PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the 2026–27 Budget Estimates

Melbourne – Thursday 21 May 2026

MEMBERS

Sarah Connolly – Chair
John Pesutto – Deputy Chair
Jade Benham
Michael Galea
Mathew Hilakari
Lauren Kathage
Aiv Puglielli
Richard Riordan
Meng Heang Tak

WITNESSES

Harriet Shing MLC, Minister for Health; and

Jenny Atta, Secretary,

Catherine Rooney, Deputy Secretary, Budget, Finance and Investment,

Naomi Bromley, Deputy Secretary, Health System Reform and Partnerships,

Ryan Phillips, Deputy Secretary, Corporate Strategy and Operations,

Siva Sivarajah, Chief Executive Officer, Hospitals Victoria,

Kym Arthur, Acting Deputy Secretary, Community and Public Health,

Louise McKinlay, Chief Executive Officer, Safer Care Victoria, and

Katherine Whetton, Deputy Secretary, eHealth, Department of Health.

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

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

On behalf of the Parliament the committee is conducting this Inquiry into the 2026–27 Budget Estimates. The committee's aim is to scrutinise public administration and finance to improve outcomes for the Victorian community.

I advise that all evidence taken by the committee is protected by parliamentary privilege. However, any comments you repeat outside of this hearing may not be protected by this privilege.

All evidence given today is being recorded by Hansard and is broadcast live on the Parliament's website. This broadcast includes automated captioning, and members and witnesses should be aware that all microphones are live during the hearings and anything you say may be picked up and captioned, even if you say it quietly.

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

As Chair, I expect that committee members will be respectful towards our witnesses, the Victorian community joining the hearing via the live stream today and other committee members.

I welcome the Minister for Health the Honourable Harriet Shing, as well as officials from Department of Health. Minister, I am going to invite you to make an opening statement or presentation of no more than 10 minutes, after which time the committee will ask you questions. Your time starts now.

Harriet SHING: Thank you, Chair, and thank you, committee members, for the opportunity to present to you today and to answer questions about the budget and about the health portfolio as it relates to our record expenditure.

I want to begin by acknowledging the traditional owners of the lands upon which we meet today. We are on Wurundjeri country, and I pay my respects to elders, past and present. I would also like to acknowledge any and all Aboriginal or Torres Strait Islander leaders or emerging leaders who are here today, who are part of the broader health and hospital system and who are working tirelessly to make sure that truth, treaty and reconciliation can be at the heart of better health outcomes for First Peoples across the state.

I am not sure whether there is a screen that means that slides can be seen, but I understand and appreciate perhaps that committee members have received the slides and that you have them in front of you in hard copy

format. I want to take us perhaps to slide 3 – noting before I get underway that there are departmental members here today who will be in a position to assist with the answering of questions – setting the stage for 2025–26 and that period as a really important year for delivering on our state's priority of planning and delivering nation-leading health care.

The objectives and the vision for Victoria's health system have been widely ventilated. They make sure that at the heart of this work patient, client, consumer and customer experience leads to better health outcomes for people at every single stage of life and that accessibility is enhanced from the middle of Melbourne right out through to the edges of the state. With increasing demand across the healthcare landscape, we know that it is important to be making really strong investments in alternative care options. That includes community-based care, virtual models of care and of course in-home care. This is about providing people with more choices and a range of options for the care pathways that meet their needs, including through early intervention and prevention, which in a best scenario means that people are not needing to access our health system through those other more interventionist approaches. So we are helping more Victorians to access care closer to home and reducing the need for hospital visits and making it easier to get support earlier.

The next slide refers to Victoria's health system and the innovations that are being undertaken. In the 2025–26 year we are on track to deliver more than 210,000 planned surgeries for the third consecutive year across the state's public hospitals. This is not happening by accident. It is a consequence of careful planning, record investment, support with workforce and those pathways through to additional specialist appointments and the work to free capability through those non-surgical pathways. We are reforming how we deliver planned surgeries with more targeted non-surgical alternatives and an even more efficient use of theatres, guided by the planned surgery blueprint. This is a document, again, which I hope to be able to speak to today, something developed alongside the profession and people with lived experience to understand where the challenges and opportunities lie for addressing surgical need across the state and making sure that we can prevent the need for surgery wherever possible whilst also continuing to provide world-class care.

We are delivering timely and convenient emergency care. We lead the nation with urgent patients seen on time in emergency departments. To be clear, however, I am under no illusions about the fact that there is always more work to do. Continuous improvement is at the heart of any well-functioning, responsive and adaptive health system, and it is innovation and adaptation that has seen progress being delivered here in Victoria that is better able to meet need and anticipate future demand. As well as giving Victorians access to alternative care with the Victorian Virtual Emergency Department delivering more than 820,000 virtual consultations since 2020, we are assisting people with those urgent non–life-threatening care options through the local health service networks, linking health services within a geographic area and giving Victorians greater access to care like dialysis and chemotherapy, again, closer to home. We began establishing them in July last year, and they are already beginning to deliver for their communities. I will give you an example: the East Metro and Murrindindi network has established a new weekly oncology service for its local Alexandra community that brings essential oncology closer to home. We know that oncology appointments can often mean that wellbeing is enhanced where people are close to their family and caring networks, and that is what this is delivering. We also commenced the virtual hospital pilot, spearheading innovation in bringing hospital-level care into a patient's home, freeing up hospital beds and helping patients to recover comfortably.

Visual presentation.

Harriet SHING: Again, we know that wellbeing and patient outcomes are better when we provide people with choices, including around in-home and in-community care.

Next slide: 'Accessible care, where it's needed'. This year we continue to support our network of urgent care clinics. Funded by the Victorian and Australian governments, the 38 clinics provide care where it is needed for non–life-threatening situations, helping to reduce the demand on our busy emergency departments.

We have delivered more services tailored to women and girls. This is an area of incredible importance to this government. Through the women's pain survey, bridging the gender gap and also making sure that there is a record investment in women's care, we are addressing the sorts of pain and discomfort that too many women have experienced for an entire lifetime, often suffering in silence or having pain diminished. The first virtual women's clinic has been an important part of delivering this care, alongside a mobile women's health clinic to

bring care closer to where people live, and public fertility care again continues to change lives, with more than 350 babies now conceived or delivered through this nation-leading program.

Expansion of the Chemist Care Now program is also enabling us to treat more conditions, and we have added these treatments to the existing program for what Victorians can do in accessing pharmacological and pharmacy-based treatment, instead of heading to the GP, including for impetigo as well as the resupply of the oral contraceptive pill. This has already delivered more than 76,000 services from over 850 chemists across metropolitan and regional Victoria.

The next slide relates to strengthening our workforce, and we have continued to strengthen our workforce, which is the backbone of our health system. We have amended the safe patient care Act, and implementing those changes has improved patient care and created safer workplaces for nurses and midwives. Designated registered nurse prescribing has also enabled trained nurses to prescribe medication, which improves access to care. The allied health workforce has increased by more than 7000 professionals in the last decade, with the state now home to more than 42,500 practitioners. We established the Victorian Centre for Advancement in Allied Health. We commenced a pilot allied health reliever pool, which is a flexible workforce option, and we boosted First Nations leadership through the governance scholarship program. We continue to prioritise the safety and wellbeing of our workplace, because everyone, whether they are selling a T-shirt or operating on somebody, has the right to be safe at work. We have expanded the rollout of the safe wards model, which is designed to enhance safety by creating a therapeutic environment for health settings, and we continue to support programs providing free and confidential wellbeing support for health workers.

The next slide relates to investing in our health system to meet increasing demand. Victoria's health system faces the same challenges that we see around Australia and globally. We see population growth, people living longer and increasing demands on the system as health presentation needs become more complex due to higher rates of chronic illness, disability and long-term care needs. And as the state continues to grow and our demographics shift, our health system is caring for more people than ever before. We continue to build on that record investment in health care to meet this increasing demand. This is about backing our health workforce and making sure that we can combine their work with new technology, models of care and the programs and facilities that Victorians need to thrive.

The funding overview will be something that we will no doubt talk about – $32 billion. This includes $3.9 billion in new investment to strengthen our health system across all aspects of health. Included in that is $1.6 billion to give every public hospital the funding that it needs to be able to continue to provide world-class care, $284 million for open and expanded newly built and community hospitals, and we are backing our workforce with $91.2 million to futureproof our health system. That includes graduate nursing, speech pathology, OT student grants, cadetships and scholarships, as well as making sure that we can support eligible non-government residential aged care providers to grow their nursing workforce.

Victoria is growing, and this is where in this budget we are responding to changing needs: $249 million for maternity services in Melbourne's west, 1500 ultrasound appointments for pregnant women, 32 new post-natal beds, $33.3 million to VicKey and that digital platform. There is so much more to go on with, Chair. Unfortunately I have been beaten by the bell, for what I hope are the best of all possible reasons.

The CHAIR: Thank you, Minister. The first 14 minutes are going to the Deputy Chair.

John PESUTTO: Thanks, Chair. Good morning, Minister and officials.

Harriet SHING: Good morning.

John PESUTTO: Yesterday's scathing Victorian Agency for Health Information data showed our critical surgery waiting list is up by 8000 on last year. There were nearly 650 people added to critical surgery category 1 surgery waiting lists. In terms of category 2, people are waiting on average six months when they should be waiting only three; for category 3 they are waiting nearly two years when they should wait only one. And there were 70 per cent more people stuck in emergency departments this year than last year. The health system is in crisis. Minister, will you commence today's evidence by apologising to Victorian patients and their families for a government that has mismanaged our health system, which after 12 years is worse than the system your government inherited?

Harriet SHING: Deputy Chair, thank you for those opening remarks. There is a fair bit in what you have talked to that I would like to address as it relates to the quarter 3 data released yesterday. In Victoria we have a population of 7.2 million people. As I indicated in my opening remarks, the population is growing. We are seeing ageing demographics, we are seeing greater complexity, and with that comes the need for a planned surgery list and system that responds to that need. Importantly, when people enter the planned surgery list they continue to receive care and they are categorised, as you would know, through a referral process as either category 1, category 2 or category 3. Yesterday's waitlist revealed that there are 68,116 people on that waitlist. That includes people who were put on that waitlist yesterday and people who are waiting extended periods of time, for example, for category 3 surgeries. I will say that again: 68,116. In comparison, New South Wales had a waitlist of 92,812 as at December last year. That is not to say, Mr Pesutto, that we do not have work to do each and every year.

John PESUTTO: But it is getting worse, Minister. That is what will be concerning Victorians today – things are getting worse. And can I ask you, in light of yesterday's scathing data – I do not think there is any way to polish it – to look Victorians in the eye and tell them that as these waitlists get worse it is your government's guarantee that no Victorian patient is going to die waiting too long for treatment in this state.

Harriet SHING: Mr Pesutto, category 1 patients – that is, those patients at the most acute end of the spectrum when it comes to being on that waitlist – are in 100 per cent of cases being seen within those target timeframes. One hundred per cent.

John PESUTTO: I put to you that is not correct, Minister.

Harriet SHING: Mr Pesutto, the category 1 outcome that we have, which is reflected in the budget papers, is nation leading. That is not to say that there is never more work to do across the system, but –

John PESUTTO: Are these figures good enough, Minister?

Harriet SHING: Mr Pesutto, what I would say to you is that when we continue to work to provide care, we are providing care within targeted timeframes to the sickest patients. That leads the nation. We are also continuing to see that the number of patients treated has gone up: 210,000 surgeries, Mr Pesutto.

John PESUTTO: But the system is not keeping up with demand. And I put it to you, Minister, that that is because your government has completely underestimated the amount required to meet demand.

Harriet SHING: Mr Pesutto, we have a *Planned Surgery Reform Blueprint*. I would recommend that to you. It was developed and delivered in accordance with what we understood to be current and then foreshadowed demand. And as I said, the surgery waitlist that we have, the planned surgery waitlist, is ensuring that where patients are categorised as category 1 they are in 100 per cent of cases being seen within those timeframes. The percentage of patients being treated within time for category 3 has gone up by 3.7 percentage points from quarter 3 last year, and category 2 patients is down by 0.1 of 1 per cent since Q3 last year.

John PESUTTO: Minister, I appreciate that, and I am giving you as much time as I can in this time that I have. But if all of that is true –

Harriet SHING: It is true, Mr Pesutto.

John PESUTTO: why are the lists getting longer and why are people waiting longer? Not only are more people on the list, but the delays that people have to suffer and families have to suffer through are getting longer too. The system is not being managed to keep Victorians healthy, and they are waiting too long for treatment. Isn't that just an undeniable conclusion from the data?

Harriet SHING: Mr Pesutto, what I would say to you is that when we are talking about comparative timeliness, in 2022–23 we had 75 per cent of all categories being achieved within timeframes. In 2025–26 we are now at 84.5 per cent. There is continuous improvement occurring across the system. But Mr Pesutto, as I indicated in my opening remarks, with population growth, with an increased complexity of need and changing demographics, a population of 7.2 million means inevitably there will be a growth in the waitlist. That does not mean –

John PESUTTO: None of which is unforeseen, Minister. In fairness to Victorians, none of that is unforeseen. That is what governments are supposed to do: plan. On the basis of what you have been talking about, Minister, in relation to the critical surgery waitlist of 68,000, can you provide this committee with information about how many of those patients on that list are children?

Harriet SHING: Mr Pesutto, I do not have that information to hand, but what I can assure you of is that the importance of providing surgical assistance, treatment and care to children and young people is a priority. That is why, as we announced earlier this year, 4000 appointments for children and young people will mean that there is better access to surgery and to those surgical outcomes and postoperative care for children and young people.

John PESUTTO: Apologies for interrupting but, Minister, they are appointments, and I understand they are the pathway to surgeries, but what I am trying to get at is you have said –

Harriet SHING: No, they are surgeries, Mr Pesutto. It is 45,000 additional specialist appointments and 4000 surgeries dedicated to children and young people – a very clear distinction.

John PESUTTO: Minister, you have just said in your evidence to this committee that this is a priority, and with you we could not agree more. But why haven't you come to this committee with that information, or can you at least provide it on notice?

Harriet SHING: Again, Mr Pesutto, we do have reporting against surgical benchmarks and outcomes. We are always in a position to look at information we can provide you. But the sickest patients, category 1 patients, in 100 per cent of cases are seen within those prescribed timeframes.

John PESUTTO: Seen and treated?

Harriet SHING: Surgery occurs, Mr Pesutto.

Jade BENHAM: Surgery occurs.

John PESUTTO: Can I just clarify for the committee, Minister –

Harriet SHING: That is what happens when you are on the waitlist, Ms Benham. You receive the surgery for which you are on the waitlist.

John PESUTTO: Well, not at the moment. You are seen. It is later obviously. Minister, can you undertake to provide that information to the committee?

Harriet SHING: Let me see what I can provide you, Mr Pesutto. Again, what I would say is the waitlist is increasing as a consequence of population growth. The waitlist in New South Wales is 92,800. The work that we are doing –

John PESUTTO: We are not in New South Wales, Minister. It is no comfort to the Victorian people and the patients and families who need treatment.

Harriet SHING: It is important to note the progress –

John PESUTTO: It is no comfort for them, Minister, to hear you and the government say, 'Look over there.' They want you to look at our own health system and manage it well.

Harriet SHING: The point that I am making, Mr Pesutto is this shows that the work that we are doing to provide diversion from surgery, to provide non-surgical care pathways, to provide assistance to people in community and at-home care, is working. There is always more work to do, Mr Pesutto, and that is where $32 billion is an important component of this.

John PESUTTO: You have had 12 years. How many more years do you need?

Harriet SHING: Well, we would not shut 12 hospitals, sell off two more, go to war with nurses and paramedics and abolish nurse-to-patient ratios, Mr Pesutto.

John PESUTTO: Politicising the discussion is no comfort to Victorian patients who are watching this proceeding and waiting too long for treatment. Wouldn't you agree?

Harriet SHING: Building 11 hospitals, 7000 additional nurses growing our workforce and making sure that we are seeing 100 per cent of category 1 patients for surgery within that target, Mr Pesutto, makes a very big difference. There is always more work to do. It is important to have clear-eyed conversations about the work within our sector, within our industry and within our workforce as part of joined-up government to deliver those outcomes, to deliver better measures of patient satisfaction, better care, better options and more choice for people.

John PESUTTO: Minister, from what you understand of the critical surgery waiting list, are there too many children on the list?

Harriet SHING: There are always going to be people on a list for surgery.

John PESUTTO: But that is not what I asked, Minister. Are there too many children on the critical surgery waiting list?

Harriet SHING: You are asking for an opinion –

John PESUTTO: No, no, it is not an opinion.

Harriet SHING: about the existence of numbers on the surgery waitlist. Again, where we have children and young people in category 1, 100 per cent of them receive their surgery within the prescribed timeframes. The most urgent need is being met in surgical terms through those outcomes within target, Mr Pesutto, whether they are children and young people or whether they are geriatric patients.

John PESUTTO: Minister, how long, on average, does it take to get on the list?

Harriet SHING: It really depends on what happens as part of a referral from a GP and whether people then access specialist care that involves treatment, and that might mean that there are a number of conversations with a patient or a client that involve non-surgical engagements.

John PESUTTO: Is that the list before you get on the list?

Harriet SHING: It is not a list before you get on the list. That is the health system, Mr Pesutto.

John PESUTTO: Minister, if not now, could you undertake to provide to the committee a breakdown of the main services that children are waiting to have in terms of surgery – for example, tonsillectomies, grommets and other conditions– and how many children are waiting for each type of surgery? Could you undertake to provide that information to the committee?

Harriet SHING: Again, in terms of a specific breakdown of the types of surgery, Mr Pesutto, let me see what I can provide you. I might in a moment throw to Ms Bromley, who can give some further information. But I want to be really clear: when people are on the waitlist for planned surgery, they continue to receive care. People do not get excluded from the health system, including through those non-surgical interventions. Whether it is occupational therapy or whether it is osteopathy or work on physio, that goes on. In instances where that occurs, somebody may come off the waitlist because surgery is no longer a pathway that they choose to exercise.

John PESUTTO: That is often a complaint, though, isn't it, Minister? Sorry to interrupt, but isn't that one of the complaints that many Victorian patients have, that there is some kind of intervention during their wait which resets the clock and for data purposes, that is used to present more favourable figures. Isn't that the case?

Harriet SHING: No.

John PESUTTO: Many patients disagree with you.

Harriet SHING: People can change categories. If, for example, there is a deterioration in somebody's condition and they have been referred as a category 3 patient, such that they require urgent surgery, and they are

then converted to a category 1 patient, then they receive that care 100 per cent of the time, within the targets. There may well also be an improvement in a patient's condition, whereupon they may move from a category 1 to a category 2 or 3.

But, Mr Pesutto, in terms of patient experience, the overall rating is 92.8 per cent. That is up from 92.6 per cent in the previous quarter. We work really hard through our clinicians and our specialists to be able to provide better patient experiences, and that is where 45,000 additional specialist appointments are important, it is where additional endoscopy services are important and the virtual care that we are providing to people through the emergency department. We continuously work to make sure that the system is joined up.

John PESUTTO: Minister, can I ask on how many occasions category 1 patients have been reallocated after the 30-day period? If you cannot provide it, can your Secretary undertake to provide that.

Harriet SHING: Reallocated after the period, Mr Pesutto?

John PESUTTO: During the period to either extend or reset the waiting list period.

Harriet SHING: I will start where I left off: 100 per cent of category 1 patients are seen within the targeted timeframe. That is reported in the budget.

John PESUTTO: Thank you, Minister.

The CHAIR: Thank you. Mr Galea.

Michael GALEA: Thank you, Chair. Good morning, Minister, Secretary and officials. Minister, I would like to take you to budget paper 3, pages 46 and 47, which outline a long list of additional funding for hospitals. Minister, how are you using this funding to invest in Victorian hospitals to continue managing care and demand?

Harriet SHING: Thank you, Mr Galea, for that question. It does raise a really important part of this conversation around our health system. The health system is the biggest part of the budget, so you can imagine what $40 billion of cuts will do to that. But every year millions of Victorians access hospital care right across the state. As I have indicated, Victoria is growing. We are continuing to invest to meet that demand and to understand what future demand looks like. We have a population of 7.2 million here in Victoria. This year alone, we are providing over $32.3 billion to our health system, up from $31 billion in the 2025–26 budget, and building on past record investments.

Members interjecting.

Harriet SHING: Sorry, Mr Pesutto, it is a bit hard to concentrate.

Building on previous investments, the 2026–27 budget invests an additional $3.9 billion in output funding to strengthen our world-class health system. This is guided by the importance of patient and client lived experience, the workforce and what we hear and know from them, continuous improvement in the way in which we design our systems and making sure that they are operationalised in a way that is efficient, that is effective and that prioritises better outcomes for patients. $1.6 billion to support our public hospitals to continue to deliver world-class care supports critical hospital care through the clinical and non-clinical staff, procuring medicines and equipment for patients, and operating services, including emergency departments, inpatient wards and operating theatres. Public hospital funding increases in 2026–27 when compared to 2025–26 reflect that ongoing investment to meet patient demand and rising costs.

The focus of this year's budget is very much on supporting sustainable service delivery and providing those targeted investments to grow our health system. That uplift recognises cost pressures that exist across the system as well. It is about financial certainty, again making sure that we have that continuity and that certainty of delivering stability to the system to meet Victorians' needs. The distribution of funding across health services is determined through the usual process of modelled budgets, and final allocations are publicly reported, as I have indicated earlier, through annual reports.

Michael GALEA: Thank you, Minister. Can you tell me how this funding builds upon previous years as well?

Harriet SHING: Yes, I can, Mr Galea. We have made some really significant investments into hospitals since coming into government across the state. We have built 11 hospitals. What we have seen previously under other governments is 12 hospitals closed, two hospitals privatised and preparation to sell the Austin.

Members interjecting.

Harriet SHING: Ms Benham, I will take you up on that. In addressing need, Ms Benham –

Richard Riordan interjected.

The CHAIR: Mr Riordan, your time will come.

Harriet SHING: Let us take Mildura, for example. That has received an uplift in funding since we came to government. It was something which, again –

Jade Benham interjected.

Harriet SHING: Returning Mildura base hospital to public hands was a really important step. And that was something which non-Labor MPs howled down from the sidelines and called a waste of money. I think 'socialist government' was one of the –

Jade Benham interjected.

Harriet SHING: Investment in public health care, Ms Benham, is something that is clearly not a priority for you.

Members interjecting.

The CHAIR: Mr Galea. Ms Benham.

Harriet SHING: I am pleased, Ms Benham, that you have endorsed the delivery of public hospital care at Mildura after we returned that hospital to public hands and that you acknowledge that the staff do a wonderful job. I agree with you there.

Sticking with Mildura, we have supported them through timely emergency care programs, including the implementation of *Standards for Safe and Timely Ambulance and Emergency Care for Victorians*. Looking at the figures from February, Ms Benham, you would be aware of that. There was $104,000 to support participation in the timely emergency care program, ward layout changes – and we know how important they are – and an ED clinical initiatives nurse. And then there was $1,013,000 to continue participation in the tech program, further changes to the physical space to support improved patient flow, a seven-day discharge model to support timely discharge over the weekend and additional inpatient bed capacity. Across the whole system, the 2025–26 budget provided a $9.3 billion investment over four years for health services. The 2024–25 budget delivered $11.1 billion to operate hospitals, boost healthcare services, give the healthcare workforce the support that they need, to help reform the way we fund public hospitals and to make sure that our health services are sustainable well into the future.

Michael GALEA: Thank you, Minister. I would like to ask on that particular point in terms of sustainable budget management within our hospital system – noting that funding has increased year on year, as you have just indicated as well – what work is being done to ensure that ongoing budget sustainability in our hospital system in a way that ensures no impact on frontline care?

Harriet SHING: Thanks, Mr Galea. At the heart of the question that you have asked are the issues of stability, accountability and sustainability. We know that the governance of public hospitals by independent boards appointed by the health minister is responsible for managing those services within the available funding envelopes, and boards are accountable for financial management, service delivery and compliance with statements of priorities. They are the formal annual agreements that health services enter into to set out funding and service activity, the way in which performance expectations and financial targets are met. And we continue of course to work with health services in delivering a range of efficiencies to ensure that we are prioritising spending in the areas that need it most. That is particularly frontline care, and obviously the department continues to work alongside health services to implement and to monitor those agreed strategies as part of the

usual performance reporting processes. Work always continues on that shared services area to identify ways where we can support health services to deliver savings in those non-frontline areas.

It is important to note, though, that an operating deficit does not impact the delivery of frontline care, and there are no impacts to frontline care or staffing as a result. The sector continues to manage operating results within available government funding, and no additional funding is being sought from government to cover deficits. Financial performance is, as I indicated, actively managed through budgets and performance oversight and also those agreed corrective actions.

Michael GALEA: Thank you, Minister. Speaking on the pressure placed on emergency departments – you touched on this in your presentation as well, but if I can ask you a bit more about some of the other initiatives that you are deploying to reduce that pressure on the emergency department system. For example, you talked about the Victorian Virtual Emergency Department, which I know my colleague as a young mum Ms Kathage uses as a fairly frequent flyer, and indeed some Liberals have even heard about the VVED nowadays.

Harriet SHING: A thousand calls every day.

Michael GALEA: A thousand calls every day. So can you talk to me about the other initiatives that you are doing to reduce pressure on emergency departments?

Harriet SHING: Absolutely. It is important to note that the number of presentations that we are seeing to emergency departments is down by 2.4 per cent from the previous quarter, and we know that that is due to a range of factors. We have got, again, some of the strongest nationally outperforming comparable jurisdictions, so New South Wales and Queensland, and we are seeing urgent ED patients on time. The AMA has been pretty clear about that in its 2026 public hospital report card. We have the best critical cardiac arrest outcomes where resuscitation was attempted in the country. And to be really clear: when people are in an emergency department, they are receiving care.

We know that demand, however, is growing, and we also know that the complexity of patients presenting to our emergency departments is changing. And we know that waiting for care is not just frustrating, it can be a really scary and distressing experience. This is where we are working with experts, with our health services and frontline workers to develop and to implement those innovative solutions. This includes ensuring that our paramedics can reach our sickest patients quickly and then transfer care of those patients to hospital staff safely and efficiently. This is where the offload cubicle model is part of the work that we are doing to ensure that we can reduce the amount of time that ambulances are spending at hospitals, offload patients to get the care that they need and our paramedics can return to the road more quickly.

The timely emergency care program *Standards for Safe and Timely Ambulance and Emergency Care for Victorians* and the ambulance offload pilot are delivering real results. Statewide performance in emergency care has strengthened since these standards were implemented, and a recent example is Goulburn Valley Health. We have seen at Shepparton hospital an 86 per cent reduction in the number of extended stays. Northeast Wangaratta Hospital also saw an improvement in the extended stay performance, with a reduction of 57 per cent. At Monash Health we have got ambulance transfer times within 40 minutes – the time it takes for clinical handover to be completed between ambulance and emergency – and an improvement of 31 per cent there. Physical emergency departments, as you indicated in your question, are not the only ways for emergency and urgent intervention to be provided. That might mean the secondary triage process within Ambulance Victoria's call centre, staffed by clinicians and paramedics providing that expert care. It might mean the work on the Victorian Virtual Emergency Department and the work that is provided in community for people to be able to access urgent care clinics and the support for doubling the VVED's capacity so that it can assist many more patients into the future. We want to make sure we are continuing to expand capacity whilst also providing alternative care pathways to reduce pressure on the system as our population grows.

Michael GALEA: Thank you, Minister. Actually, the very first initiative in budget paper 3, page 46, is for additional paediatric planned surgery and specialist care, which seeks to address this head-on. What sorts of system challenges does this seek to address through this output?

Harriet SHING: Thank you. This perhaps builds on a question that Mr Pesutto asked earlier around supports for children and young people and specialist care. For children and young people who are in category 1 of the planned surgery waitlist, they are being seen, as all other category 1 patients are, in 100 per

cent of instances within the prescribed timeframes. But there is always more work to do, and that is why there is an allocation of 4000 surgeries for children and young people. That will then be part of a broader framework that includes 45,000 additional specialist appointments for medical, nursing and allied health care for children and young people, and improving access to planned surgeries for paediatric patients is a really key focus that is also guided by and assisted by technology. Making sure also that we can provide wraparound care and support for children and young people is of essential importance. Reducing the amount of time that they are spending away from school, away from their families and away from the things that really help to manage their wellbeing and their recovery is at the heart of an integrated health system that is delivering on whole-person support.

Michael GALEA: Thank you, Minister. I probably do not have time to go to my final question on that subject, but you did mention the Victorian Virtual Emergency Department before – over a thousand calls a day, which is quite significant. That shows that awareness is spreading about this.

Harriet SHING: We want that to continue, Mr Galea. Please tell everybody you know.

Michael GALEA: Thank you, Minister.

The CHAIR: Thank you very much. We are going to Ms Benham.

Jade BENHAM: Thank you, Chair. Minister, first of all, from someone that has watched that transition of Mildura Base Public Hospital, the politicisation of public health – or health for those in the regions particularly – I think is inappropriate. But also, do you accept that patients watching this from all over the state get incredibly frustrated when the government will not accept that there is a problem here? There is a problem, and I know that there have been patients on that waiting list who have not been seen within the specified timeframes. That was raised with the previous Minister for Health. So do you accept that patients and people get frustrated when we continually hear the government talk about how well the public health system is doing in Victoria?

Harriet SHING: Ms Benham, it is important to note that there is no finish line when it comes to delivering health care, when it comes to providing pathways to surgery, diversion, non-surgical pathways, access to specialist or general practitioner, allied health care or clinical in-community care. What I would invite you to do, if you have specific examples of cases, is to bring them to my attention. I have not heard anything from you to date. I am very happy to perhaps have conversations about individual matters offline, again noting consent and privacy. I do not want to create any issues here. But again, when we talk to the work that we are doing, it is not with a sense of smug complacency. It is about saying that across the system the work that we are doing and the progress that we are making are having an impact. Comparatively speaking, we can see that these interventions that we are making are changing outcomes for individuals. There is always more work to do, and that is where, again, there is $30 million that we have put into Mildura Base Public Hospital since we brought it back into public hands.

Jade BENHAM: Thank you. And we do need to catch up about the offsite allied health.

Harriet SHING: Please.

Jade BENHAM: That would be great. Secretary, how many patients were removed from the elective surgery waitlist because they died before getting surgery?

Jenny ATTA: Ms Benham, I do not have that figure to hand.

Jade BENHAM: Are you able to provide it? It has been provided to this committee before.

Jenny ATTA: I am certainly happy to see what we can provide, yes.

Jade BENHAM: Okay. Great. Thank you so much. I want to go to budget paper 3, page 48, talking about local health service networks and collaborative care through local health service networks. Have all the regions commenced their clinical services plan – probably a question for the Secretary?

Jenny ATTA: Ms Benham, all services, all networks, the six regional and six metro networks, are engaged in developing those clinical service plans. I do not think they are all finalised just yet.

Jade BENHAM: It is a source of frustration, though, is it not? It has been a wait.

Jenny ATTA: Well, again, that is –

Harriet SHING: I might just leap in there in terms of it is not an opinion, this is about –

Jade BENHAM: No, no, no. We do engage with our local hospitals particularly.

Harriet SHING: Yes. So when we established the local health service networks last year, it was about making sure we could actually reduce duplication and improve the best patient care, and we see concrete examples of that occurring around making the health system stronger and more connected.

Jade BENHAM: Okay. If I can go back to the Secretary: given that those clinical services plans have commenced, can you confirm from all this planning that no service or job losses will occur within any community?

Jenny ATTA: All of the planning is about improving care and response for communities. That is the basis of it, looking at opportunities for better coordinated care across services. The clinical service plan process, that is being worked through very carefully across the individual services that make up part of the collaborative network. That work is being led by clinicians within services, obviously consistent with the objectives that we have set for each network. So each network is responsible for meeting their community care needs as close to home as possible. So we want –

Harriet SHING: That might be oncology care in Alexandra because of that partnership with Eastern Health and Alexandra District Health.

Jade BENHAM: But communities are not going to lose service delivery, jobs?

Harriet SHING: That is enhancing what people can access within a geographic region, Ms Benham.

Jade BENHAM: So they are not going to lose – a pretty simple question.

Jenny ATTA: We want to support more equitable and consistent care for patients; increase consistency of quality and safety of care; strengthen workforce attraction, retention and support; deliver support services at scale. And as networks mature, they will continue to look at what are the improvement opportunities.

Harriet SHING: And that is why there is $49 million to assist that; we are doing that because it is beneficial and because it provides more patient options.

Jade BENHAM: Okay. So which of the 27 recommendations remain outstanding to be implemented from the *Health Services Plan* final report?

Harriet SHING: Government accepted in full or principle 26 of the 27 recommendations of the plan. Recommendation 7.1 relating to directed consolidations of health services outlined in the report was not accepted. That is again a really important point to note. But if health services initiate those voluntary mergers that deliver those clear benefits, then those efforts would be supported – but voluntary is the key thing here, Ms Benham.

Jade BENHAM: Can I go back to the Secretary, though? Ms Atta, have you got a list of which recommendations have been acquitted, delivered, and which ones are outstanding?

Jenny ATTA: Well, there is only one outstanding. The others were all accepted, and they are all delivered or in progress.

Jade BENHAM: So 7.1 was not accepted?

Jenny ATTA: That is right.

Harriet SHING: Save for voluntary mergers, Ms Benham.

Jade BENHAM: I am sorry, Minister, with respect, I am asking the Secretary because of the conversations we have had before. Which of the recommendations – 7.1 was not accepted, so which is the outstanding one?

Jenny ATTA: Sorry, I thought the question was: how many did government accept?

Jade BENHAM: No, no, no. How many of the recommendations remain outstanding to be implemented?

Jenny ATTA: I might have to come back to you on that. They are all delivered or in progress, is my understanding. I do not have a –

Jade BENHAM: So 'in progress' would be outstanding.

Harriet SHING: Well, no. The recommendations, as they are termed, though, often involve continuous work. If you look at recommendation 9.1, it says the department progresses further, so that is a continuum of work, Ms Benham.

Jade BENHAM: Yes, got that. I am just looking for an updated list on where we are at with all of those. A key component of the *Health Services Plan* was formalised linkages from regional to tertiary metropolitan centres. Has this been formalised, and if not, how many remain outstanding? And when will this be completed, Secretary?

Jenny ATTA: Sorry, Ms Benham, just go to the first part.

Jade BENHAM: A key component of that *Health Services Plan* was the formalised linkages between the regional and tertiary metro centres. Has this been formalised, and if not, how many remain outstanding, and when will they be completed?

Harriet SHING: The work is underway.

Jenny ATTA: Yes, it is in progress – a lot of really important collaborative work across the networks and with our specialist hospitals to look at how we formalise and maximise the value of those linkages. It is important to note that the networks and the reform were stood up at the start of July 2025, so we are not yet 12 months in. There have been a range of key priority work and early priorities that the networks are working through, including to formalise those relationships between networks, between children's, women's and tertiary hospitals.

Harriet SHING: That is not static work.

Jade BENHAM: No. Again, I understand. I am just looking for where we are at. Is it soon? Is it going to be years away? I am just after a progress report, if we can get that. Happy to take it on notice. I just want to understand where we are at with that.

Jenny ATTA: Yes, it is certainly being progressed, and we can see what information we can provide there. But that is a key recommendation coming out of the plan. That is a focus of the work as we move through it in the first 12 months.

Jade BENHAM: Yes, which is why having a look at the progress of the key recommendations from the plan is so important and then getting that is also of, obviously, great interest. I want to go to workforce. So, sorry, you will provide that list?

Jenny ATTA: We will see what we can provide in terms of –

Jade BENHAM: Great. Thank you so much.

Harriet SHING: A lot of it is ongoing, though. Again, I just want to manage some expectations here around a static point in time versus something that is inherently dynamic.

Jade BENHAM: If we can get that too as of the 30th – no, no, that will not work. If we can get 30 April, like where work was at on 30 April, that would be great.

Harriet SHING: All regions are different. So again, that is a really important thing to note. And it is not a cookie cutter approach, so different things will happen at different times in different regions.

Jade BENHAM: Yes, got that. That is fine. If we can just get a report, that would be great.

Harriet SHING: Let us see what we can provide you.

Jade BENHAM: I want to go to occupational violence now. I am not sure if you are aware, but the Mildura Base Public Hospital CEO and staff did a very public call for the public to rein it in, because occupational violence is a real thing that they are dealing with, as all health services are. Secretary, how many code grey and code black incidents have been reported for the current financial year in Victorian public health services? I am happy to take that one on notice too.

Jenny ATTA: Ms Benham, I do not have that information in front of me. It is important to note that with all of the different codes for hospitals, those local operational decisions are triggered for a range of reasons. It is very much something that is managed at the hospital level.

Jade BENHAM: No, that is fine. Are you able to provide that, though?

Jenny ATTA: I am not sure if we have that level of data. It is very much held at the hospital level, and there is communication with the department around significant events.

Jade BENHAM: It was provided last year to the –

A witness: We will see what we can provide.

Jade BENHAM: Great. Also, how many code yellow activations have been initiated in public hospitals in this financial year?

A witness: We do have that.

Harriet SHING: We do.

Jade BENHAM: I have seen that one before, because we have had a couple.

Harriet SHING: Since 1 July 2025 the department has been notified of 14 code yellow activations relating specifically to demand. They have been spread across the state, Ms Benham. All of them have occurred at regional and rural hospitals.

Jade BENHAM: All of them?

Harriet SHING: Yes. Since 1 July 2025 the department has been notified of a further 37 code yellow activations relating to ICT, telephony or infrastructure failings. They are matters then that sit, in large part, beyond the control of the department. They have been geographically dispersed and related to incidents like gas leaks or NBN failure or storm damage or bushfire impacts. They are a couple of the examples of when and how code yellows can occur.

Jade BENHAM: Didn't Royal Melbourne have a code yellow? I am sure they have had a code yellow recently. When was that?

Harriet SHING: Can we maybe come back to you in terms of Royal Melbourne? Let us see what we can find you.

Jade BENHAM: Okay. Great. If you can include the code yellows in with the report of the code greys and code blacks, that would be very handy.

Harriet SHING: Sure. In Mildura – again, Ms Benham, relevant to your question – I think that there have been some issues around a combination of winter viruses, cardiac cases and then high demand and high acuity, but no ICU or resus beds, and emergency department admission access impacting emergency care, again whilst that other care was being provided.

Jade BENHAM: Yes, correct. Thank you so much. If we can go to community health now – and we know community health providers punch well above their weight all of the time –

Harriet SHING: They certainly do.

Jade BENHAM: and we love them for that. The budget provides – this is budget paper 3, page 46, still – $21 million over four years for chronic disease care. This is allocated to 4500 people living with chronic disease across Victoria's 24 registered community health services. Secretary, community healthcare funding – there is $4.3 million allocated to the community-based chronic disease program. How is this funding allocated across all of those 24 registered community health services in Victoria?

Harriet SHING: Well, it is $20 million over four years, just to be really clear.

Jade BENHAM: Yes. So $4.3 million this year?

Harriet SHING: To expand the care pathways for the chronic disease program?

Jade BENHAM: Yes. So how is that spread across the 24 community health services?

Harriet SHING: So that –

The CHAIR: We are coming back. Ms Kathage.

Lauren KATHAGE: Thank you, Chair, Minister and officials. Minister, I want to stay on the topic of children. You were speaking to Mr Galea about investments that are being made. Why are children waiting for care, and how will that investment you are speaking about bring about different outcomes?

Harriet SHING: Thank you, Ms Kathage, for your question. One of the things that we know can be a real challenge for care for kids is the disruption and the often complex nature of presentations for children within our health and hospital system. Children can wait for care for a number of different reasons, but again, when we are talking about care within that category 1 space, 100 per cent of people are provided with that surgical care within the targeted timeframes. Paediatric care is also an incredibly dynamic environment. Children's presentations can change from day to day, and this is where, again, often specialist and non-specialist interventions need to be provided. Sometimes children need to be prepared for surgery. They may not be well enough to have surgery, and this is where those other pathways are important.

We do work really hard to make sure that we can provide care in ways that meet people where they are. This is also about providing care closer to home for children, because we know that that improves their wellbeing as well. We also need to make sure that we can work with health services to address that long-waiting cohort. We have seen some really meaningful systemwide improvements to planned surgery access for the adult population, but under-18s have not experienced the same improvement. That is where, again, those 4000 surgeries specifically for children and young people are really important. In 2024–25 there were six health services with high volumes of paediatric patients. They received a total of $780,000 for the Better Access for Vic Kids initiative. That was about ensuring that under-18s had better access to shorter wait times for surgery. That occurred across the Austin, Eastern, Monash, Royal Children's Hospital, the Eye and Ear, and Western Health.

That is about using funding to deliver initiatives based on local need. That includes high-intensity theatre lists and also making sure that we can continue to build on those investments in this year's budget. It is an integrated system, though, and that is where it might be endoscopy or it might be paediatric cancer treatment, paediatric palliative care or a range of other initiatives that come together across the entire health system.

Lauren KATHAGE: Thank you. I think you mentioned earlier Specialist Advice Now and VicKey. Are you able to explain a bit more about what they are and how they are intended to help?

Harriet SHING: Yes, absolutely. Technology and those virtual pathways are really important in the direct delivery of care, but we also know that the systems that sit behind the delivery of care are as important, so again any cuts to those particular parts of the health system will be felt very, very keenly. There is an investment of $33.253 million over four years to expand and deliver VicKey. That is a digital platform that is designed to streamline processes, improve communication with patients and enable clinicians to spend more time on patient

care. If that then reduces the amount of time that clinicians are spending on administrative work or on the exchange of information, then that eases pressure on the system in turn. There is $7.958 million to establish and pilot a new Specialist Advice Now service, and that is about making sure that we can support the work of VicKey and ease the challenges of referral pathways and assistance and access to specialist care, including through the GP network.

VicKey is currently active across 19 health organisations within metropolitan and regional Victoria, and there is a 20th health system to come on board by the end of next month. That will then mean that we can enable a pipeline of other health services that are waiting to come on board, to be added, and that will then deliver us, unless there is a funding cut, 30 health services by 2029. That is about additional functionality being worked into the system. Specialist Advice Now is also going to mean that we can avoid those unnecessary specialist appointments. It can also mean that we can better utilise the expertise and the connection of GPs to their local communities. Better health workforce utility from the flexible nature of a specialist's work will be an important part of this. 45,000 specialist appointments being added to the budget is another important component of this.

That is a very long way of me saying that integrating systems improvements and reforms helps to increase efficiency, reduce duplication, enhance patient outcomes and ensure that other parts of the system can better talk to each other. The health system here in Victoria, and indeed any jurisdiction around Australia, is enormous, and making sure that we can use technology to streamline the delivery of that care leads to better patient outcomes, better access and more treatment closer to home.

Lauren KATHAGE: And a good investment too, because they are permanent changes and improvements that are being made.

Harriet SHING: Indeed.

Lauren KATHAGE: Page 65 of the 'Department Performance Statement': I know we have spent a bit of time on this already, but I note that in terms of achievement there is year-on-year improvement in timeliness. But we have got further work to go in achieving those targets, as you have outlined. Can you explain how this package of work underway that you have been describing is bringing about improvements and how we compare to other jurisdictions? We have heard the example of New South Wales, but could you expand on that?

Harriet SHING: Yes, absolutely. Last year Victoria delivered more planned surgeries than ever before, and again, that is happening because of careful, innovative collaboration across all parts of the health system. We do want to make sure that we can continue to support millions of Victorians every year, whether through surgery, through non-surgical pathways, through community care or virtual support. And making sure that we also have the resources, the funding and the capability to assess and diagnose and treat patients is essential in supporting people not just during the planned surgery pathway, but before and after. That is where, again, we have got those really important investigative procedures like colonoscopies that are important in that space too. Those initiatives to permanently increase hospital surgical capacity are important, alongside delivering the timeliness of care. As I have said earlier, 100 per cent of category 1 patients are being seen within the prescribed timeframe, and the AMA has been clear about the importance of and the effect of the planned surgery reform blueprint, alongside our ongoing commitment to making sure we are clear eyed about the challenges, pressures and demands that exist across the system and the need to be constant in our vigilance, funding and support for addressing them.

Embedding virtual care into the delivery of specialist care is also really important, and that is where Specialist Advice Now is essential. The department has worked really closely with a number of health services to develop models which reduce that unnecessary or avoidable process of review appointments, for example. If we can have that in a way that is delivered with a GP, then we take pressure off the specialist network and we free up capacity more broadly. There are projects around substituting medical staff with allied health professionals, so within ENT – ear, nose and throat – work or nurses in appointments as well. Our nursing, midwifery and allied health workforce is incredibly important in making sure that we deliver that care in a way that meets people's needs and ensures that they are able to recover and to recover well. We want to be able to scale those successful models across the system as part of that continuous improvement. It is going to take hard work and focus, and it is going to take a lot of ongoing commitment, expertise and compassion from our health workforce. We have the best health workforce in the world.

Lauren KATHAGE: Thank you. I appreciate hearing about the foundational system improvements that are being made. I can see on page 53 of BP3 an item 'Opening and operating hospital facilities'. How is that investment addressing those system challenges?

Harriet SHING: Hospital facilities are an inherently central part of the delivery of care, and we need to, as I said earlier, integrate a range of reforms that not only enable hospitals to operate more efficiently, productively and effectively but also have demand upon them reduced wherever possible. Our health system interacts with millions of people every single year, and a really important part of that are the physical spaces that we create. Opening new hospitals – 11 new hospitals since 2014 – is enabling us to deliver new services, and it is also about making sure we are turning that bricks and mortar into real patient care. This is about strengthening access and equity in health care across the system, and it is also about providing staffing and service readiness. I know Mr Hilakari is delighted in particular about Werribee and Werribee Mercy and what that means for making sure we can operationalise the upscaled ED. The work on Melton hospital will be complete in 2029 – the 12th hospital, which I think is the same number of hospitals that were closed under former coalition governments. We are making sure that we can continue to reduce demand on some of our busiest emergency departments, especially the Northern and Casey hospitals, so that they can continue to provide that life-saving care. The expansion of the Angliss as well is about providing additional inpatient bed capacity and providing better access to care for Melbourne's east. Community hospitals as well – we are making sure that we can deliver those community hospitals in areas where, again, they can meet that need, take pressure off the larger health services and their operations and deliver on work to work alongside virtual models of care. That is a pipeline. That is work that goes on. I think you are hearing from the Minister for Health Infrastructure later on this afternoon, so no doubt that that conversation will continue.

Lauren KATHAGE: How does that build on previous years' funding?

Harriet SHING: The 2025–26 budget has got $634.3 million to open and operate hospitals within that facilities budget initiative. That includes, for example, Cranbourne Community Hospital. The work at Craigieburn Community Hospital and Phillip Island Community Hospital sits alongside the work we have done, for example, down at Peninsula – $1.1 billion and 130 additional beds. Previously there were pretty limited options for after-hours care and urgent care and mental health and wellbeing support. I think you have heard from the Minister for Mental Health about some of that work as well, but today we know that new services and those innovations which I talked about in my opening remarks, like the urgent care clinics and virtual emergency care, have been a real game changer.

At this point I also want to acknowledge the work of the Commonwealth government in continuing to provide funding for the urgent care clinics as part of this year's budget. We are seeing that that multibillion-dollar investment is enabling us to augment what we know works here in Victoria to deliver that care closer to home. The community pharmacist program is another really important part of this work. This will enable people to access treatment for some of those common health conditions without needing to head along to a GP – that is, the oral contraceptive pill, treatment for impetigo, straightforward UTIs. The work around the virtual women's health clinic is another area that I did want to highlight as part of those investments. Frankston and Footscray hospitals earlier this year and the work on Monash and what is happening in that part of the world continue to build upon an integrated approach to managing demand, anticipating future need and a workforce that is able to operate across community, clinical and specialist settings.

Lauren KATHAGE: Thank you. And Mernda Community Hospital opened last year, which has been great for the community. I met the lovely Allan having dialysis there three times a week and not having to travel so far as an elderly man, and it has made a real difference to his life. How is the status of the community hospital program overall?

Harriet SHING: We are continuing to deliver community hospitals – six that are online now, a seventh coming online shortly, Point Cook in construction, and again, making sure we can combine that with other sorts of support and doing that in a way that anticipates how people are accessing services and how people are accessing care. We have invested over $800 million since 2018 in those initiatives.

Lauren KATHAGE: Thank you, Minister.

The CHAIR: Thank you, Ms Kathage. The committee is going to take a very short break before resuming its consideration of the Department of Health at 9:45 am.

The committee will now resume its consideration of the Department of Health. We will go straight to Mr Riordan.

Richard RIORDAN: Thank you. Chair. Hello, Minister. How are you?

Harriet SHING: Hello, Mr Riordan.

Richard RIORDAN: I just want to finish off on the question of Ms Benham. We were just about to get to the answer, and it was about the $4.5 million allocated to community health care. I think you said there was $21 million over the next four years but $4.5 million in the next budget, or $4.3 million. We were just wanting to know how that was going to be allocated across the 24 community health services. How are you going to divvy that up?

Harriet SHING: Thank you very much, Mr Riordan. The $20.1 million is about expanding that program to reach around 4500 clients, and this is about delivering over 1 million hours of allied health –

Richard RIORDAN: Sorry, the question was just specific to the $4.5 million in this coming year of the 21 services. How much of that were they getting? Is it just going to one service or is it going to all of them?

Harriet SHING: What we will be doing is expanding on the existing care pathways. That will take place in a way that works across registered community health services, and it will deliver that evidence-based clinical care through a multidisciplinary team that includes chronic disease, nurses, health coaches, allied health clinicians.

Richard RIORDAN: Just specifically, of the 21 services, are they all getting a share of the $4.3 million or is it going just to one service?

Harriet SHING: The program has been pioneered and tested over the last four years by Each. That is in partnership with Eastern Health and local community health and primary health partners. Those referrals are received directly from Eastern Health hospital admission risk program, HARP, and there is an evaluation that has been done to ensure that we can provide services to priority cohorts.

Richard RIORDAN: And the 21 services get how much of the $4.5 million?

Harriet SHING: Again I am happy to throw perhaps to the Secretary for some further detail.

Jenny ATTA: Mr Riordan, we are in planning now. We are working with Community Health First on exactly how that will be allocated across registered community health services.

Richard RIORDAN: Would you expect it to be going across to all 21, or you would be targeting just –

Jenny ATTA: We will need to finish that planning work, but we are working very closely with the sector hand in hand on how that will be allocated.

Richard RIORDAN: Right. Okay. So you do not really know how it is going to be – it is not targeted at any one –

Jenny ATTA: It will be determined by what health services tell us, Mr Riordan.

Richard RIORDAN: Right. Okay. Minister, I just want to go back to some commitments. Secretary, in 2018 the government promised to build a $400 million national proton beam therapy centre in Parkville to treat children with cancer. Children with brain cancer are still having to travel to the United States to get this treatment. Is the government considering establishing a proton beam therapy centre – yes or no?

Jenny ATTA: For me, Mr Riordan?

Richard RIORDAN: Yes.

Jenny ATTA: My understanding is that the Commonwealth government are considering this process nationally, and all jurisdictions are engaged with the Commonwealth on looking at possibilities.

Harriet SHING: That is right. There is ongoing discussion happening with the Commonwealth, Mr Riordan.

Richard RIORDAN: So you have not been able to progress it since 2018?

Harriet SHING: We in 2018 talked very strongly to the need for that extremely specialised model of care, with a view to delivering that here in Melbourne, and we are continuing to work with other jurisdictions and the Commonwealth.

Richard RIORDAN: So there is nothing to be announced imminently?

Harriet SHING: I do not have any announcements to make today, Mr Riordan.

Richard RIORDAN: No, not today, Minister, but for a promise that has been in the system for a long time, we are really no closer to it at this stage.

Harriet SHING: Well, where we have shared funding and planning pathways and discussions for delivery of an extremely specialised national access to a care pathway, Mr Riordan, that is something that does need that work to go on and to be progressed, including with other jurisdictions and the Commonwealth.

Richard RIORDAN: Speaking of 2018 election promises, of course in my own electorate there is the Torquay hospital. Minister, you were in Geelong on 5 May, and you were reported as saying, 'We will continue to develop and deliver all of the community hospitals that we have made as part of that commitment.' Now, famously, last budget you took Torquay completely out. You still have the block of land, and you have still got the signs up telling the community you are going to build a hospital. Can you clarify very clearly: is the Torquay hospital, which we were supposed to be opening for this election – I think all we do on that block is get Jess, our leader, with a lawnmower to mow all the long grass on it. But what have you got to finalise on that, please?

Harriet SHING: Thanks, Mr Riordan. One of the things that I do want to mark out very clearly in answering your question is the work that we are doing to ensure that every dollar we invest is delivering the best value for Victorians and providing the care that they need closer to home –

Richard RIORDAN: But, Minister, you have gone to two elections on this. You have had all your candidates and everybody in the Geelong region stand on the paddock for two elections in a row. You keep committing to it. You dropped it last year. You then told the paper in Geelong when under the spotlight of the press that you are honouring the commitment. So are you honouring it or are you not honouring it?

Harriet SHING: We have still got further service planning that is being undertaken across the area, Mr Riordan, and that is about determining those optimal care models for Torquay, of which –

Richard RIORDAN: So when you announced it for two elections in a row – and you have delivered seven of them already, you said, in evidence to Ms Kathage before – you did not do the service planning in the Geelong region, the second-biggest city in the state.

Harriet SHING: In the Geelong region, Mr Riordan, we have invested significantly. Again, you just have to look at Barwon Health's investment in paediatric emergency.

Richard RIORDAN: No, no, no. This is a commitment that you and your colleagues took to two elections in a row. You have happily stood on a paddock in front of signs and glossy promotions that you are going to do it, and then you recommitted to it only a week or so ago. But it is a bit rubbery, Minister. Is it going ahead or not going ahead?

Harriet SHING: Well, it is actually about making sure that we can deliver the health care in a way that is going to meet demand, Mr Riordan. And we have had the investment. Since the announcement was made, we have seen the Medicare urgent care clinic in Torquay –

Richard RIORDAN: No, that is federal government. You have not done that. Your good friend Libby Coker has danced around with that. You have not done anything with the paddock.

Harriet SHING: The $500 million investment at Barwon women's and children's, the dedicated children's emergency department at University Hospital Geelong, the new early parenting centre in North Geelong –

Richard RIORDAN: Minister, I did not ask about what you have done in Geelong. I have asked about what you have done for Torquay, because you and your colleagues have rocked up and made a song and dance for two elections, pillorying everybody for not providing Torquay hospital, and you have just got a paddock. And I have got photos, Minister. When you first announced it there were no trees. There are trees covering the sign now, it has been empty for so long, and you have left the sign there.

A member: Have you committed to it?

Richard RIORDAN: We do not know, because they have not done the service planning, apparently. We are not going to make announcements just randomly like the government seems quite happy to do.

The CHAIR: Mr Riordan –

Richard RIORDAN: I mean, health care, Minister, as you well know, is a really important issue. People make decisions about where they live because of hospitals. You keep making this announcement to the community for cheap votes, and you will not commit to it, even though you have gone to two elections on it.

The CHAIR: Mr Riordan – excuse me, Minister – the minister is going to answer your question. I am assuming there is a question in there.

Richard RIORDAN: Well, she has given me a rundown on everything –

The CHAIR: Mr Riordan, do not talk over the top of me. Mr Riordan, this is your time. You have asked a question. The minister is attempting to answer it. Let her answer your question.

Richard RIORDAN: Okay. Yes or no, Minister?

The CHAIR: Mr Riordan! Minister.

Harriet SHING: We have built 11 hospitals, Mr Riordan. The track record –

Richard RIORDAN: But not in Torquay, Minister.

The CHAIR: Excuse me. I am going to say this to Ms Crozier in the gallery: I can hear you from here. You are not to say anything, and you are not to wave around. Ms Crozier, you will be removed from the public gallery if you continue to wave around. I can hear you from here.

The minister is attempting to answer your question, Mr Riordan. Or is it Ms Crozier's question? I am not sure by the way she continues to point.

Richard RIORDAN: It is my community that is being impacted.

The CHAIR: Excuse me, Mr Riordan. Then allow the minister to respond.

Harriet SHING: I think Ms Crozier is happy to continue to text Mr Riordan from the gallery, so that might mean that we get a bit of quiet.

But we do want to make sure that we are addressing the needs of communities, including as they change. And when we make announcements, we –

Richard RIORDAN: So what has changed in the last two years?

Harriet SHING: The way that people access care, Mr Riordan, has changed pretty dramatically, which is where we have made investments, and we continue that planning for every part of the state.

Richard RIORDAN: Minister, you have allowed the maternity services at Epworth to close, which means there is only one maternity service from the Barwon south-west region all the way through to, nearly, Warrnambool. I mean, we have women in our region bypassing some days when Geelong hospital cannot deal with it. You could be pregnant and in labour in Colac and be bypassed all the way to Werribee. That is a change in health delivery services in my region; I have no doubt about that.

Harriet SHING: The change in the health services delivery for your region, Mr Riordan, includes a $500 million investment at Barwon women's and children's. It includes a dedicated children's emergency department –

Jade BENHAM: So we are spending more and getting less.

Richard RIORDAN: Good point, Ms Benham. We are spending more and getting less.

Harriet SHING: at University Hospital, the new early parenting centre in North Geelong –

Richard RIORDAN: Minister, I have not asked you about any of those things. I just asked you where your commitment for Torquay is and what has changed since your team stood proudly, only four years ago, promising this wonderful facility. And now you are saying nothing has changed in seven other communities but in the Torquay community everything has changed so much that you cannot commit to that hospital.

Harriet SHING: We build and deliver better health care, Mr Riordan. We will continue to do so.

Richard RIORDAN: You put signs up in paddocks.

Harriet SHING: It is $32 billion, Mr Riordan, and we have a pipeline to continue to deliver on the bricks and mortar.

Richard RIORDAN: The people in Torquay do not care what you have done in Footscray. They do care what you have done in their community when you have gone to the election two years in a row, standing there saying, 'We're going to build it.'

Harriet SHING: The people in Torquay, Mr Riordan, are accessing the Victorian Virtual Emergency Department. They are accessing the Victorian virtual women's clinic. They are accessing the urgent care clinic.

Richard RIORDAN: That virtual clinic does such a good job when a little child falls off a skateboard on the foreshore at Torquay and needs a bandage put on.

Harriet SHING: This is where I would encourage anybody in that scenario, Mr Riordan –

Richard RIORDAN: To drive 45 minutes into Barwon Health – yes, that is a great option. Thank you, Minister. They will be very grateful for that alternative.

The CHAIR: Excuse me, Mr Riordan, the minister was attempting to answer your question.

Richard RIORDAN: The minister is ducking and diving, and there is no other way to put it. We will move to some more questions.

The CHAIR: Excuse me. Minister, did you want to finish your response?

Harriet SHING: We are determined to continue to provide health care all over the state, Mr Riordan, and this is where it is a record investment. We saw hospitals from Birregurra right out through the La Trobe Valley closed.

Richard RIORDAN: Minister, please, you are embarrassing yourself with that answer. You are just filibustering with all those notes that you have got sitting in front of you.

The CHAIR: Excuse me, Mr Riordan. You know you are being disrespectful. The minister has answered your question. Perhaps you have another one.

Richard RIORDAN: Yes, we will move on, because she cannot answer it, sadly. In 2022 the government announced the Making it Free to Study Nursing and Midwifery initiative. This provided scholarships for students commencing in 2023. Secretary, I will refer to the performance statement, page 67, 'Health Workforce Training and Development'. In 2022 Daniel Andrews gave false hope to young Victorians through the free nursing and midwifery initiative. Thousands of students have completed their studies only to find now that they do not have a job. 1500 nursing graduates and 500 paramedic graduates will not get a job this year. How many nursing graduates will not get a job in 2027?

Harriet SHING: Thank you, Mr Riordan

Richard RIORDAN: Oh, that was to the Secretary.

The CHAIR: Excuse me. The minister has a response. The minister is entitled to respond.

Richard RIORDAN: I am entitled to ask the question.

The CHAIR: You have asked the question, and I suggest that there is a bit of hush so the minister and others can answer.

Harriet SHING: Thank you, Mr Riordan. Across our healthcare workforce, public hospitals employ more than 160,000 people, and that includes nursing and midwifery and allied health. And since 2014 on to 2025, the public health workforce in hospitals has grown by 51.31 per cent. That includes nurses at 47.57 per cent. We want to make sure we are continuing to invest in those pathways, including through additional graduate positions for nursing graduates.

Richard RIORDAN: Is that why this year in your training budget you have got some money this year and there is nothing in the forward estimates for healthcare training?

Harriet SHING: Again, we continue to invest in workforce –

Richard RIORDAN: It does not look like it. 'Blank line – zero, zero, zero' does not look like continuing to invest.

The CHAIR: Thank you, Minister. Thank you, Mr Riordan. We are going to Mr Tak.

Meng Heang TAK: Thank you, Chair, Minister and officials. With reference to page 61 of the 'Department Performance Statement', Minister, can you outline how the 2026–27 budget is supporting Victoria's community health organisations?

Harriet SHING: Yes, I can. Before I do I just want to perhaps address, with your indulgence, something which Mr Riordan had raised. There is $31.3 million to deliver targeted solutions for current workforce issues, and that includes graduate nursing programs, cadetships, scholarships and grants programs. So I will leave that with you, Mr Riordan.

Thank you very much for that question on the work of community health organisations. We want to make sure that we are continuing to support the entire health sector, including community health. These services contribute to better health outcomes for the entire community, and we do want to make sure we are continuing to build on what has been some pretty longstanding support for community health, with that boost for chronic disease care as well. The 2026–27 budget has got, as I have indicated in answering previous questions, $20 million over four years to expand the care pathways for chronic disease support, and that will reach more than 4500 clients across the state.

Expanding the care pathways into a statewide program is really important. Again, equity of care is essential in delivering a health system that is responsive and dexterous and can meet population growth and changes in the complexity and the acuity of care, particularly as our population ages. Having a team that is able to deliver that clinical care through chronic disease nurses, the work of nurses and health coaches and allied health clinicians will mean that we can anticipate and meet that need and help people to navigate the health system. It can be an incredibly complex thing, and it can also be something which people are fatigued by when they themselves are managing their own health issues. So we want to make sure that that is something we help people with to

access the programs and services that mean they can get treatment and they can be supported to recover and to access rehabilitation and education, for example, as well.

Meng Heang TAK: Thank you.

Harriet SHING: We have got that program that has been piloted. We will continue to make sure that we can deliver more than a million hours of care. As the Secretary indicated in an answer to a previous question, that planning continues. We will be guided by the work of and the positions taken by the sector in telling us what is going to assist to the greatest extent, in the most efficient way possible, and ongoing funding support is a big part of that work.

Meng Heang TAK: Thank you, Minister. I also note the recent community campaign to support and sustain the bulk-billed GP services run by Cohealth, a community health program that is provided and funded by the Victorian government. Minister, can you explain further how the 2026–27 budget is supporting community health organisations across the state, including Cohealth?

Harriet SHING: Yes. Thank you for that question. This sits primarily with the Commonwealth in terms of primary care provision; that sits within the medical benefits scheme. But we do provide Cohealth with support, and they get substantial funding every single year. In 2024–25 the Victorian government allocation for Cohealth was just over $68 million. So they received the largest envelope of funding, and they also get substantial funding year on year. They are anticipated to get around $80 million for 2025–26 and 2026–27 in the aggregate. They do an incredible power of work in making sure that some of the most complex members of our communities – some of the members of our communities with the most complex care needs, I should say – are given the care, treatment and whole-person support that they need, and that is part of an integrated care delivery model. It might extend to referrals to other services, referrals to support organisations, whether it is for homelessness or for other supports around access to educational or training pathways. We will continue to work closely with the Commonwealth in relation to these matters as they relate to Cohealth. This is a matter which has had some significant publicity in recent times. We did have a review commissioned by the Commonwealth and Cohealth that has provided some opportunities for improvement, sustainability, accountability and transparency. Again, the Commonwealth has ensured that ongoing operations for Cohealth can continue to deliver that care, with $1.5 million to enable them to do that.

Meng Heang TAK: Thank you. I also note that Infrastructure Victoria has called for government to support infrastructure funding to the community health organisation. Minister, when will government commit to providing long-term sustainable funding for Cohealth, including infrastructure funding, to help this organisation provide services from the Hoddle Street location?

Harriet SHING: This is again something which sits primarily with the Minister for Health Infrastructure, so it will be Minister Horne's opportunity, perhaps, to talk to these matters this afternoon. But the Hoddle Street building is owned by Cohealth, so decisions about its long-term future are a matter for the Cohealth board. Government will, as I said earlier, continue to work really closely with Cohealth to make sure that their needs are understood and that we can assist them and assist communities to continue to receive that care that they need. We have got a really proud track record of assisting people through infrastructure funding to be able to access that care in a range of different settings, and that also includes the other infrastructure projects I have talked about around the state in response to earlier questions. But it is, again, services like Cohealth that do provide that care to some of the most vulnerable people in the state and the work of the Commonwealth to ensure that further funding is available to enable that to continue.

Meng Heang TAK: Thank you, Minister. If I can take you to 'Department Performance Statement' at page 74, it is noted that 90 per cent of the dental emergency triage category 1 clients are treated within 24 hours. Can you describe the type of emergency that might lead to someone being triaged in category 1 and explain what the typical experience might look like for someone who needs emergency dental care?

Harriet SHING: Emergency dental care is one part of the dental health program that is intended to assist people who are otherwise not able to meet the costs of dental care and would otherwise have little or no access to dental care. It is about making sure that those vulnerable cohorts, including children and young people, Aboriginal and Torres Strait Islander people or people with healthcare or concession cards, have access to that support. There is $239.3 million in the 2026–27 budget to improve the oral health outcomes for Victorians, and

this includes the Smile Squad, which has not only provided treatment to children in place, but has also provided that early intervention and education. If we are helping young people to learn how to brush and floss for good oral and dental hygiene, then we are also going to see a corresponding reduction in demand for treatment.

When we have a situation where a Victorian who is eligible finds themselves in a dental emergency, they do not actually go on to a waitlist as such. They are provided with the first available appointment. So as the measure that you have referred to suggests, 90 per cent of these people are seen within 24 hours. Anybody who has ever had a challenge with an abscess or a broken tooth will know every minute counts, and so that 24-hour timeframe for 90 per cent of those people is important. A young person, for example, who is eligible and who has had a blow to the face while they are playing sport on the weekend, if they are assessed as a triage category 1, that most urgent emergency category, will get the dental care that they need at very little cost. But again, that early intervention and prevention is so important in making sure that we are preserving and improving oral health and dental hygiene for people so that we are then reducing the likelihood of them needing that emergency care. There will always be situations involving, for example, sporting injuries, collisions or coming off your bike where emergency dental care is needed. But if we can free up other parts of the system because we are helping people to get better habits and to improve their oral and dental health, then we are enabling a system to function that can meet more of that need more often.

Meng Heang TAK: Thank you, Minister. I also note that in the DPS almost a quarter of a million priority emergency clients – to be exact, 249,000 – were provided with dental care. Minister, what would be the consequence for those people if they were unable to access this critical service?

Harriet SHING: I might take you back to an earlier point that I made. People do not get placed on a waitlist if they are priority or emergency clients, they are given the next available appointment. That is where, again, being seen within 24 hours for 90 per cent of that cohort is important to note. The waitlist exists for people who require routine care, and about 74 per cent of the people seen between 2024 and 2025, July to June, were either priority or emergency clients. This is about also making sure that we are addressing particular vulnerabilities within that group – people who are homeless or rough sleeping, for example; pregnant women; children and young people; Aboriginal and Torres Strait Islander people. The majority of these priority clients are children. We want to make sure that we are clear that every child aged from 0 to 12 is eligible for public dental. We want to make sure that the money we spend on public dental is deployed in the best possible way to provide equitable access to care, to dismantle some of those barriers that exist, particularly where cost of living is front of mind for people, and to provide support to some of the most vulnerable populations across the state.

Meng Heang TAK: Thank you, Minister. Also, page 52 of budget paper 3 outlines an investment in dental services at Mernda Community Hospital. Minister, can you talk to how you are providing dental for Victorians who might otherwise miss out in locations right across the state?

Harriet SHING: There is $239 million in the budget for dental care, and that includes school-aged children attending public schools. You would have seen the school dental program, the Smile Squad, out and about, and that is about making sure we are delivering care, again, in a range of different ways. One of the themes that I have discussed today that I hope is evident is the way in which those various options are coming together to provide better health outcomes, either in response or in a pre-emptive early intervention and prevention model. We have got $2.5 million in 2025–26, so $5.1 million over two years, for public dental services at Mernda to enable us to continue to deliver dental chairs and also the staff to be able to deliver those services. Being able to provide the investment that I have talked about will enable us to deliver dental care to about 335, just shy of that thousand eligible Victorians in 2026–27. We can make sure that people can access dental care across our state in the ways that already exist through the Royal Dental Hospital of Melbourne, but then also the community health services, the Smile Squad and a range of services that exist, particularly in rural and regional settings as well.

The work across our public dental system is really important. I do not think people across our public dental system get the reward or the recognition that they deserve in terms of public shout-outs, so I do want to acknowledge their work. It is something that means that wait times are continuing to improve. That additional investment in services delivered by Oral Health Victoria is making a difference, and I want to extend my thanks and respect to everybody who provides those services every day.

Meng Heang TAK: Thank you, Minister.

The CHAIR: Thank you, Mr Tak. We are going to Mr Puglielli.

Aiv PUGLIELLI: Thank you, Chair. Good morning, Minister and officials. To start us off, I am on budget paper 3, page 46, the Department of Health outputs.

Harriet SHING: Yes.

Aiv PUGLIELLI: The government previously announced VicHealth would be abolished as a standalone entity and absorbed into the department, as recommended by the Silver review. As that abolition has not yet occurred, can I ask how much funding VicHealth is receiving for the 2026–27 budget year?

Harriet SHING: Yes, you can, Mr Puglielli, and it is lovely to hear from you in the course of this hearing. To be clear, there is no funding cut to VicHealth in the 2026–27 year. I just want to be really, really clear about that. When we talk to the priorities and the work that we are delivering around health promotion and chronic disease management – it is something I have touched on already in answers to a number of other questions – I want to begin by really recognising the work that VicHealth did when it was established around 40 years ago to lead a global conversation about what health education looks like, the impact of tobacco on habit-forming activity that is damaging to health. We know that sports and arts organisations and community events were peppered with references to cigarette promotion. We have seen some really significant changes that have occurred across the health prevention and promotion landscape since then.

We accepted the recommendation of the *Independent Review of the Victorian Public Service* – the Silver review – to absorb VicHealth into the Department of Health to reduce duplication and to improve those efficiencies without compromising service quality. We have a number of programs that continue to operate in a range of settings. It might be the SunSmart program, the diabetes and kidney function and health programs, the work that we are doing, including with the Commonwealth – people would have seen that there is an anti-vaping campaign that is now currently being worked through – and obesity programs as well. This builds on the really important work that happened there. We have got expanded programs through the Healthy Loddon Campaspe programs, women's health and sexual and reproductive health as well. Of course I have touched on chronic disease prevention.

Aiv PUGLIELLI: I will come to some of those later.

Harriet SHING: Yes, sure.

Aiv PUGLIELLI: Thank you. Minister, for that information. The specific question, though, was how much funding is VicHealth receiving for the 2026–27 budget year? You said there is no cut, but how much funding are they receiving?

Harriet SHING: There are no savings impacts to VicHealth associated with this particular decision. We are continuing to work through the process for a refreshed approach to health promotion.

Aiv PUGLIELLI: I appreciate that, but is there a number? How much funding are they receiving for the budget year?

Harriet SHING: We do have, again, an ongoing process, so I want that to be able to play out. We are in discussions between the Department of Health and VicHealth to make sure that we can understand what that looks like.

Aiv PUGLIELLI: There is not a number, though, you can provide?

Harriet SHING: Again, those conversations are continuing, Mr Puglielli.

Aiv PUGLIELLI: Really? In the budget papers there is no number for VicHealth? It is being funded, you are saying?

Harriet SHING: Yes.

Aiv PUGLIELLI: You cannot tell us how much?

Harriet SHING: Again, that is about making sure that as we progress the work of the Silver review health promotion continues and that VicHealth can continue to be able to deliver its programs in the immediate future. We are in a position to be able to deliver that.

Aiv PUGLIELLI: I appreciate the information you are providing. I do find that quite incredible, though, Minister. I might move on. Can I ask: is there going to be any reduction in FTE given that absorption of VicHealth into the department?

Harriet SHING: The idea, Mr Puglielli, is that when we address the opportunities for efficiencies we can do so in a way that enables frontline work to continue and that enables duplication and inefficiency to be reduced. There have not been any savings impacts identified for VicHealth in the 2026–27 year. We do want to make sure that we can have that integration planning continuing around how the Department of Health and VicHealth can continue to deliver those services. That sits alongside a range of other reforms that have informed the work of the Silver review and government's response to it.

Aiv PUGLIELLI: So no reduction in FTE? Is that what I am taking from what you have said?

Harriet SHING: We will continue to work with the VicHealth board through the Department of Health to make sure that we have that effective integration taking place.

Aiv PUGLIELLI: Okay. I would just like to understand, though: if there is no reduction in the funding, if there is no reduction in the FTE, why was VicHealth identified to be absorbed? What is being saved here?

Harriet SHING: For 2026–27 there are no saving impacts.

Aiv PUGLIELLI: So then why absorb it into the department? I am not sure I follow.

Harriet SHING: Again, because where we have duplication and where we have programs that can and are being delivered more broadly –

Aiv PUGLIELLI: To clarify, though, are you saying that duplication will then exist in the department if there is no reduction in FTE and no reduction in what is being resourced?

Harriet SHING: The Department of Health will continue to deliver health promotion and education work.

Aiv PUGLIELLI: I might move on. I am not sure I entirely follow, but I do appreciate the information you have put on record, Minister. So you are assuring this committee that no programs or activities currently provided by VicHealth will be cut over the forward estimates?

Harriet SHING: For 2026–27, Mr Puglielli, that is the case. The impact of the Silver review and government's acceptance of it means that in absorbing VicHealth into the Department of Health we will be able to realise efficiencies across health promotion and education whilst continuing that work. And again, we also want to make sure that we are making good use of the resources that exist, including as the Commonwealth has stepped into that space as well.

Aiv PUGLIELLI: Yes. So that is 2026–27 you have just spoken to.

Harriet SHING: Correct.

Aiv PUGLIELLI: Over the forward estimates, what would we expect to see with relation to those programs and those activities that VicHealth has resourced?

Harriet SHING: We have got that detailed integration planning, as I said, that is continuing between the department and VicHealth. We do want to make sure that that can take place in a way that enables us to work with the board and with leadership. VicHealth are in the best position possible to talk with us, not only about the work that has been happening internally within the organisation but also how VicHealth's work is overlapping with other work on health promotion and education that is already being done, including through the department, through other parts of government, including through community sport, for example, through education, the Active Kids sports vouchers, the work with the Commonwealth on the vaping program. We have the public health networks that are also stepping into that space around public health education, and I have

talked about chronic disease as well. There is a lot of work that we need to do to make sure that we are understanding how VicHealth's work fits in that space and how we can also reduce and remove duplication.

Aiv PUGLIELLI: Thank you, Minister. I will move on to community health, staying on the same budget page. I understand community health services are provided funding based on service delivery hours. Are you able to inform us if the community health funding in this budget has been indexed to keep up with rising costs of treatment and an increasing load being placed on these services?

Harriet SHING: You will appreciate, Mr Puglielli, I am wrangling many folders of very detailed information here. In the interests of time, with the clock ticking for you, Mr Puglielli, can we perhaps come back to you on that one? Is that all right?

Aiv PUGLIELLI: Yes, that is all good.

Harriet SHING: Thank you. You are a lone ranger when it comes to your own questions today, so let us move on.

Aiv PUGLIELLI: I might move on instead to specific services within community health, and I am still on the same budget page. Speaking to those specific services, I understand North Richmond Community Health, Access Health and Cohealth have all asked for community health funding that they receive from government to be tied to particular outcomes so that they may use it with flexibility to fund their operations as the community need dictates. Is the government open to this proposition?

Harriet SHING: Again, when we deliver on community health we do want to make sure that we are addressing where that acuity of need sits. I have had the opportunity to meet with community health services in the time that I have had the portfolio to hear about the range of services that they provide. They do have a pretty broad scope of practice, and we want to make sure – you know, Cohealth is one of these organisations – that we are meeting their needs. They have got that social model of health and they have got those targeted services that they provide. We have got the funding of $21.2 million allocated to the community health chronic disease program. We are also making sure that we have got support for the community health demand management toolkit. This is also about ensuring that we have got the focus on early intervention, prevention and whole-person support. Now, as I referred to with Cohealth, we have got $68 million in funding for them across a range of programs, more than $80 million over a two-year period, to assist them with a range of programs. That builds on the work that we have got across targeted programs. They include community asthma, family and reproductive rights education, family planning –

Aiv PUGLIELLI: Thank you for this information. I suppose the question is more around the way that the funding is occurring as opposed to what the funding is. Are you putting to the committee that you are funding based on specific tied outcomes, which is what they are requesting? Is that what you are saying?

Harriet SHING: Tied outcomes are determined by reference to the information that community health providers give us around what their modelled need will be. So again, we do want to make sure that we are responsive to that, and that is across the entire health system. We need to understand where current and emerging need exists so that we can invest in that, and also to understand where it may not arise, so that we can make decisions about how to allocate funding in areas where that need is greatest. Mr Puglielli, I have managed to track down, just back to your earlier question, the answer to your earlier question about indexing. Community health funding is actually indexed annually.

Aiv PUGLIELLI: It is?

Harriet SHING: Yes.

Aiv PUGLIELLI: Okay. Great. Thank you. I will move on to another matter. In March this year the Premier and the then health minister announced that from July people will be able to access the contraceptive pill from pharmacies without a script. Are you able to update the committee on what specific expert advice that initiative was based on? What advice was sought prior to that announcement being made?

Harriet SHING: Yes. Thank you. I can actually do that. The Chemist Care Now program has been a really important part of making sure that we can understand and address need, including need that can be delivered

through a range of community-based programs, and in expanding Chemist Care Now to offer 23 services in 2026–27 we are responding to that need. Victorians can already receive treatment, as you have identified, for a range of presentations – so urinary tract infections, a resupply of hormonal contraceptives, treatment for shingles, flare-up of mild plaque psoriasis and impetigo and select travel health vaccines. We do want to make sure that we are continuing to deliver on a range of safeguards as well, and this is where the safeguards that are in place as they relate to oral contraceptives do not depart from any of the TGA advice. That is an important thing to note here. The ability for appropriately trained pharmacists to supply schedule 4 medication under the program is consistent with the existing roles and responsibilities for the regulation of medicines, and all schedule 4 medications under the program have the necessary approvals that are required under the Victorian legislation. You can also –

Aiv PUGLIELLI: Can I perhaps rephrase my question?

Harriet SHING: Of course.

Aiv PUGLIELLI: Which stakeholders specifically advised providing the contraceptive pill from pharmacies without a script?

Harriet SHING: That was part of a range of considerations around what we know to have been a challenge in accessing oral contraception. The women's pain inquiry was very, very clear about challenges in accessing care and treatment, particularly where oral contraceptive treatment is prescribed for other purposes – that is, for heavy and prolonged bleeding, for example, which can contribute to a really significant range of health concerns. This is where access to oral contraception has been –

The CHAIR: Thank you. We are going to Mr Hilakari.

Harriet SHING: Always keen to continue this conversation, Mr Puglielli.

Mathew HILAKARI: Thank you so much, Minister, and thank you officials for your attendance this morning. There have been a lot of great insights into the health system and how it is progressing and the more work to do, and I appreciate that acknowledgement, Minister. Minister, I am going to take you to workforce within the healthcare sector. I do love, as you could tell, the questions around dental care and public dental care. I am so pleased that Point Cook community hospital will have public dental chairs as part of that service when it opens. But I will take you to workforce, which is equally important, because you need those health professionals across our system, and to budget paper 3, page 53, around health workforce training and development. Minister, could you tell us a little bit more about how we are developing our health workforce in Victoria?

Harriet SHING: I certainly can, Mr Hilakari. One of the things that I want to make sure that we can be clear about is the ongoing opportunities that we have to invest in workforce capability but also scale. Across the state we see every single day hundreds of thousands of people working within our health system to provide care, either through early intervention and prevention or in that clinical or surgical setting, and we have seen significant investment to increase that pipeline of workforce capacity. We have increased it by 50 per cent. We have increased our paramedic workforce by 50 per cent. We have increased the number of nurses and midwives as a consequence of engagement in good faith around the value of the work that they provide. What that means is that we can build on the previous investments around making it free for studying of nursing and midwifery through the $270 million investment. There are 250 graduate placements. There are also pathways through rural and regional health, mental health and aged care for graduate placements, and we want to make sure we are supporting people across all stages of their career. Importantly, we also have an integration with the TAFE and training pathways. Where we are combining those efforts through TAFEs, universities and teaching hospitals, we are seeing that more people, particularly in rural and regional areas, are able to access those pathways, do not have to move to Melbourne and are able to stay closer to home, and therefore health outcomes are able to be delivered to meet demand in those areas.

We also strengthened nurse-to-patient ratios. We were the first jurisdiction in the world to implement them. They were then rolled back, and what we did, as you know, was legislate them. This is where, again, making sure that we are supporting our workforce into the future through that workforce capability is about ongoing recognition of the need to ensure that people are at the heart of a well functioning and enormous health system that is sufficiently dextrous and responsive to need. We will keep working with students, with health services

and, again, with other jurisdictions to ensure that we have got that pipeline, getting people into meaningful roles and helping them to meet their aspirations. Recruitment, retention, professional development and an opportunity wherever possible to ensure we can attract people to work in the Victorian health system from elsewhere, including through scholarships and cadetships, are important there too. And speech pathology and OT as well are really important. Those grants are also about providing 250 grants to specialist pathology and OT graduates to work in rural and regional Victoria.

There is a lot going on there, but we also know that as the population grows, as it ages and as presentations become more complex, we need a workforce that is equipped through training and educational pathways to deliver the service that people need.

Mathew HILAKARI: As I move about in my community, we know there are challenges in all workplaces. I do not think there is a single worksite that I go to who say they are flush with workers; it is just an economywide issue. Nationally, within the health workforce, how is that headed? But also, in particular reference to rural and regional Victoria, what are some of the efforts that we are undertaking to make sure that we have the staff that we need to do these critical works?

Harriet SHING: We are seeing as a result of the interventions we have made on the way that people work, the work systems around them and the sorts of systems that support work administratively through technology and through other care pathways that we have got greater retention of staff within the workforce. That is one really important component of workforce capability and availability. We have got 160,000 people working in our public health system. We have got an opportunity to continue to grow the workforce. We have got more than 40,000 nurses, midwives, doctors and allied health professionals across our hospital system and health services system, and we know that it is working. In 2024–25 we had the lowest rate of nurse separation in more than a decade. Again, there is a direct link there to be made, as it relates to nurse-to-patient ratios, as it relates to the way in which terms and conditions for nurses and their workplace entitlements are discussed, negotiated and agreed.

Our nurses are the highest paid in Australia. The conditions that we have delivered for them reflect the needs – what we hear and what we listen to from nurses and midwives every single day about what they need and how we can contribute, whether that is through pilot programs to test what we do when we combine nursing and midwifery, what it means to alleviate pressure in other parts of the system and as we continue to develop and support rural and regional workforce pilots as well. And the rural urgent care nursing capability development program – it is a very long title, but in essence it means that we have got registered nurses working in those urgent care centres in rural and regional Victoria. It means that that reduces the amount of travel that people are having to do as well.

Mathew HILAKARI: And terrific health care by registered nurses. My mum was one for all her career. Minister, rates of violence in the health sector are really challenging to hear about. How are we attempting to address those?

Harriet SHING: This is a really important question, Mr Hilakari, and I just want to be very unambiguous in what I say here: violence is unacceptable. Violence against any worker is unacceptable, irrespective of the job that they are doing, and violence against healthcare workers is inexcusable. When people come to a health worker for assistance or for support at a time of enormous vulnerability, the very people who provide that assistance, expertise, care and support deserve better than to be harassed, intimidated, threatened or injured. There is always more work to do to make sure that we understand what is happening on the ground when there may well be a culture of entitlement to act without perceived consequence, and that is not okay. It is not good enough.

I am continuing to work with the sector to understand the impact of violence, the impact of intimidation, the interface between those who are working in the system every day and the people who are using and perpetrating violence against them. I have been really grateful for the opportunity to have conversations with the ANMF, health services, Ambulance Victoria and the unions to talk about what is being done, what needs to change and how we can continue to provide those safeguards for people who are providing their care and their expertise to people in those situations.

Public health services are required to report instances of occupational violence in annual reports. They are tabled in Parliament. We have also got WorkSafe reporting mechanisms there. Public hospitals reported a 16 per cent increase in 2024–25 on the incidents reported of occupational violence. Caution is needed when we interpret that data. Comparing between services and years, we can have a lot of variation where, for example, we have got those larger health services and emergency or residential care facilities in place. But again, the themes are the same: violence is never acceptable, violence against health workers is inexcusable. We have invested more than $47 million in initiatives to support better response, prevention and de-escalation of occupational violence and aggression. That includes de-escalation training, the Health Service Violence Prevention Fund and the Safewards model. We are also through Safer Care Victoria providing guidance and resources to ensure that health services have those minimum standards for occupational violence and aggression training, interactive e-learning modules, guidance on security, as well as code grey standards and post-incident support resources.

This is a really complex challenge. It is a challenge not unique to the health system, and it is a challenge not unique to Victoria. We also want to make sure that we are holding individuals accountable for their actions where they may be a user or a perpetrator of violence against any worker in the health system. We are also ensuring that we have got better call triage and dispatch and that we are assisting with offload cubicles and making sure that people in often distressed or agitated states who might be inclined to use violence are able to be offloaded into emergency departments. We are offering alternative pathways for non-threatening conditions. The Victorian Virtual Emergency Department is managing complex care, including through secondary triage – which again, no doubt we will have an opportunity to talk about shortly in ambulance services – and urgent care centres are freeing up patient beds.

But there is always more work to be done. I have been determined to understand the impact of violence on our workforce and to address not just what is happening but to look to opportunities to prevent this from happening, to reduce the incidence of violence and to make sure that our workers are made and kept safe. I have been clear in conversations with the department, with agencies and with health services about the need to deploy resources and lived experience to making sure that we have better response, and that builds upon a round table that was conducted last year by the mental health minister and the former health minister for an occupational violence sector round table. I am in the process of rescheduling the next sector round tables to occur in June.

Mathew HILAKARI: The Member for Laverton and I saw some of that in the built environment with Werribee Mercy's emergency department and separate entrances and spaces for people who are experiencing challenging behaviour. Minister, digital investment was also something that we saw, and innovation is what we want to see to support our health workers. How are we doing that through this budget?

Harriet SHING: Innovation and digital and technological access and pathways are really essential in not just making things more efficient but scaling up the way in which we can deliver care. It is also about making sure that we have the right reporting frameworks in place through VicKey –

Mathew HILAKARI: Some digital intervention there, Minister.

Harriet SHING: through specialist care – that is right; great use of technology there, Ms Benham – and making sure that we have got a really good exchange of information. There is health information sharing capability through the CareSync Exchange, which I know my predecessor was really engaged in and with, and there are authorised environments for clinicians to access relevant patient information. Reducing the need for patients and consumers and clients to tell their stories over and over again then reduces susceptibility to inconsistent or incorrect information being recorded. CareSync Exchange is currently used across nine metropolitan Victorian health services, with delivery underway to additional services. It has to be a landscape of digital capability, bricks and mortar, workforce and allocation of the right resources in the right ways in the right timeframes to the right people.

Mathew HILAKARI: Minister, in the brief time we have left, maternity services and delivery in the west of Melbourne – tell us more.

Harriet SHING: Last year at Joan Kirner alone we saw 7400 babies born, of around 85,000 across the state. $249 million to assist with maternity care for mums and bubs across the west is a really important investment. We do want to make sure that everything from neonatal care right through to additional maternity beds is able

to be delivered to provide that response to population growth and world-class excellence in care every day. Thank you to all the staff delivering that work.

The CHAIR: Thank you. Yes, we are a busy bunch in the west, having babies.

Minister and officials, thank you very much for taking the time to appear before the committee today. The committee will follow up on any questions taken on notice in writing, and responses are required within five working days of the committee's request.

The committee will take a break before beginning its consideration of the portfolio of ambulance services at 11 am. I declare this hearing adjourned.

Witnesses withdrew.