PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the 2025-26 Budget Estimates

Melbourne – Tuesday 10 June 2025

MEMBERS

Sarah Connolly – Chair
Nicholas McGowan – Deputy Chair
Jade Benham
Michael Galea
Mathew Hilakari
Lauren Kathage
Aiv Puglielli
Meng Heang Tak
Richard Welch

WITNESSES

Mary-Anne Thomas MP, Minister for Health; and

Jenny Atta, Secretary,

Naomi Bromley, Acting Deputy Secretary, Hospitals and Health Services,

Professor Zoe Wainer, Deputy Secretary, Community and Public Health,

Catherine Rooney, Acting Deputy Secretary, Finance and Support,

Siva Sivarajah, Chief Executive Officer, Hospitals Victoria,

Louise McKinlay, Chief Executive Officer, Safer Care Victoria,

Lance Emerson, Deputy Secretary, eHealth, and

Julie Walsh, Acting Deputy Secretary, People, Operations, Legal and Regulation, Department of Health.

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

I ask that mobile telephones please be turned to silent.

I begin by acknowledging the traditional Aboriginal owners of the land on which we are meeting, 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 here with us today.

On behalf of the Parliament the committee is conducting this Inquiry into the 2025–26 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 make 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. The broadcast includes automated captioning. 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 very quietly.

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

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

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

Mary-Anne THOMAS: Thank you very much, Ms Connolly. Can I join you in also acknowledging that we are on the lands of the Wurundjeri people and, like you, I pay my respects to elders past and present, and I also wish to acknowledge any Aboriginal or Torres Strait Islander people who may be joining us.

Visual presentation.

Mary-Anne THOMAS: Can I thank all of the committee members for the opportunity to present before you today and the officials who are joining with me. In this budget we are focused on what matters most to Victorians: easing cost-of-living pressure by investing in our world-class health system and backing our doctors, nurses, midwives, paramedics and all the other frontline health workers so Victorians can get the care

that they need where and when they need it. Once again, we are delivering record funding into our health service system.

Next slide, please. In the 2024–25 financial year we have been busy establishing 12 local health service networks in response to the health service plan. The networks will enable health services to work better together to deliver more accessible, higher quality care for Victorians wherever they live. We are reducing the gender health gap, with 15 new women's health clinics and our nation-leading inquiry into women's pain, which heard from over 13,000 women and girls. The women's health clinics provide girls and women with access to comprehensive and quality care closer to home, while the inquiry into women's pain is now being finalised, and I look forward to receiving its recommendations to improve pain care for women now and into the future.

The new RSV mothers and infant protection program is offering protection to pregnant women and infants at increased risk of severe RSV, keeping them healthy and well and driving down hospitalisations. We are on track once again to deliver 210,000 planned surgeries in 2024–25, but more importantly, we continue to see improvements to the number of patients being treated in time, with April data showing a 5.2 percentage point improvement in the number of surgeries delivered within recommended time compared to April 2024. We will continue to deliver reform as set out by the Planned Surgery Reform Blueprint, with initiatives such as patient support units being expanded to 28 health services in 2025–26. As a Labor government, we have an ongoing commitment to enhancing the capacity and capability of Victoria's health workforce. Our continued investment in the workforce since 2014 has resulted in a 78 per cent increase in the number of doctors and almost 50 per cent growth in total staffing across Victoria's public hospitals. We introduced stronger and safer nurse-to-patient and midwife-to-patient ratios, ensuring the very best care for Victorian patients and their families. In 2024–25 we provided grants to 400 junior trainee doctors to help grow the general practitioner workforce, and I expect we will meet our commitment to have supported 800 trainees by the end of this calendar year. We have also supported 108 speech pathologists and occupational therapists to begin their careers in rural and regional Victoria.

Next slide, please. The total annual investment in Victoria's health system now exceeds $31 billion, and the 2025–26 state budget includes the biggest investment ever in frontline care. This includes a record $9.3 billion for Victoria's public hospitals, ensuring they have the certainty to plan for the future and keep delivering the world-class care that Victorians rely on.

Next slide, please. This budget provides further investment to help Victorians access the care they need when they need it. $436.7 million is provided to expand the virtual emergency department at the Northern Hospital, the first of its kind in Australia. The virtual emergency department provides free expert care from emergency doctors and nurses to more than 600 callers every day, and our investment will significantly increase its capacity, enabling the service to support 1000 calls per day in the 2025–26 financial year. As we continue to grow the service we will be able to serve 1750 calls every day by 2028–29 – or more than 600,000 calls every single year.

Next slide, please. This budget also includes $634.3 million to open and operationalise nine new or expanded hospitals, delivering even better care for local communities. This includes bringing on line the brand new Footscray Hospital, Frankston Hospital and Maryborough and district hospital. The budget also supports the opening of three community hospitals in Cranbourne, Craigieburn and Phillip Island. Funding will also support the operationalisation of redeveloped emergency departments at Swan Hill District Health, Albury Wodonga Health and University Hospital Geelong. We are also boosting our engineering infrastructure replacement program by $61.8 million and adding $52.3 million to Victoria's medical equipment replacement program, ensuring our public hospitals have the best equipment.

Next slide, please. More than $18 million has been invested to transition our successful community pharmacist pilot to an ongoing and expanded community pharmacist program. Under the expanded service pharmacists will now be able to treat even more conditions usually only available with a prescription, including allergies, nausea and high blood pressure. We are also investing $27.6 million in 2025–26 to deliver the right care at the right time, including continuing support for the 12 existing urgent care clinics that continue to be funded by Victoria. Delivered in partnership with the Commonwealth, Victoria's 29 urgent care clinics are free, open seven days a week and accessible without an appointment. A further $58.4 million over two years will help to better manage ambulance ramping by improving patient flow through hospitals with major emergency

departments. This investment will help emergency departments see patients sooner and help ambulance services provide a timelier response.

Next slide, please. Protecting the health of all Victorians is our priority, and that is why we are investing $38.3 million to support the continuation of local public health units and oversight of water regulation, epidemic thunderstorm asthma program and extreme weather alert system. LPHUs play an important role when it comes to public health protection, prevention and regulation, keeping communities healthy, safe and well. Continuing our work towards a cancer-free Victoria, we are delivering $8.1 million to support a targeted suite of programs and services that will continue to stabilise the cancer system and support the objectives of the recently launched *Victorian Cancer Plan 2024–28*. This includes increased access to precision cancer care, clinical trials and tailored cancer support services for Aboriginal Victorians.

Next slide, please. We are delivering $95.1 million to support more nurses, midwives and healthcare professionals at all stages of their career, including access to education programs and clinical placements. We are supporting registered undergraduate nursing and midwifery students to get experience within our public hospitals, providing more nurse practitioner roles and helping nurses and midwives across the state to build their capability and transition to higher roles if they so choose.

Next slide, please. Continuing our work as a national leader when it comes to transforming the delivery of women's health, this budget invests $5.6 million and $1.4 million to support the health of Victorian women and girls and strengthen health outcomes. This of course builds upon our previous investment of more than $170 million for 20 new comprehensive women's health clinics, nine new women's sexual and reproductive health hubs and women's health research initiatives and scholarships to expand the women's health workforce. This includes investments into the 1800 My Options service, which will continue to provide evidence-based information on contraception, pregnancy options, abortion care and sexual health, and our clinical champions project from the Royal Women's Hospital, which delivers health professionals training, secondary consultations, clinical guidance and mentorship.

Next slide, please. We know that when we listen to Aboriginal Victorians, we get better health outcomes, and that is why we are working with the Dandenong and District Aborigines Co-operative Limited, DDACL, and the Victorian Aboriginal community controlled health organisations to ensure they can continue delivering culturally safe care to their communities. Almost $13 million will support DDACL to fund an upgraded, modern facility to deliver clinical, social and wellbeing services to Aboriginal and Torres Strait Islander people in Melbourne's south-east. As part of our work to make sure all women feel safe accessing care, $15.8 million will enable 10 Aboriginal community controlled organisations to support mums with culturally safe maternity care before and after their baby's birth.

In Victoria equality is not negotiable. That is why we are delivering $15.3 million for our LGBTIQ+ communities to ensure that they have the specialist health care they need. We are also investing $3.4 million to continue GP care and support health coordination for asylum seekers and newly arrived refugees. Chair, this is a budget that delivers what matters most to Victorians.

The CHAIR: Thank you very much, Minister. The first round of questions is going to go to Mr Welch.

Richard WELCH: Thank you, Chair. Thank you, Minister. Actually, my first question is to the Secretary, if I may, referring to budget paper 3, page 49, 'Backing our hospitals'. Following the government's announcement on 10 January this year regarding health service network groupings, can you confirm that all 12 local health networks will be established and functional by 1 July 2025?

Jenny ATTA: Thanks, Mr Welch. All of the 12 networks from 1 July will be established and working in collaboration with their member services in line with the reforms as set out in the *Health Services Plan*.

Richard WELCH: Thank you, Secretary. In regard to Bayside Health, that comprises 20 or so entities, including Wonthaggi Hospital, Kooweerup health service, the Alfred and Frankston hospitals, and that comes into operation on 1 January 2026. Can you confirm that this network will have just one CEO and just one overarching board?

Jenny ATTA: It is the plan for the local health service networks that they move to those joined-up governance arrangements – one CEO and an overarching board.

Mary-Anne THOMAS: And I might just jump in there, if I may.

Richard WELCH: No, that is okay.

Mary-Anne THOMAS: No, no, no, because I think –

Richard WELCH: That is fine. I am happy with that answer.

Mary-Anne THOMAS: But I think that you are talking about an amalgamation which is being led by the services themselves, including Alfred Health –

Richard WELCH: Thank you, Minister. That is fine.

Mary-Anne THOMAS: and Peninsula Health –

Richard WELCH: That is not my question.

Mary-Anne THOMAS: No, but it is quite different to the LHSN. So this is a –

Richard WELCH: That is okay.

Mary-Anne THOMAS: But I need to make that point.

Richard WELCH: I would like to get on with my next question, if I may, Minister.

Mary-Anne THOMAS: But I do need to make that point because it is quite different. This is being led by the health services themselves.

Richard WELCH: Thank you, Minister. Secretary, when will the CEO of Bayside Health be decided?

Jenny ATTA: I do not have that information with me, Mr Welch.

Mary-Anne THOMAS: Mr Welch – apologies, Secretary, but I can jump in there.

Richard WELCH: Do you know when the CEO will be appointed?

Mary-Anne THOMAS: What I can tell you is that the first step is for a proposal to come to me, and I need to –

Richard WELCH: When will that proposal come to you?

Mary-Anne THOMAS: Well, I need to approve that. I am not leading that process. It is being led by the health services themselves.

Richard WELCH: So we do not have a date at the moment?

Mary-Anne THOMAS: Well, they are working towards an end of this –

Richard WELCH: Have you given them a deadline?

Mary-Anne THOMAS: They are working to an end of this calendar year to come forward –

Richard WELCH: By the end of this calendar year?

Mary-Anne THOMAS: with their proposal.

Richard WELCH: Thank you. Secretary, when will the board be appointed?

Jenny ATTA: Again, the services are working together on that to bring advice to the minister.

Richard WELCH: Is there a date by which it needs to happen?

Jenny ATTA: We have the 1 January date when it will be stood up, but the services are working together to bring advice to the minister on those matters.

Richard WELCH: Okay.

Mary-Anne THOMAS: I need to approve that, Mr Welch.

Richard WELCH: Will the Bayside network only have a singular annual report for all entities?

Jenny ATTA: I am sorry, Mr Welch, can you repeat that?

Richard WELCH: Will the Bayside network have a singular annual report across all entities?

Jenny ATTA: We will be working through the processes for the reforms. As the minister said, this is an amalgamation that is generated by and being worked through by the services involved, and it would be the expectation that ultimately they would have one annual report.

Mary-Anne THOMAS: In the same way that Grampians Health was a merger process that was led by those health services themselves. It is quite different – I need to make that point – to the local health service networks, which are being led by my department, driving increased collaboration across our health service.

Richard WELCH: So what will be the mechanism for the individual entities for doing their reporting within that structure if there is just one annual report?

Jenny ATTA: Well, Mr Welch, all of this is being worked through. It is the subject of discussions at the local service level. There will be advice coming through for the minister to approve. So it is premature for me to provide –

Mary-Anne THOMAS: Mr Welch, I would suggest that you look to Grampians Health as a model of what happens once services have come together in an amalgamated service, which is what is happening at Bayside – quite different to the local health service networks. This is being led by local health services themselves.

Richard WELCH: Thank you, Minister. Secretary, will there be any job losses as a result of this amalgamation?

Jenny ATTA: Mr Welch, the amalgamation of those services is being worked through at the local level. It is about how those services work together. There is no reduction in services to be provided. There is no intention other than to look at the benefits in terms of clinical service delivery for those health communities that can be generated.

Richard WELCH: But will there be any budget savings?

Mary-Anne THOMAS: Mr Welch, I might just interrupt for a moment. I am not quite sure that you understand the way in which our health service systems are governed.

Richard WELCH: No, I do not need an explanation, thank you.

Mary-Anne THOMAS: No, but they are –

Richard WELCH: It is my time; I would like to ask my questions, please. Will there be any savings? What will be the budgetary savings from this process?

Jenny ATTA: There are no targeted savings for those services coming together in that particular instance around an amalgamation, as the minister said. That is a singular example, different to the local health service networks.

Richard WELCH: So no budgetary savings. Will there be –

Mary-Anne THOMAS: Correct, no budgetary savings are required.

Richard WELCH: Will the amalgamation involve extra cost?

Jenny ATTA: We are currently working with those services as part of that amalgamation to work through, including to look at whether there are any resourcing requirements to support the coordination, the transition and the change management. That is all to be worked through.

Mary-Anne THOMAS: Yes, and we have previously supported and we will continue to support health services that are looking to implement change. That is all about ensuring that they deliver more and better care closer to home for the communities that they serve.

Richard WELCH: But that will be budget-neutral, will it? There will be no budget impact of that?

Jenny ATTA: We will continue to work with the services to support that amalgamation, as I think happened in the past –

Mary-Anne THOMAS: That is right.

Jenny ATTA: with the Grampians amalgamation.

Mary-Anne THOMAS: And let us be clear, we have not received a proposal yet. We have not received a proposal.

Richard WELCH: So we are going into this exercise but we do not know what the budgetary impact will be.

Mary-Anne THOMAS: Well, no, hang on. We are not going into this process; our health services are talking to one another at the moment about bringing forward to government a proposal, and we are expecting to see that by the end of the year. When we receive that proposal, we will consider it, but until such time as that, it is a proposal that is being led by the health services themselves, not by my department.

Richard WELCH: Given that Bayside Health is only going to have one board and one CEO once it is fully implemented – that is what I have taken from that – is it the expectation that the other networks will follow and eventually end up with just one CEO and one board also?

Mary-Anne THOMAS: Secretary, if you do not mind, because this is a reform that has been driven by myself as minister, it is probably a question that is better directed to me. Can I be clear that our government, including the Premier and I, made it very clear that there will be no forced amalgamations as we work to implement the *Health Services Plan*. With our local health service networks, they are just that – they are networks.

Richard WELCH: But will they have a single CEO and a single board?

Mary-Anne THOMAS: No, they will not. The hospitals within those health service networks will continue to have their own board and their own CEOs.

Richard WELCH: Unlike Bayside.

Mary-Anne THOMAS: Well, Bayside, as I have tried to explain, is a voluntary merger proposal.

Richard WELCH: Voluntary. Okay. Just on the consultation around Bayside, has that consultation been completed?

Mary-Anne THOMAS: That is a question that is probably best directed to the board chairs at Bayside, who continue to talk to their communities and are working to bring forward a –

Richard WELCH: Are you involved at all, Minister?

Mary-Anne THOMAS: No, not at the moment. But there is actually a requirement to consult, and I am sure that that will be followed. We will make sure that those health service systems comply with all the community consultation requirements that are laid down for such a process and which I would expect to have been undertaken before I would seek to approve such a proposal. However, I can say that I have met with many, many CEOs and board chairs right across the state, including each of the CEOs and board chairs that are involved in this proposal at Bayside, and they have expressed to me, at varying points, their desire to come

forward with a merger proposal, which was driven entirely by the opportunities that they saw to deliver better care in their communities. And what is more –

Richard WELCH: Thank you, Minister. I would like to move on now.

Mary-Anne THOMAS: I just want to make the point, though, that –

Richard WELCH: No, I do not need any further points. Thank you. Minister, I would like to ask about the IT systems. How many different IT systems are currently in place across the Victorian health and hospital system?

Mary-Anne THOMAS: Quite a lot. I do not have the exact number, but I can tell you that we have a number of electronic medical record systems in place. I think it is around four or five. Importantly, this budget continues our support for CareSync, and CareSync is a really important component of our IT system because it enables these different systems to talk to each other. Mr Welch, as I am sure you would understand, here in Victoria we have traditionally had a very devolved hospital system – that is, our hospitals are run by their boards – and I have been working in the time that I have been minister to drive greater cooperation and collaboration so that we do not see a thousand flowers blooming when it comes to IT.

Richard WELCH: That is a relevant point to my next question. When the amalgamation takes place, will all those entities have a common IT system? Medical records, pathology, diagnostic information – will that all be shared?

Mary-Anne THOMAS: That is what they will be working towards. But, again, I would need to see what the health services themselves are proposing up to government in terms of how they –

Richard WELCH: Is it your expectation that it will be ready on day one?

Mary-Anne THOMAS: Not necessarily, because as I said, we have got CareSync in place, and CareSync we continue to invest in, which helps the services and the different IT systems talk to each other. But our government is absolutely committed to ensuring that we have electronic medical records across our health system so that we can better share that information so that patients do not need to repeat their story from one health service system to another.

Richard WELCH: For example, in Bayside, is it the expectation that they will have one common system?

Mary-Anne THOMAS: Over time it would be my expectation that they would work towards that if it was the best system for them. But these are decisions that they will need to make, because as I have said, our hospitals are run by their boards, so the boards will make those decisions, Mr Welch.

Richard WELCH: So how much has been invested in CareSync?

Mary-Anne THOMAS: CareSync? We committed funding to deploy a statewide health information exchange via $182.3 million in the May 2021 budget. This project was expanded with $64.761 million in May 2022 to better support mental health reform recommendation 62.

Richard WELCH: Just back on the lack of common systems across the amalgamated group, how are they going to work as a singular group if they are all operating on disparate systems?

Mary-Anne THOMAS: Because CareSync enables them to share the information. So it is not unusual –

Richard WELCH: So CareSync will be implemented at the time?

Mary-Anne THOMAS: Hang on. You have asked me the question; let me explain to you that there are a number of common platforms that are used by health services all around Australia. There are about four or five. I think over time, though, we would like to reduce that number, but we want to make sure that we are listening to hospitals as to what works for them and that we are meeting their needs to deliver the care that their patients need.

The CHAIR: Thank you, Minister. Ms Kathage.

Lauren KATHAGE: Thank you, Chair, Minister and officials. Thank you very much for being here. Minister, on page 53 of budget paper 3 there is information set out there about the community pharmacist program. We had you out to visit our local pharmacist in Mernda, which was great, and this budget is continuing support for that program. Are you able to talk us through what has been achieved so far that has led us to wanting to continue supporting it?

Mary-Anne THOMAS: Yes. Thanks very much, Ms Kathage, for that question, and can I say it is always a delight to be able to join you in your electorate and to observe how well connected you are in that community and the passion that you have for delivering care in as many different pathways as possible to your growing communities, which is always evident in our visits.

As you say, we implemented a pharmacy pilot here in Victoria, and we did that in order to expand the options for Victorians to access the care that they need, where and when they need it. We understood of course that it has been very difficult, or has been over some time, for Victorians to be able to access a bulk-billing GP. I am glad to say, though, that with some reforms being led by the Albanese Labor government we are seeing some real changes there, but this initiative of the pharmacy pilot was really in response to the concerns that we heard very clearly from community that there are some things for which you just need to get care really quickly. For example, the most popular service being delivered by the community pharmacy pilot program was treatment for uncomplicated UTIs, and of course women were the predominant users of this service, because when you have a UTI you need treatment fast, right? So if you have to wait for a GP appointment, that could indeed lead to that condition only becoming worse. So there were UTIs, and of course the other thing was a resupply of the oral contraceptive pill – once again, the pill is an effective form of contraception but only if it is taken as prescribed, which means every day within a certain timeframe. Many Victorian women find themselves with very busy lives, juggling a whole range of things, and perhaps they forget to go back to their GP to get their script renewed or they have gone away for the weekend and they have run out of a supply. So these are some of the problems that the pharmacy pilot sought to address. I am delighted that the pilot itself helped over 45,000 Victorians receive fast free care. Given its success, we have decided to invest a further $18.1 million in this budget to expand the program, and it has been a real pleasure to be able to work with the pharmacy guild on this program and to really unlock all the skills of our community pharmacists who know their communities really well and who are there to deliver really, really great care.

With the expansion of the program there are two things that I want to highlight. The first of course is that it is no longer a pilot. It is now going to be implemented as a permanent, ongoing part of our healthcare system. Secondly, we are going to expand the number of conditions which pharmacists will be able to treat to at least 22. I look forward to that rolling out. I have had the opportunity to visit many of you in your communities, and you know as well as I do how much our pharmacists are looking forward to the continued expansion of this program. Ms Kathage, if I may, we did do obviously an evaluation before making a decision to make this program permanent, and let me tell you a little bit more about what that evaluation told us: 27 per cent of pilot services were delivered in rural and regional areas, something I know Ms Benham will be very interested in, ensuring that country people can also access the many benefits that flow from this program and where it can be even more challenging to access GP services; 97 per cent of Victorians who utilised the pilot service reported satisfaction with the care they received; 98 per cent said that the pilot met their healthcare needs; 76 pilot services delivered care that benefited Victorian women, including for the resupply of the oral contraceptive pill; and 76 delivered care that benefited Victorian women for the treatment of UTIs. So this has been a great outcome from the program.

Lauren KATHAGE: You touched on that it was more commonly women who were accessing treatment for UTIs. I know the government has got a broader women's health agenda, so how do you see this program fitting into or supporting that goal?

Mary-Anne THOMAS: Thank you again for that question. Obviously our government fully understands the needs of women in Victoria. One of the reasons why we do that is we have so many women in our caucus and indeed in our ministry, and we have really made it a focal point of our work to make sure that we are meeting the needs of Victorian women and girls and doing everything that we can to close this gender health gap that exists. The expansion of the program will definitely meet the needs of many more girls and women, but this is complemented also by the rolling out of our 20 women's health clinics, the establishment of a virtual women's health clinic, the establishment of a mobile women's health clinic and the establishment of an

Aboriginal women's health clinic. We have also expanded the number of sexual and reproductive health hubs that we have here in Victoria, and we now have 20 of those in operation.

As I noted in my presentation, 13,000 women and girls came forward to tell us and share with us their experience of pain, and we know that for too long many of the conditions that women experience and suffer from have been underdiagnosed or ignored and women have been told that the pain that they are experiencing is in their heads when in fact it is often an actual ailment or disease that remains undiagnosed. There is still plenty of work for us to do, but I think we have got all the structures in place in order for us to deliver the care that Victorian girls and women need and deserve. It is great to be able, as I said, to really utilise all the skills and abilities that are out there, and our community pharmacists, again, are absolutely critical to that. As you know and as I know, when we meet and talk to our pharmacists they are very ready to deliver more and better care to Victorians.

I am thinking about, though, as you are asking the question, that women in our state juggle so many different responsibilities, like yourself as a very busy mum of three children. I know that you make good use of all of the health services that we have available, because you and I have shared those stories. But as the community pharmacy pilot expands, I was really pleased to see that some of the conditions that we are hoping to be able to treat include some that I know busy mums of school-age children will know intimately – things like school sores and reflux and so on. We really are trying to implement a program that makes it easier for women and girls to access the care that they need when they need it.

In terms of the pharmacy pilot, another important point that I would make is that unlike New South Wales and Queensland, who charge a payment for their community members to access the consultation from the pharmacist, we will not be doing that in Victoria. We understand that many Victorians are challenged by cost-of-living pressures, and so everything in our budget is really designed to drive down those cost-of-living pressures, whether it is the pharmacy pilot or whether it is the women's clinics. And I can tell you stories that I am hearing from my own community and that have been shared with me by many of my colleagues about how women are valuing the opportunity to go to a clinic where they are listened to and where their concerns are acknowledged, heard and most importantly acted upon. We are delivering on our commitment. We said we would transform the way in which women's health care is delivered in this state, and I am very proud that we are doing that, because the stories are coming directly back to me – women telling me about how they were able to talk about health conditions that they previously felt too uncomfortable to talk to their regular GP about, or in fact had raised with their GP and were not really taken seriously. That opportunity to meet with someone who is dedicated to really understanding, listening and resolving the problem –

Nick McGOWAN: Come and talk to the women in Maroondah, Minister.

Lauren KATHAGE: I think it must be like a real burden being lifted off somebody's back when they get to go and speak to somebody, and what I have seen in my community is that word is spreading woman to woman. It is not through the traditional networks of how you hear about health services, but women are telling women. People talk about their teenage daughters to each other, and they share ideas to help their daughters. It is really changing the way that women feel about their bodies and about their health. I think it is amazing.

Mary-Anne THOMAS: One of our commitments of course is to reduce the shame and stigma that has for too often been associated with a range of conditions that women experience. While we have talked a lot about issues like endometriosis, polycystic ovarian syndrome, menopause, perimenopause and so on, older women in my community have come to me to talk about issues like prolapse and incontinence, and I am here to champion those women and to make sure that they can access the care that they need – wherever they live, Mr McGowan.

Nick McGOWAN: I was going to add to that, Minister, hopefully in Maroondah as well, because the women in Maroondah –

Mary-Anne THOMAS: With 20 clinics right across the state we have accessible care to women –

Nick McGOWAN: are still waiting for the emergency department for children that was promised in 2018, some seven long years ago, so the women of Maroondah have not been heard nor listened to.

Mary-Anne THOMAS: I am sorry, Chair.

Lauren KATHAGE: It was put to me by a woman in my community that when she was a young woman it was a Panadol or a hysterectomy, that was sort of the choice, and now we have a full range of services for women.

Mary-Anne THOMAS: And the women's pain inquiry has told us that many women are prescribed antidepressants for their pain when in fact their pain is physical and real, but they are being told it is in their head. Now, they are suffering depression; it is because their pain has not been resolved, so we need to get to the bottom of it.

Lauren KATHAGE: Talking about access, attitudes can be a barrier for women to access health care, but going back to the community pharmacists program, we know that there can be a physical access issue for regional Victorians to access health care. I think you said the evaluation showed 27 per cent of users were in rural or regional Victoria. Can you speak to the changes we are making for regional Victoria?

Mary-Anne THOMAS: Yes. Once again, our government has a real focus on ensuring that all of the reforms that we are delivering in health are equally benefiting those in rural and regional Victoria. Indeed I bring a regional bias to the work that I do, proudly so, because I want to make sure that every initiative that we seek to implement benefits people living in rural and regional Victoria. The relationship that regional and rural Victorians have with their community pharmacists is really second to none, and I had the great pleasure of recently being at Malmsbury Pharmacy and Gisborne pharmacy and talking to those in my local community about the way in which what we are doing is benefiting their communities.

The CHAIR: Thank you very much, Minister. I will go to Mr McGowan.

Nick McGOWAN: Minister, it strikes me that your IT systems are a complete dog's breakfast. I mean, you say there are between five to six –

Mary-Anne THOMAS: Four to five.

Nick McGOWAN: And this is in addition to the information sharing Act that went through the Parliament in 2023. So with respect to the Bayside amalgamations, which are anticipated to commence on 1 January 2026, when will you receive advice in respect to what that will look like? And when will your deadlines be for decisions?

Mary-Anne THOMAS: Well, as you would expect, I am aware of this planned proposal. I will await that being brought to my attention, and I will make my decision then.

Nick McGOWAN: So they will continue to manage up, and you will just sit waiting. Is that what we understand?

Mary-Anne THOMAS: It is the role of each of the health service boards to ensure that they are managing the health service in order to meet the needs of their communities, and they are responsible for reporting up to me on the way in which they are doing that. But this proposal is still being developed by the health services that are within the Bayside region.

Nick McGOWAN: I understand that, Minister, but in all reality if what you are anticipating is that this new body, whatever it looks like, will take effect from 1 January 2026, surely you and the department have some understanding of the timeline in terms of when you will receive initial advice.

Mary-Anne THOMAS: No. Sorry, I need to be clear. The proposal needs to come to me by 1 January 2026.

Nick McGOWAN: So that is not for implementation – 1 January?

Mary-Anne THOMAS: No.

Nick McGOWAN: It is just that the proposal needs to come to you by 1 January.

Mary-Anne THOMAS: Yes. I am anticipating that I will have the proposal by then. I mean, it is up to the health services themselves, Mr McGowan. This is what you are seeming to struggle to understand. Our health

services are managed by boards, and they make many decisions themselves in relation to the way in which they deliver care to their communities and how they organise themselves. In contrast, the local health service network program is one that is being led by my department in response to the *Health Services Plan*. This is being led by the health services themselves. I will respond to them when they write to me formally, and I have not received any formal notification from them to date.

Nick McGOWAN: And how will they fund this work that they are doing, Minister? Is that out of their existing budget? How will they fund –

Mary-Anne THOMAS: Which work?

Nick McGOWAN: The work they are doing in terms of their proposed amalgamation – surely this involves a considerable amount of work.

Mary-Anne THOMAS: They will come forward with a proposal. And as the Secretary has already identified, if I approve their proposal to amalgamate, we will then have a plan for that to take effect. As occurred when the health services that now make up Grampians Health came together – my department supported that amalgamation through some additional funding, as you say, to support the bringing together of these separate entities. But we will jump that hurdle when we come to it, because as I have said, while I am expecting a proposal by the end of the year, I do not have one at the moment.

Nick McGOWAN: Have the other boards written to you individually? How has that worked, Minister?

Mary-Anne THOMAS: I am sorry –

Nick McGOWAN: Help me understand. How does this work? The individual boards themselves – have they have written to you individually or have they all written to you as one?

Mary-Anne THOMAS: I have already explained. I have not received a formal proposal.

Nick McGOWAN: From anyone – not a single board.

Mary-Anne THOMAS: Well, I do not have any – I am not –

Nick McGOWAN: I am not talking about the proposal proper; I am talking in terms of their discussion with you. Individually, have those boards illustrated or communicated to you as minister that they are undertaking this process to consider a voluntary amalgamation?

Mary-Anne THOMAS: As I said in my previous answer, I have had the opportunity to meet with CEOs and boards of all of those hospitals, but I have done that as part of my regular commitment to travel around the state and visit health services. I have had those conversations with those individual boards. But the boards themselves – and again, I do not have this in front of me, Mr McGowan – did put out some commentary to the media about their intention.

Nick McGOWAN: And yet you can tell us there will only be one annual report. How is that the case?

Mary-Anne THOMAS: Because if they become one organisation, they will only have one annual report.

Nick McGOWAN: Says who, Minister?

Mary-Anne THOMAS: If I approve their proposal, then they are one entity and they have one annual report.

Nick McGOWAN: So you have already put one condition on them, Minister? What other conditions have you put on them?

Mary-Anne THOMAS: Sorry, what conditions?

Nick McGOWAN: You were waiting to receive a report from them to suggest to you amalgamation, but you are already putting a condition on them that they have one report.

Mary-Anne THOMAS: No. That is not a condition that I put on them. That is how the corporations Act works.

Nick McGOWAN: Minister, the operation of the Act works in many ways. You could have –

Mary-Anne THOMAS: And the *Health Services Act* – both Acts. I mean, one entity, one report.

Nick McGOWAN: But you are presuming –

Mary-Anne THOMAS: If they come together.

Nick McGOWAN: That is right.

Mary-Anne THOMAS: Yes.

Nick McGOWAN: You do not see the irony of that?

Mary-Anne THOMAS: No. If they propose to come together as one entity and if I am satisfied with their proposal, then they will work to do that.

Nick McGOWAN: Secretary, I refer to the 'Department Performance Statement', page 64. Palliative separations in 2023–24 were 8909 and the target for 2024–25 was reduced to 7816, yet the expected outcome is 8410. Given these figures, why has the government ignored the demand and reduced the target again, which is not aligned to the funding that is required to support that activity?

Jenny ATTA: I am sorry, Mr McGowan. Can you just tell me which –

Nick McGOWAN: Page 64.

Jenny ATTA: Sorry, which performance measure were you referring to?

Nick McGOWAN: That is the palliative separations. In 2023–24 there were 8909, and the target for 2024–25 is reduced to 7816, yet the expected outcome is 8410.

Mary-Anne THOMAS: Mr McGowan, more people have received care in our system. That is something I am actually quite proud of. We have seen an increase in the number of people that have been able to receive palliative care in our health service system.

Nick McGOWAN: Well, similarly, the target, Minister, for community palliative episodes in 2023–24 does not reflect what is happening in terms of what is required to meet the demand in palliative care services. In 2023–24 the figure was 16,051; for 2024–25 the target was 15,500 but the expected outcome is 15,774, and that is with a reduction of this target this year. Why is that?

Mary-Anne THOMAS: I can help you with that question. Obviously one of the things that is happening is the model of palliative care continues to evolve and change as we seek to meet people's wishes to die at home and deliver palliative care at home. So consistent demand for home-based palliative care services is reflected in the higher than expected 2024–25 target. We are using our beds more flexibly in order to meet demand.

Nick McGOWAN: Secretary, Eastern Palliative Care are exceeding their target of 100 per cent community palliative care episodes by 10 per cent month on month. They are not the only service seeing a massive demand and exceeding their targets – south-east palliative care have confirmed their demand is increasing by up to 30 per cent month on month – yet there has been no further money for palliative care in the last three budgets, remaining static at –

Mary-Anne THOMAS: Mr McGowan, could you give us a page reference for that, please?

Nick McGOWAN: I will come to that. Yet there is no further money for palliative care for the last three budgets, remaining static at $121 million. Why has the government failed to address this increase in demand? I am happy for you to correct the record, Minister, if you think palliative care has gone up in funding.

The CHAIR: Have you got a –

Nick McGOWAN: Page 64, 65.

Mary-Anne THOMAS: Of?

Nick McGOWAN: The performance statement, Minister. It is a simple question about the palliative care budget. I am sure you would have that to hand.

Mary-Anne THOMAS: The 2024–25 budget delivered $36.9 million over four years for palliative care, and these outcomes contributed to the Department of Health's non-admitted services output as well. Investment in palliative care aims to ensure that health expenditure is as effective as possible and ensure that we are delivering palliative care to meet the needs of our diverse communities.

Nick McGOWAN: So there is no increase in funding for community palliative care – is that correct?

Mary-Anne THOMAS: Well, I think the point we are trying to make here is that the funding that is available is used to meet the needs of communities, and indeed we have outperformed in terms of our non-admitted services.

Nick McGOWAN: Isn't that precisely the point, Minister?

Mary-Anne THOMAS: I am sorry?

Nick McGOWAN: Isn't that precisely the point, Minister – that there is actually unmet demand, that there is not an increase in the palliative care funding?

Mary-Anne THOMAS: No, it is not. The actual number of patients that are able to be treated has increased.

Nick McGOWAN: But the funding remains static.

Mary-Anne THOMAS: I am not quite sure where you are getting your funding reference from.

Nick McGOWAN: Well, Minister, I am happy for you to correct the record, but the funding – please enlighten us. The palliative care funding – you have said it is at current levels. Can you explain to us how it is more than it was previously?

Mary-Anne THOMAS: Well, again, I am looking at our performance statements and seeing that the delivery of palliative care in the community has increased.

Nick McGOWAN: Community palliative care, Minister?

Mary-Anne THOMAS: Sorry – community palliative care. Yes.

Nick McGOWAN: Secretary, I refer to budget paper 3, pages 49 and 51, and the $8 million over two years of funding for a cancer system for the future. Victoria is facing a tsunami of cancer cases, very sadly. Forty thousand cases a year are diagnosed, and that is predicted to reach 50,000 a year by 2032. Without immediate investment, the devastating reality is that one in three Victorians will continue to die from cancer. How is the government going to implement the goals in the *Victorian Cancer Plan 2024–2028* with only $8 million over two years across the sector?

Mary-Anne THOMAS: Well, Mr McGowan, I am happy to answer that question. Having launched the cancer plan myself, I think it is probably a question that I am able to respond to. Our government has invested more than $400 million since 2014 into our cancer care system in order to ensure that Victorians receive the best care. This funding has supported the rollout of new and expanded cancer screening initiatives, novel cancer research and clinical trials, service improvements and workforce upskilling – including, importantly, for our regional patients at the Grampians Health Ballarat Regional Integrated Cancer Centre –

Nick McGOWAN: Minister, if all you are going to do is read off the sheet, I would rather the Secretary answer the question, then.

Mary-Anne THOMAS: Well, no. Again, Mr McGowan –

Nick McGOWAN: It is a serious question, Minister, and you are not answering it with any seriousness. It is $8 million over two years of funding. How is that going to help treat 10,000 extra cancer sufferers?

Mary-Anne THOMAS: Well, as I have tried to explain, it builds on a base of funding that is already in our system. That base funding has already delivered transformative care. Indeed, our commitment to legislate a cancer plan has had a profound impact. So let me tell you, because these are real lives, Mr McGowan –

Nick McGOWAN: Well, I understand there are 10,000 more real lives, but they have only got $8 million in funding over the next two years.

Mary-Anne THOMAS: Well, hang on.

Nick McGOWAN: I am happy for the Secretary to answer the question. If all you are going to do is read off a sheet, I would rather you table the sheet.

Mary-Anne THOMAS: We had a goal –

The CHAIR: Excuse me, Minister. Mr McGowan, the minister is genuinely attempting to answer your question.

Nick McGOWAN: The minister is genuinely reading off the sheet.

The CHAIR: I am interested in hearing the minister's response, and it forms part of the evidence of this inquiry.

Nick McGOWAN: The minister can just table the response, quite clearly. I would rather hear from the Secretary.

The CHAIR: Excuse me, Deputy Chair, you are bordering on being rude. Minister.

Mary-Anne THOMAS: Thank you. Our cancer plan set forth a goal to save 10,000 lives by 2025. That is a goal that we have already achieved. Here in Victoria, we are on track to eliminate cervical cancer in this state. And we are able to do that –

Nick McGOWAN: Minister, I do not underestimate the importance of that for a second, but you are not answering my question.

Mary-Anne THOMAS: But this is about saving lives, Mr McGowan.

Nick McGOWAN: My question is about the additional 10,000 cancer cases, and is $8 million over two years sufficient?

Mary-Anne THOMAS: Yes, but I am trying to explain to you some of the things that we are doing in order to help drive down cancer in this state. We are on track to eliminate it. One of the reasons why we are able to do that is because of the way in which our government has supported the promotion of self-collection for cervical screening. This means more women are able to get the screens that they need more quickly.

The CHAIR: Thank you, Minister. Mr Galea.

Michael GALEA: Thank you, Chair. Good morning, Minister, Secretary and officials. Thank you for joining us today. Minister, I would like to ask you about workforce challenges – specifically budget paper 3, page 54, which goes into the government's investment into the healthcare workforce. Specifically there is an item in relation to capability development for rural nurses and midwives. Minister, can you talk to me a little bit more about this program and what this funding will be setting out to achieve in the upcoming financial year?

Mary-Anne THOMAS: Absolutely. Thanks so much, Mr Galea. As I said in my introductory notes, as you would expect, as a Labor government we have a real commitment to growing our healthcare workforce in order to be able to deliver more and better care to Victorians but also because we want to see people able to pursue really great jobs in the healthcare sector. There are a couple of things of which I am really, really proud. Last year our healthcare workforce grew by 7.6 per cent – in one year. That is the fastest growth we have ever seen. This is really encouraging, particularly off the back of the COVID pandemic. When we were in the emergency

phase we were experiencing workforce challenges, so to see that growth is really, really good. And there are reasons why we have growth here in Victoria and why Victoria is a place where nurses and midwives choose to grow their careers. The first of those reasons is that we have legislated safe nurse-to-patient and midwife-to-patient ratios – and if you will indulge me for a moment, let me tell you that were the first jurisdiction in the world to deliver nurse-to-patient and midwife-to-patient ratios. We did that under health minister Andrews in fact, so a little while ago. But when the government changed, the incoming Liberal–National government then tried to bargain away those ratios through the enterprise agreement. We made a commitment that we would legislate them so that any future Liberal–National government could not tear them down in the way that they sought to during the time that they were in government. As a consequence of having legislated safe –

Nick McGOWAN: Point of order.

The CHAIR: Deputy Chair, do you have a point of order?

Nick McGOWAN: I do. The minister has claimed that Victoria is the first jurisdiction in the world to implement nurse-to-patient ratios, when the minister would know that California, in the United States, was in actual fact the first jurisdiction to do so, not Victoria.

Mary-Anne THOMAS: We were the first jurisdiction to implement ratios. We were the second jurisdiction to legislate them.

The CHAIR: Excuse me, Mr McGowan. There is no point of order. The minister is providing evidence to the committee. The minister to proceed.

Michael GALEA: So you had to legislate them because the last Liberal–National government actually removed them after the Victoria was the first in the world to implement them.

Mary-Anne THOMAS: Yes, that is right.

Nick McGowan interjected.

Michael GALEA: Minister, thank you. Please continue.

Mary-Anne THOMAS: We did that, and I recall meeting some nurses who had come to work in Victoria from Ireland who said that one of the reasons for working here was the legislated ratios. The second factor is that this year I was very pleased to see that our hospitals were able to reach a groundbreaking enterprise agreement with our nurses and midwives, one that delivered a 28.4 per cent wage increase to them. The reason why that increase is so large is that our government decided that we would work to implement a Fair Work Commission decision into pay equity that recognised that the nursing professions had traditionally been undervalued because they were so highly feminised. So we are very pleased to be able to introduce that.

But in terms of the $95 million and the work that we are doing to support our nurses and midwives in rural and regional Victoria, a program that has been established in Victoria and is very well supported by our government is the Maternity Connect program. What this program does is seek to ensure that midwives, in particular in rural and regional Victoria, have the opportunity to have rotations and placements at busy metropolitan hospitals. For instance, as we know, out at Western Health, at Joan Kirner, where we have around 28 babies being born every day, there is ample opportunity to be able to grow your clinical skills and expertise. Maternity Connect is about ensuring that those midwives that may not have the exposure to as many births in their rural and regional communities can maintain their skills through the program. More than 600 nurses and midwives have participated in the program, and it delivers positive outcomes for everyone that is involved.

Another component with regard to supporting rural nurses and midwives is the rural urgent care nursing capability development program. Once again, that is about delivering professional development and clinical opportunities to 200 regional and rural nurses, ensuring that we have got ongoing investment into the rural urgent care nursing capability development program. Once again, it is about enabling placements in very busy, big metro EDs or indeed even in our big, busy regional EDs. For instance, in my own community we are served by an urgent care centre up at Central Highlands Rural Health Kyneton campus, but the opportunity, as you can only imagine, for a nurse from that hospital to rotate through, say, to the Northern at Epping really makes sure that our nurses have the opportunity to continue to grow and maintain their clinical skills.

That $95 million also maintains another great program, which is called the RUSON and RUSOM program. Let me explain: RUSON stands for registered undergraduate student of nursing, and a RUSOM a is registered undergraduate student of midwifery. These are nurses and midwives in training who are registered to be able to work in our healthcare settings, and they are highly valued by the other clinicians with whom they work. But also for these young people, and predominantly they are young people, it is an opportunity to earn an income in their profession while they are completing their studies, rather than taking up casual jobs in other industries. It also of course helps those trainee nurses and midwives to determine that that is the career for them. I can tell you that RUSONs and RUSOMs are very highly regarded and sought after when it comes to recruiting nurses and midwives into our public healthcare system. We are very, very proud to be able to continue to support that program. There is a parallel between this program and indeed the safe nurse-to-patient and midwife-to-patient ratios that I talked about earlier: that is that this program, similarly, was devised under a previous Labor government, once again, where former Premier Andrews was the health minister at the time. Mr McGowan, these are just the facts, I have to say.

Nick McGOWAN: I am happy to deal with the facts, Minister.

Mary-Anne THOMAS: That Labor government looked to introduce RUSONs and RUSOMs, then they were taken away by the Liberal government that came into power in 2010.

Michael GALEA: Thank you, Minister. The statistic of a 7.6 per cent increase just in the last year is very interesting. I note that when it comes to primary care as well, even though it is a federal area, the state does still provide a number of supports for GPs, including in rural areas through a grants program, which is referenced on page 12 of the department questionnaire. The RACGP has stated that Victoria has the largest number of GPs in rural training of all the states, which is all the more remarkable when you consider the larger rural populations in New South Wales and Queensland. But, Minister, can you talk to me a little bit about this grants program and what this funding is doing to support more GPs in rural areas?

Mary-Anne THOMAS: Absolutely. Thank you very much for the question. During the pandemic and beyond, it was abundantly clear to everyone within our health service system that our primary care system was broken. This was as a consequence of almost a decade of underinvestment and neglect by the former Liberal–National federal government – because you cannot just grow a GP workforce overnight; you need to continue to invest in the clinical placements – and what we saw during that time was a freeze on the Medicare rebate and an underinvestment in the training places that were needed. Now, as a consequence of that, we were suffering significant challenges when it came to Victorians being able to access primary care where and when they need it. It is why in fact we created the urgent care clinic model here and why we rolled those clinics out, because Victorians were not able to access primary care when they needed it and they were going to our emergency departments. So we created urgent care clinics. But we also, in working with the RACGP, recognised that because of the neglect of primary care by the former federal Liberal–National government over time –

Nick McGowan interjected.

Mary-Anne THOMAS: Mr McGowan, I am going to take up the interjection. The six-year freeze on the Medicare rebate was delivered by a person who was identified by doctors as the worst health minister ever, Mr Peter Dutton. So let us just be clear about who led the freeze on the Medicare rebate. We worked with the RACGP on what we needed to do in order to support the growth of the GP workforce.

Nick McGowan interjected.

Michael GALEA: Do you know how the constitution of this country works?

Nick McGOWAN: I do.

Michael GALEA: And how primary health care is actually run by the federal government?

The CHAIR: Excuse me, I cannot hear the minister.

Members interjecting.

The CHAIR: Excuse me, Deputy Chair and Mr Galea. Deputy Chair, the minister is providing evidence to the committee. I cannot hear her evidence.

Mary-Anne THOMAS: We made an election commitment that we would support 800 junior doctors through a grants program that would cover the salary gap between what they could expect in a traineeship in another speciality in one of our hospitals versus what they could expect as a GP trainee and then $10,000 to cover their exam costs. This program will support 800 junior doctors in training to become general practitioners in our health service system here in Victoria, and that is something that we are really proud of. We are also proud to work with the Commonwealth on the rollout of a single employer model, which again, is a program that seeks to support rural generalist practitioners in rural and regional Victoria. So, as you said in the question to me, Mr Galea, it is clear that while primary care is a federal government responsibility, and we are happy now to have a partner in Canberra that recognises this and made substantial commitments in the lead-up to the last election in terms of funding and support to grow access to bulk-billing GPs, we have done our little bit to support the growth of the general practice workforce. General practice is at the absolute heart of a highly functioning healthcare system, so we do need to continue to support GPs. But our government, with this commitment to support 800 junior doctors to take up the opportunity to become a general practitioner, is nation leading, and indeed I was really proud when the national president of the AMA Dr Nicole Higgins held us up as the standard, and she then sought to get commitments from the federal government in relation to implementing programs like this in order to help grow our general practice workforce both here in Victoria but of course right around the nation.

Michael GALEA: Thank you.

The CHAIR: Thank you, Mr Galea. The committee is going to take a very short break now before resuming its consideration of the health portfolio at 9:45 am. I declare this hearing adjourned.

The committee will now resume its consideration of the health portfolio. I am going to go to Ms Benham.

Jade BENHAM: Thank you, Chair. Morning, Minister. Morning, Secretary. I want to go back to community palliative care. Given that there has been no increase in funding, what advice have you received in relation to the expected increase in demand within the acute healthcare settings? In other words, how many people are going to die in hospital rather than be able to die at home because there is not enough funding to meet the demand of people wishing to have community palliative care and die at home?

Mary-Anne THOMAS: Which budget paper are you referring to?

Jade BENHAM: Sorry, we are on 'Non-Admitted Services'. It is page 65 of the 'Department Performance Statement'.

Mary-Anne THOMAS: Ms Benham, can I just start by thanking you for the question. Let us be clear: this year we are investing $31 billion into our health service system. That is a record amount of funding, and our health services use that funding in order to meet the needs of their communities. Again I go back to –

Jade BENHAM: Sorry, Minister, in the interest of time – I have got a lot of questions I need to get through – if we can come back to the question: how many people are going to die there rather than at home, where they would rather be?

Mary-Anne THOMAS: Hang on. I have got to kind of reject the premise of that question.

Jade BENHAM: But, Minister, if there is not enough funding there to support community palliative care –

Lauren Kathage interjected.

Jade BENHAM: that is the real-life reality.

Mary-Anne THOMAS: That is right. I might take up Ms Kathage's interjection.

Jade BENHAM: No, this is my time. Sorry, Minister, I would just like the question answered.

Mary-Anne THOMAS: Who says there is not enough money? In fact what has happened is that we have seen an increase in the number of community palliative care episodes, so in fact we have exceeded our target.

Jade BENHAM: Correct.

Mary-Anne THOMAS: That has meant that more people have been able to access the care that they need at home. As we have discussed, many people express a preference to die at home, and our health service system is supported by our government with $31 billion in funding in order to meet the needs of their communities.

Jade BENHAM: Community palliative care says their demand is increasing month on month. Secretary, I might go to you. Community palliative care are required to provide the department with the data that they collect on these patients, and they are saying that it is going up month on month. They have reported to the department the increase in numbers they are dealing with, but it appears to have not taken any of this data into consideration for budgeting purposes. Where does the data go and what is the department doing with it, given the enormous demand that is continuing to increase?

Jenny ATTA: Ms Benham, the department monitors activity right across the public health system. As the minister has said, community palliative care is continuing to be delivered, in fact, above the target set for it. We will continue of course to monitor and provide advice to the minister on all metrics, all measures, across our hospital system – something that we look at really closely and will continue to do so. But I think a key point to make is that hospital budgets have increased year on year.

I am really pleased to see that there is a lift in funding for all hospitals and health services coming out of the 2025–26 budget. $31 billion in the Victorian public health system is the highest level to date, and where we are seeing any performance issues or funding needs, of course we will be bringing that advice to the minister.

Jade BENHAM: The budget, though, has remained static. For community palliative care, it has been $121 million for the last three years. Community palliative care are saying that their demand is going up month on month on month. It seems that the data that is being provided to the department is not being taken notice of, because the funding is remaining static.

Jenny ATTA: It is not the case. Any data that the department has access to and is monitoring for performance and effectiveness right across the system is all taken seriously. That the community palliative care is reaching more Victorians than ever before, I think is the key issue here, and where that data is suggesting to us that there is any need to adjust resourcing, we will be bringing that advice to the minister as we go forward.

Jade BENHAM: Thank you, Secretary. I am going to move on to elective surgery waiting lists now. Secretary, I refer to the 'Department Performance Statement', page 64, and the number of patients admitted from the planned surgery waiting list. Last year the then Secretary told this committee that the department's intention was to progressively bring all planned surgery lists into the elective surgery information system. Yet data for regional hospitals such as Bairnsdale, Mildura and Wangaratta is still not included in the data, and one year later we cannot see these lists and get a full picture of the waiting lists across the state. Why has the government failed to do this, as indicated 12 months ago?

Mary-Anne THOMAS: I will take up that question, because I was here 12 months ago, and I am really pleased to be able to advise you, Ms Benham, that indeed we are expanding the ESIS – that is, the elective surgery information system – project to a further eight rural and regional health services. Indeed –

Jade BENHAM: Including those three mentioned?

Mary-Anne THOMAS: And Mildura will be one of those as well.

Jade BENHAM: When will that happen, Minister?

Mary-Anne THOMAS: Well, we are expected to commence public reporting in the 2025–26 financial year or earlier if possible. This is really good for a range of reasons, as you said. We want to increase the transparency of our data, particularly as we continue to deliver record planned surgery in this state. In fact we remain the only state, Victoria, that still delivers 100 per cent of category 1 surgeries within the clinically recommended time. We are the only state that does that, Ms Benham, and I really look forward to Mildura becoming a part of our ESIS system. One of the other reasons for that of course is that we are expanding our patient support units, which is an innovation delivered by the blueprint for surgery recovery and reform. Mildura will receive one of those as well.

Jade BENHAM: Fantastic. Speaking of Mildura, Minister, are you aware of the code yellow last week?

Mary-Anne THOMAS: Yes, I am.

Jade BENHAM: What immediate steps is the government going to take to relieve pressure on the services at Mildura Base Public Hospital?

Mary-Anne THOMAS: Thank you for the question. Across the system we have seen increased demand on our emergency departments, and our government is working with each one of our health services to ensure that they are supported to respond to that record demand. When it comes to Mildura, of course this is a hospital that was privatised by a former Liberal –

Jade BENHAM: Minister, coming back to the code yellow, do you accept that a 48-hour code yellow is unacceptable?

Mary-Anne THOMAS: Yes, I do. It is unacceptable to me, and that is why we are implementing a range of reforms. What is important here, Ms Benham, is that our government has in place a very concrete plan in order to address the challenges that are being experienced at some of our EDs.

Jade BENHAM: Great. What is that exactly?

Mary-Anne THOMAS: Well, I will explain it to you. We have had record demand. It is why we continue to invest in alternative pathways to an emergency department. They include our UCCs, and you have one in Mildura. I would also encourage you to inform your community that the virtual emergency department exists for them as well, because we do know that 86 per cent of people who have accessed –

Jade BENHAM: But, Minister, what happens to those that need to be admitted?

Mary-Anne THOMAS: Hang on –

Jade BENHAM: That is why people are waiting in that emergency room. Our bed capacity is nowhere near enough, so what is the government going to do about that? How many more code yellows will be needed?

Mary-Anne THOMAS: If I could complete the answer, that would be appreciated. The virtual emergency department also helps drive down presentations to our emergency departments. That means that those that are seen – we are able then to assess in a timely way their care and needs. Can I also say that here in Victoria we are very proud of the fact that we continue to deliver care to those that need it most immediately. The most seriously ill or injured people arriving at an emergency department will continue to be seen immediately.

Now, the issue that you talked to is about bed capacity and patient flow. Across my department we have done a lot of work in order to improve patient flow through our hospitals. That is why Mildura, for instance, is a member of the timely emergency care collaborative, which is looking at ways in which we can better move people through our healthcare system. Earlier this year I announced the standards for safe and timely ambulance and emergency care. It is a really excellent piece of work, which I recommend to you, which outlines 10 standards that are already in some of our busiest emergency departments, showing real improvement in terms of making sure that people are getting the care that they need, in the right place, at the right time.

Jade BENHAM: Not in Mildura. It is getting worse.

Mary-Anne THOMAS: This is why we will continue to work with and support Mildura. Across a range of fronts there is no doubt that we need to deliver some support.

Jade BENHAM: Minister, in the interests of time: are there any immediate plans?

Mary-Anne THOMAS: Well, yes. I am happy to also tell you that not only is Mildura getting a patient support unit, we are also opening four new subacute beds this week as a consequence of some minor capital investment that our government has made, which should help improve patient flow through the emergency department. I also need to point out that, frankly, I have had some concerns at Mildura. It is why I appointed a delegate to the board, Ms Therese Tierney, a highly respected healthcare leader. She was initially appointed for a three-month period, but I have decided to put her on the board for a further 12 months, because I want to do everything in my power to ensure that the people of Mildura are receiving the highest quality care.

Jade BENHAM: Thank you, Minister. I want to move on now to Blackburn Public Surgical Centre, and this one is for the Secretary. Does Blackburn Public Surgical Centre have 24/7 medical cover?

Jenny ATTA: Ms Benham, I do not have that information available. I will just see if –

Mary-Anne THOMAS: I can tell you a bit about Blackburn surgical centre. Blackburn surgical centre was previously owned by the Healthscope group, and our government purchased two private hospitals to turn them into public surgical centres. Now, the thing about our public surgical centres is that they deal with planned surgery only; they do not do emergency surgery at all. It is to help us deliver –

Jade BENHAM: Do they have 24/7 health cover?

Mary-Anne THOMAS: on our commitment to deliver 210,000 planned surgeries. We would need to talk to Eastern Health about the way in which they are managing Blackburn as part of their network of health services. But I can say this –

Jade BENHAM: It is a yes or no question, Minister: do they have cover?

Mary-Anne THOMAS: Every health service has access to emergency care through the virtual emergency department.

Jade BENHAM: So you are confirming they do?

Mary-Anne THOMAS: I am advised –

Jade BENHAM: There is no emergency department at the surgical –

Mary-Anne THOMAS: No. That is right, but any of the clinicians have access to the virtual emergency department across the system.

Jade BENHAM: Does Blackburn Public Surgical Centre have 24/7 medical cover – yes or no?

Mary-Anne THOMAS: Yes. They have on-call medical practitioners.

Jade BENHAM: Okay. Since the centre opened in 2022, on how many occasions has an ambulance been called to transport a post-op patient from Blackburn Public Surgical Centre to Box Hill Hospital because there was no doctor available to attend to the patient's medical needs?

Mary-Anne THOMAS: I do not have that data.

Jade BENHAM: Could you provide that on notice?

Mary-Anne THOMAS: It may be available. I am not sure.

Jade BENHAM: Surely that data would be available.

Mary-Anne THOMAS: But can I say this –

The CHAIR: Apologies, Minister. I am going to go to Mr Tak.

Meng Heang TAK: Thank you, Chair. Minister, I refer to budget paper 3 on page 54, which mentions the government's further investment in the Victorian Virtual Emergency Department. Why has the government decided to significantly expand the VVED?

Mary-Anne THOMAS: Mr Tak, thank you so much for that question. The virtual emergency department that runs out of Northern Hospital is one of the great innovations of our time when it comes to the delivery of health care in this state. Whilst Mr Sivarajah is now the CEO of Hospitals Victoria, he was previously the CEO at Northern Health during the time that the virtual emergency department was established, and I know that he will understand that I am going to call out Dr Loren Sher and Dr Suzie Miller for the extraordinary work that they have done in creating what is essentially a whole new model of care that is changing the way in which Victorians can access emergency care.

What we know from the virtual emergency department is that it is able to treat patients with a range of conditions, and it does this in a number of ways. The last time I was out at the virtual emergency department Ms Kathage was there with me, because we were out also with the Premier celebrating the fact that half a million Victorians have been able to access the care that they need through the virtual emergency department. I was pleased to see that this is a service that continues to grow and evolve to meet the needs of Victorians. For instance, a couple of things that I was very pleased to see – the virtual emergency department will keep people under observation. This is a fantastic initiative. To meet parents who make contact with the virtual emergency department and have an initial consult – the clinician says, 'You know what, I just want you to continue to monitor your child, but I'm going to stay here and I'm going to check back in with you in an hour's time and then maybe a bit longer.' We can see the opportunity for this model of care to continue to grow. Virtual care will play an ever increasing role in the way in which we deliver health care here in this state because it means that we can bring the very best, highly specialised care to more Victorians, no matter where they live.

Now, the virtual emergency department has played a really important role in – and this is why I recommended it to Ms Benham – enabling our health services to manage their EDs much better and ensure that they are able to deal with the most urgent cases, the category 1, 2 and 3 cases that present to our emergency departments, whereas our virtual emergency department is able to resolve a whole range of category 4 and 5 concerns and indeed a number of category 3 concerns as well. We know, because our health services and our patients have told us, that around 86 per cent of people that have used the virtual emergency department would otherwise have come to a physical ED, and that then creates a highly stressful environment, including for our healthcare workers, who have to triage everyone that presents.

So the virtual emergency department: we will continue to invest in it, and we will continue to grow the number of people that it is able to see, because with virtual care and the capacity to be able to text someone their script, an e-script, people are able to access care that they need from the comfort of their own homes, freeing up unnecessary trips to the hospital – unnecessary trips which I might say are particularly stressful for families with young babies or indeed and in particular a cohort that I am very interested in, which is people living in our residential aged care service.

Can I tell you, Mr Tak, that prior to the establishment of the virtual emergency department, our ambulance service was being called out to many, many of our residential aged care services for falls and so on where in fact the resident did not need to be transferred to a hospital. But now the paramedic can also use the virtual emergency department to resolve the concern in place. This again results in unnecessary transfers to hospitals when, quite frankly, the last place that we really want our older Victorians to be is in a very busy emergency department in the middle of the night, when they can receive the care that they need virtually, either with a paramedic or without, and have their issue resolved. So that is why we will continue to invest, Mr Tak.

Meng Heang TAK: Thank you. My supplementary question – and, Minister, you already answered part of the question – is: can you explain how the VVED fits into the health system and how it helps to divert non-emergency cases alongside the other care options, such as the urgent care clinic, the GPs and the actual physical EDs?

Mary-Anne THOMAS: Thanks, Mr Tak. Your question gives me the opportunity to reflect on how much our health system has changed and reformed in a very short period of time, in the last five years. We have seen these new models of care come on board that are all about increasing accessibility. The other big change that is happening is about the referral pathways between these different models of care. You have got the virtual emergency department, and you have got the urgent care clinics. We have now got our expanded general practice – sorry, our expanded pharmacy program. So these are three types of care that did not exist only five years ago. I know that Ambulance Victoria, for one, very much welcomes each of these innovations, because previously our hardworking paramedics were transporting everyone to hospital. That was causing significant demand in the system and, quite frankly, bringing people to hospital who could have had their care needs met elsewhere.

The urgent care clinics, for instance, provide another pathway for Victorians to self-refer or to be referred by Nurse-on-Call, by the virtual emergency department or indeed by our ambulance services, and the urgent care clinics play a really important complementary role to the virtual emergency department. Now, we are all aware that there are a range of conditions that may impact us – particularly, say, viruses and so on – where the answer is a medical answer or we may be able to be prescribed some medicine. However, if you break an arm, then the

virtual emergency department is not going to be able to help you, but the urgent care clinic can, because urgent care clinics are GP led, but they are there to deal with fractures, burns and bruises and some of that hands-on medical care. The UCCs are playing a really important role in delivering that type of care. And I know, because I have had the opportunity to meet with them and talk to them, that the GPs that are working in our urgent care clinics love the work because they get to do things that used to always happen in a GP practice. They love the suturing and the plastering and some of that – again, as I said, that real kind of hands-on medicine.

So these complement each other, the urgent care clinics and the virtual emergency department. But quite frankly, we will continue to invest in and grow the virtual emergency department, because as I said, we know that around 86 per cent of people using the virtual emergency department would otherwise show up to one of our physical emergency departments and only increase strain on the system but also, more importantly than that, on themselves, as they will be waiting. You will be waiting at an emergency department because an emergency department must treat the most critically unwell or injured people first. So if you have a slight fracture or you are running a temperature, you will wait, but at an urgent care clinic you can rock up, no appointment needed, and it is free of charge. As I said, these were announced by our government, by Premier Andrews, and I might say Premier Perrottet, because it was the Victorian and New South Wales governments that came together to announce this during the COVID time, when we had inaction from the federal Liberal–National government that meant that we had to step in with a new model of primary care that would better meet the needs of Victorians at a time when the system was under extraordinary pressure. Thank you.

Meng Heang TAK: Thank you, Minister. Do we have any profiles of who is using the VVEDs most, and do we know why that is the case?

Mary-Anne THOMAS: Yes. The virtual emergency department really meets the needs of parents, because one thing we know about small children is that they run a lot of fevers. They can often look unwell and be of concern to their parents, and they will – and I note Mr Hilakari is nodding in agreement here.

Mathew HILAKARI: I have been there a couple of time.

Mary-Anne THOMAS: Yes. More frequently than not this will happen in the evening when the local GP practice has closed for the day, and so that is when the virtual emergency department really comes into its own and is able to provide not just that medical care but the reassurance of knowing that you have been able to see a highly qualified and experienced nurse or doctor who is able to resolve that concern for you there and then and either reassure you and say 'It's going to be okay, and you can head off to see a doctor in the morning,' or 'No, you need to start antibiotics now so I'm going to send you through a script right now so that you can start the treatment for your child.' So parents of little ones. But as I said earlier, for our older Victorians, particularly those who are living in residential aged care, things are changing of course with the federal Labor government implementing changes to ensure that we actually have a registered nurse in a nursing home. So things are changing with those registered nurses now being available. But when we first established the service it was really of grave concern to me that in privately run aged care services there may not be, as Ms Benham said, any clinical nursing staff on duty and therefore people were being transferred to hospital when really they did not need to. But the virtual emergency department does enable them or a staff member or a paramedic to utilise the virtual emergency department and resolve that concern for that older Victorian there and then.

Meng Heang TAK: Thank you, Minister. With the remaining time I just would like to touch a little bit on planned surgery – the performance statement on page 64, which also discussed planned surgery performance. I note that you already answered many of the questions, but in particular category 2 and category 3 surgeries have improved significantly over the last year. Minister, can you explain why this is the case?

Mary-Anne THOMAS: Yes, it is because we are implementing the blueprint for the reform of planned surgery, which is another excellent piece of work – and I might say Ms Naomi Bromley, sitting next to me, was one of the leaders. The important thing here is time to treat, and what we are doing is driving down the time to treat, so we –

The CHAIR: Thank you.

Meng Heang TAK: Thank you, Minister.

The CHAIR: Thank you, Mr Tak. Mr Puglielli.

Aiv PUGLIELLI: Thank you, Chair. Good morning. Just starting on budget paper 3, page 49, the 'Backing our hospitals' line, Minister, are you aware of any state-funded hospitals that do not provide surgical abortions?

Mary-Anne THOMAS: Thank you very much for the question, Mr Puglielli. In my time as minister I have worked very hard to increase access to both surgical and medical termination of pregnancy, and it is my expectation that these services are available in our public health system. I might say there will be cases where the workforce is not available to deliver, say, surgical termination. But it is certainly my expectation that there is a referral pathway in place.

Only a couple of months ago I hosted – well, the department hosted and I was a speaker there, with Professor Wainer, who joins me today – an abortion symposium. Now, we held that symposium because we wanted to share knowledge and best practice across the system. Frankly the work that I have been trying to do is to make sure that abortion care is seen as health care in our public healthcare system, so once again really normalising women's health care. We do know, because of the work that Women's Health Victoria have done, that there are areas where it is more difficult to access an abortion than it should be. But I am committed to doing a range of things in order to address that, including the sexual and reproductive health hubs, the women's health clinics and the removal of the formulary that applied to registered midwives – registered midwives used to have a list of medicines that they were able to prescribe and MS-2 Step was not one of those. I have now removed the formulary, which means that they are able to prescribe to their full scope of practice, which includes MS-2 Step. I think what we will see over time is that there will be a greater take-up of medical abortion that is more readily and easily available to deliver and support women to access that service. But it is true that there are still some workforce challenges when it comes to access to surgical termination.

Aiv PUGLIELLI: Can I ask, are state-funded hospitals required to report to the department regarding their provision of surgical abortion, specifically?

Mary-Anne THOMAS: It is my expectation, as I said, that our public health services offer a full suite of health services to Victorians, but recognising of course that not every hospital can deliver every service because you require the workforce in order to deliver that. For me the most important thing is to ensure that I have got that spread right around the state. I can tell you that here in Victoria, 23 of our health services provide access to surgical termination.

Aiv PUGLIELLI: Okay. You mentioned some specific instances where there are, for example, workforce challenges. Are you able to provide the committee with a list of hospitals that are not providing surgical abortion?

Mary-Anne THOMAS: Well, the only point that I would make in relation to that is that this may fluctuate based on the availability of healthcare workers, so it is not a set-in-time piece. But I could also perhaps pre-empt where you might want to go on some of this, Mr Puglielli. We do also maintain here in Victoria a capacity for conscientious objection to the delivery of abortion services. Individual healthcare workers may not want to deliver those services and we do not make them do that. However, it is certainly my expectation and indeed I think it is a requirement that women and girls seeking access to abortion care are referred to a person or an alternative service where they will be able to get the care. But, Mr Puglielli, I think the biggest challenge still remains in the regions. That is why access to medical abortion is so important because it is much easier to get the workforce, if you like. The abortion symposium was also about, as I said, growing this community of practice, making sure that clinicians who deliver abortion services are connected to one another. Really we want to strive here in Victoria to be the best when it comes to delivering all of the health services that Victorian women and girls need and deserve.

Aiv PUGLIELLI: Thank you. Just moving on – last year the government abolished the Victorian Assisted Reproductive Treatment Authority, VARTA. Can I ask, since VARTA was abolished, how many FTE staff have been appointed within the Department of Health to undertake its regulatory functions specifically for IVF and assisted reproductive treatments?

Mary-Anne THOMAS: Thank you for that question. Look, the government is really committed to ensuring that we have got a strong, safe assisted reproductive treatment sector and one that Victorians can have confidence and faith in. The health, welfare and wellbeing of Victorians born as a result of treatment procedures is always paramount to us. That is why our government has delivered a range of reforms to

strengthen and modernise ART regulation and ensure that donor-conceived people can access the information they need in a supportive way. As I am sure you would also recognise, Mr Puglielli, a lot has changed since VARTA was first set up. Indeed assisted reproductive treatment and access to fertility care is now a normal part of so many people's journey to start or grow a family and part of the health care that we look to provide.

To support the successful transition of the donor registers we have worked carefully to transition sensitive data and establish the services and supports that Victorians need. It is a highly complex and consequential piece of work that is supporting Victorians for decades to come, and we are working to make sure that we get it right. There is a voluntary counselling service. There is one counselling appointment that is still mandated so that we are confident that people know exactly what they are doing, but the ongoing counselling mandate seemed to me to be a bit paternalistic. However, a voluntary counselling service has been established at the Royal Women's Hospital, including the recruitment and training of staff to ensure that counsellors are appropriately experienced and trained, and that service will be taking referrals in coming months. While that service is being established one of the most highly experienced previous VARTA counsellors is in place at the department performing the position of donor registrar and can provide counselling if required.

We have also established a donor conception advisory group to provide advice through the transition process and the ongoing establishment of the new regulator. Educational materials remain available for Victorians on the VARTA website while work is underway to review and transition these important materials, ensuring continuity of access for all. Important information about the registrar also available on the department website. As I said earlier, technology has changed enormously since the establishment of the donor registers in 1988, and the department is undertaking a substantial IT project to upgrade those donor registers. This will improve application processing times and improve the long-term viability of the data managed in the donor registers. I note that no new funding was requested during the budget. We have been able to incorporate this into the work of the department.

Aiv PUGLIELLI: Thank you. Can I ask, since the department has taken over VARTA's regulatory functions – I believe it was 1 January 2025 – how many improvement notices have been issued?

Mary-Anne THOMAS: I do not have that information available.

Aiv PUGLIELLI: Are you able to take that on notice?

Mary-Anne THOMAS: Sure.

Aiv PUGLIELLI: If you are doing that, can I also ask for prohibition notices and enforceable undertakings?

Mary-Anne THOMAS: Sure.

Aiv PUGLIELLI: All right. Thank you. Moving on to the community pharmacist program, the government has decided to expand and make permanent to the community what was the pharmacy pilot.

Mary-Anne THOMAS: Oh, can I just give you one bit of information that may help, sorry?

Aiv PUGLIELLI: Please do.

Mary-Anne THOMAS: We have obviously kept a close watch on Monash IVF here in this state, understanding that there were some significant challenges with Monash IVF in Queensland. We are observing that they have launched an independent investigation, and to be frank with you I would have expected – because we would have done this in Victoria – that the Queensland regulator should investigate this incident. I am not sure that the Queensland government committed to doing that. However, the Victorian health regulator has requested information from Monash IVF about their operations and their procedures and will work with them to ensure that here in Victoria they are well aware of our strict safeguards and ensure any risks are identified and mitigated.

Aiv PUGLIELLI: Thank you. Just on the community pharmacist program, I understand that there was an evaluation that was conducted in relation to that program for it to be then made permanent. Can that evaluation be provided to the committee?

Mary-Anne THOMAS: I am happy to take that as a question on notice. There is information in relation to that online, I think, Mr Puglielli.

Aiv PUGLIELLI: Okay. I believe there were issues previously potentially around cabinet-in-confidence in relation to this document. But if that is not the case, that can be provided. Yes, thank you. Excellent. On public dental service provision, I understand looking at 'Department Performance Statement' page 74, 'Dental services', under 'Persons treated' the number of persons treated actual was 286,669 for 2023–24. Can I ask: how many were treated in the 2024–25 financial year?

Mary-Anne THOMAS: Professor Wainer will give you that figure.

Aiv PUGLIELLI: Thank you.

Zoe WAINER: As of 31 March – obviously we have not finished the financial year – a total of 229,001 people have been treated.

Aiv PUGLIELLI: Thank you.

Mary-Anne THOMAS: And I have found it myself here, and we expect we will meet our performance targets for this financial year in relation to public dental.

Aiv PUGLIELLI: Okay. Thank you, Minister. We are five years into the 10-year action plan to prevent oral disease. Just looking at the four quantitative goals in that plan, can you provide us an update on our progress towards increasing the proportion of children entering primary school without dental cavities to 85 per cent from a baseline of 64 per cent?

Mary-Anne THOMAS: Which budget paper are you referring to?

Aiv PUGLIELLI: It is in relation to the 10-year action plan, so it would still be under public dental service provision.

Mary-Anne THOMAS: And you are on which page?

Aiv PUGLIELLI: It is in health outputs.

Mary-Anne THOMAS: Thank you. In terms of our dental program, I can outline to you that this year's budget is investing $218.3 million into our dental services to provide public dental care to 332,150 eligible Victorians and that this program provides public dental care for all children zero to 12; young people aged 13 to 17; adults with healthcare, pension and concession cards; and all ATSI people. As the Deputy Secretary has pointed out, we are going to meet our performance targets for this financial year in relation to our public dental health program, and I can also report that wait times have decreased.

Aiv PUGLIELLI: Thank you.

The CHAIR: Thank you, Mr Puglielli. We will go to Mr Hilakari.

Mathew HILAKARI: Thank you, Minister and officials, for your attendance this morning. That is great to hear about the dental progress. Following on from Mr Tak around planned surgeries, categories 2 and 3, I reference as well page 64 of the 'Department Performance Statement', and I am just hoping you can explain how we have gone over the last year and whether we are headed in the right direction, like dental.

Mary-Anne THOMAS: Thank you so much for that question, Mr Hilakari, and I am pleased to be able to give you the short answer, which is yes, we are seeing year-on-year improvements. And we know it is really important for Victorians to be able to access safe, timely care, and planned surgery is no different. The work that has been done in our public health system over the past few years is nothing short of extraordinary. We have had the busiest time ever in our theatres, and we have delivered more planned surgery in the past year than has ever been delivered in the state of Victoria before. Once again, we anticipate the delivery of 210,000 planned surgeries. As I have already had the opportunity to outline to you, Victoria remains the only jurisdiction where 100 per cent of category 1 planned surgeries are delivered within the clinically recommended

time, which is 30 days. That is an extraordinary effort and one of which I am really proud, and I want to take the opportunity to thank all of our clinicians for the extraordinary work that they do.

When it comes to category 2 and category 3, we have seen improvements in the median time for treatment. Category 2 has improved by four and category 3 by six days respectively, year on year, and the percentage of patients treated within clinically recommended time is continuing to improve. Quarter 3 of this year shows an increase of 3.1 per cent in comparison to the same period last year to 82.6 per cent of people receiving their planned surgery within the clinically recommended time.

Some people talk about the waitlist, and the waitlist is important. But our waitlist here in Victoria is bigger than the waitlist in Tasmania. And do you know why – I think you do, Mr Hilakari – it is because our population is significantly higher.

Mathew HILAKARI: Just slightly higher.

Mary-Anne THOMAS: Slightly higher. But what really matters is the time to treat and the work that we are doing to ensure that we are getting category 2 people, for whom the clinically recommended time is 90 days, and category 3 people, for whom the clinically recommended time is 12 months, and we are seeing those people within those recommended times. We are seeing improvement year on year in the median wait times for both of those categories.

But it is important for me also to point out that there may be a range of reasons why people are not receiving the care within that time. Within the department and amongst our clinicians, including, I might call out, Professor Ben Thomson here, who is our chief surgical adviser, surgeons call what we call a 'waitlist' a 'preparation list'. Let me tell you why they call it that: because in fact undergoing surgery of any kind is a significant procedure and therefore it is important that a person undergoing anaesthesia and having part of their body cut open is the fittest and most well they can be before they undertake that surgery. That is why clinicians call it a preparation list, because the time has to be used by some patients to ensure that they are the fittest that they can be before they undergo surgery. People talk a lot about orthopaedic surgery, for instance – hip and knee replacements – but it is really important that our surgeons work now with physios and with the patient themselves, making sure that their lifestyle is as healthy as it can be or that they are supported by physio with muscle strengthening and so on. This is really important because not only does it ensure that the surgery is as safe as it possibly can be, it also reduces the recovery time and means that the person can get the most value from, say, that joint replacement.

Talking about looking at some of our performance measures too, one of the things that I was really pleased to see here is – well, there are a couple of things that jump out at me – post-acute clients not readmitted to an acute hospital. We are 5 per cent higher than our target, sitting at 95 per cent. While not directly related to planned surgery but to acute care, which will include, potentially, category 1 planned surgeries – yes, Deputy Secretary Bromley is confirming that for me – what that is telling me is this is a measure of safety and quality. We want to make sure that when planned surgery occurs we do it once and do it right, and that means, as I said, ensuring that the person who is being operated on is the healthiest and fittest that they can be. So it is really great to see that. That is as a consequence of this work. I am going to carry this around, because the *Planned Surgery Reform Blueprint* is changing the way in which planned surgery is delivered in this state, and it is working because it has been designed by and for clinicians. Thank you.

Mathew HILAKARI: Yes. Great. Minister, looking forward now, as opposed to backward – and I know that document will go to some of that effort – $9.3 billion has been delivered for hospitals in this budget.

Mary-Anne THOMAS: Correct.

Mathew HILAKARI: What does that go to in terms of continuing to improve planned surgeries and taking those numbers forward?

Mary-Anne THOMAS: Some of the increase in this year's budget to our hospitals has been so that we can maintain the momentum around the delivery of planned surgery, including 210,000 planned surgeries this year. If we achieve that this year, that will be two years running. Last year we got 209,500 and something – very close – and 210,000 this year, and of course we track this very closely. But, Mr Hilakari, this has been able to be delivered because fundamentally our health services and the clinicians that work within them have rethought

the way in which they deliver planned surgery. I want to share with you a couple of what I think are really fantastic examples. Austin Health has implemented a recurring bone and joint surgery week. They have one week totally dedicated to bone and joint surgery. Now, why does this make a difference? It means that everyone is prepped up and ready to deliver those surgeries, that the theatres are set up in order to deliver those surgeries and that all the prostheses that are required are there and available and ready to go, so they are able to deliver more surgeries than they normally would if they chopped and changed between different specialities. It makes sense, right?

Mathew HILAKARI: Of course.

Mary-Anne THOMAS: Another fantastic initiative which was supported by a bit of additional funding from us was enabling some of our health services to focus on paediatric surgery during the school holidays. Again, it makes absolute sense: (1) kids are not missing school; (2) parents are more likely to be able to be available during that time.

Mathew HILAKARI: What do the kids think of that? Do they think that was a good thing, or is there maybe no data on that yet?

Mary-Anne THOMAS: It really is important. It shows how patient-centred care is at the heart of this reform work as well.

Mathew HILAKARI: The health system is thinking about people's lives.

Mary-Anne THOMAS: Absolutely. I did talk about patient support units before. I know that the Member for Mildura is very pleased to learn that Mildura will be getting a patient support unit, so I expect she will be listening to now understand exactly what they do. One of the things that they do is make sure that we stay in touch with patients who are on the preparation list to see how they are travelling but also to remind them – these are busy families, as we all know – when their surgery is coming up, reminding them of what they need to do in order –

Mathew HILAKARI: That preparation work is really important.

Mary-Anne THOMAS: Preparation work, including not to eat on the morning of surgery and so on. But you know, before the blueprint, before we implemented these reforms, we did have occasions when we would have no-shows, right, because people forgot. But we cannot afford to run a health system like that anymore, because it is not good for the patients, not good for the system. Patient support units help ensure that patients understand that we are there caring for them while they are waiting for their surgery.

Another significant change has been the number of people who have now been able to have their conditions resolved without actually needing surgery. There was a great feature article in the *Age* not long ago about this, because again, I want to underline that surgery is inherently risky. If you can resolve without surgery, this is always going to be a better outcome. There is so much work that is being done. Of course we have also brought on board new facilities in order to support planned surgery, like the Blackburn Public Surgical Centre, like the Frankston Public Surgical Centre – two private hospitals that we purchased. I note that the Shadow Minister for Health Ms Crozier, at the time called this a socialist manoeuvre. Well, if it is delivering more care for Victorians, making care more accessible for Victorians, by bringing more health services into the public sphere, then so be it. I am proud to do that. We know what the record of those opposite is. Indeed one would think that the Member for Mildura wants to see Mildura hospital back in private hands.

Jade BENHAM: No, no-one has ever said that.

Mary-Anne THOMAS: Under our government, there will be no privatisation of health services.

The CHAIR: Excuse me, Minister, there is a point of order.

Jade BENHAM: On a point of order, Chair, I would ask the minister to retract that statement. I have never said that – never claimed it – and it is untrue.

The CHAIR: Minister, I do not have a copy of the Hansard transcript in front of me. Do you wish to withdraw that statement?

Mary-Anne THOMAS: Well, Liberal–National governments have a record of closing and privatising hospitals.

Jade BENHAM: I have never said that. That was before my time. I have never said that. I would like a retraction, thank you.

Mary-Anne THOMAS: I am not sure that I said that you said that, Ms Benham.

Jade BENHAM: You said, 'Ms Benham wants the Mildura base hospital privatised'.

Mary-Anne THOMAS: No, I said, 'One might think that', because of the record of the National Party –

Jade BENHAM: Based on what?

Mary-Anne THOMAS: Because of the record of the Liberal–National parties in government.

Jade BENHAM: Well before my time – I was still at primary school.

The CHAIR: Thank you, Minister. Thank you, Ms Benham.

Jade BENHAM: I was at primary school.

Mary-Anne THOMAS: But I am happy to withdraw.

The CHAIR: Thank you, Minister. The minister is to proceed.

Mathew HILAKARI: I might actually take us to the COVID catch-up plan. I guess Ms Benham was saying really that she opposes privatisation of the health system, which is good. I might take us to the COVID catch-up plan and how that has been built on by the planned surgery blueprint.

Mary-Anne THOMAS: Of course during the COVID pandemic a number of planned surgeries needed to be paused while we prepared for the emergency response. Indeed 2022, when I became minister, was the most challenging time in our health service system, and the reason was that while all Victorians were actually open for business and out and about, it meant that COVID spread exponentially through our community. Fortunately, we were vaccinated at that time, but it did mean that our clinicians were falling ill with COVID. The COVID catch-up plan did just that, and now the blueprint is our enduring reform.

Mathew HILAKARI: Okay. Great. From that blueprint we are going to see improved numbers over time –

Mary-Anne THOMAS: It is all about the time to treat.

Mathew HILAKARI: Thank you.

The CHAIR: Thank you, Minister and Mr Hilakari. Minister and department 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 is going to take a very short break before beginning its consideration of the portfolio of ambulance services at 10:50 am. I declare this hearing adjourned.

Witnesses withdrew.