so presumably, if they know what is good for them, they will hand it over.

Ms HENNESSY — And there are other obligations under the Financial Management Act as well that we bear, so I am happy to bear those.

Mr MORRIS — Can I move on to an entirely different subject, the national proton beam therapy centre? I think this question is probably appropriate for Ms Peake. The centre was allocated 50 million last year. None of that 50 million, as I understand it, has been spent. It is 5 million in 2017–18. I am just wondering what that 5 million will be spent on.

Ms HENNESSY — I will get Ms Peake to speak to that. The assertions that you have just put are not correct, Mr Morris, so, if we could, I will just correct what you put in your question, because it was not correct. I will ask Ms Peake to do that.

Ms PEAKE — So there has been initial planning work that has led to the finalisation of a business case. In terms of that first expenditure, that is a business case the core parts of which we have shared with the commonwealth, and it will inform the work from here.

Mr T. SMITH — Just going back to bullying very quickly, could you provide also a percentage of DHHS workers who said they felt bullied in the 2016 People Matter Survey?

Ms PEAKE — Certainly, Mr Smith. I am happy to take that on notice. We are very transparent with our staff on the results of the People Matter Survey. It is something we feed back to staff, so I am happy to do so.

Mr T. SMITH — Also the conciliator that you were talking about before, is that a permanent appointment?

Ms PEAKE — It is.

Mr T. SMITH — Also, what is the cost of the conciliator?

Ms PEAKE — It is a VPS position, so I would have to check the level of it and come back to you on that.

Mr T. SMITH — On notice, that would be great. I have also got nine questions on notice which I would like to — —

The CHAIR — No, Mr Smith.

Mr T. SMITH — They are very important questions.

The CHAIR — No. Ms Patten, until 12.30 p.m.

Ms PATTEN — I have got a couple of quick queries. One is about the HACC program and certainly the change to the HACC program, which is now HACCPYP, so it is just for young people. I noted in the budget on page 239 that — —

Ms HENNESSY — Ms Patten, could I just interrupt you? HACC is Minister Foley's bailiwick. I am happy for you to ask the question and for Ms Peake to tell you what she knows, but I am no good to you.

Ms PATTEN — No problem. We will wait for Minister Foley.

I was then turning to page 248 of budget paper 3 and looking at the participation rate targets for breast cancer screening and for cervical cancer screening, and I was just interested that we have got a target for 17–18 of 54 per cent for breast cancer and 62 per cent for cervical. I suppose in my mind it is like, 'Why wouldn't we be targeting 95 per cent or much higher numbers?', so I was interested in why our target is half of the eligible women for breast cancer and 60 per cent for cervical.

Ms PEAKE — Thank you, and I might start if the minister does not mind. We are also going through a process at the moment with renewing the cervical screening program. The targets that we have set this year are really ahead of looking at that renewal, which will be coming in the near future. That will mean a change to cervical screening intervals — women will need to screen every five years rather than every two years — so it will significantly alter the participation rates and the number of women screened during the intervals. A lot of women are waiting for that new screening process to come in. The target age range will change as well, so I think this is a measure that we will talk to the committee about changing once that program has been reviewed.

Ms PATTEN — So you anticipate that that 62 per cent target will grow once we go to the five-year testing period.

Ms PEAKE — Correct, and it will be a different age range that we will focus on as well, so the nature of the target and the actual numeric of the target will be something we will be looking to adjust in future years.

Ms HENNESSY — Do you mind if I make just a couple of comments, Ms Patten?

Ms PATTEN — Yes, and I was also interested in the breast screening at 50 per cent.

Ms HENNESSY — Yes. Similarly there are many local government areas where we are under target in terms of breast screening, and it is a little bit like immunisation rates — it can surprise you. You might assume that it is in lower socio-economic groups where you have lower rates, but I know, for example, in places like Wangaratta, where we have just opened up a new BreastScreen, they are much higher than the statewide average. In this budget — and I take your comments on board in respect of the output budget — we have got some funding to do 10 000 more breast screens each year as well. BreastScreen do a really terrific job trying to target those groups where we have got unacceptably low rates of breast screening. Those groups are not a surprise.

Ms PATTEN — So, Minister, are you suggesting that the extra money to get 10 000 more women to be screened for breast cancer is not included in the targets?

Ms HENNESSY — I would anticipate that we should see a larger target. The process of budget output measures is a little bit like sausage making. I think there is a rule of thumb around when you get to a statistically significant difference is when you change the target. Your question sensibly says, 'If you are putting more money in, why would you not see a better result?'. I am saying I want to see a better result, and I am confident that with the additional investment we will achieve one.

Ms PATTEN — Great, thank you.

Ms HENNESSY — I have an update here for you, Ms Patten: $500 000 to the Office of the Public Advocate for training and advice on advance care directives, and that is recurrent money in respect of the issue of advance care directive training.

The CHAIR — I would like to thank the witnesses for their attendance: the Minister for Health, the Honourable Jill Hennessy; Ms Peake; Mr Symonds; Mr Stenton; Ms Skilbeck; Ms Congleton; Mr Wallace; and Mr Foa. I think there were 13 questions taken on notice, so the committee will follow up on these in writing. A response answering the question in full should be provided in writing within 10 working days of the committee's request.

Witnesses withdrew.