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

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Budget Estimates 2015–16

Melbourne — 13 May 2015

Members

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Mr David Morris — Deputy Chair
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Witnesses

Ms Jill Hennessy, Minister for Health,

Dr Pradeep Philip, Secretary,

Mr Lance Wallace, Deputy Secretary, Corporate Services,

Ms Frances Diver, Deputy Secretary, Health Service Performance and Programs, and

Professor Chris Brook, Chief Advisor, Innovation, Safety and Quality, Department of Health and Human Services.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2015–16 budget estimates. All mobile telephones should now be turned to silent.

I welcome to the hearing today the Honourable Jill Hennessy, MP, Minister for Health; Dr Pradeep Philip, Secretary of the Department of Health and Human Services; Mr Lance Wallace, Deputy Secretary of Corporate Services; Ms Frances Diver, Deputy Secretary of Health Service Performance and Programs; and Professor Chris Brook, Chief Advisor, Innovation. Safety and Quality.

All evidence is taken by this committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing, including on social media, are not afforded such privilege. The committee does not require witnesses to be sworn, but questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

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

Departmental officers may approach the table during the hearing to provide information to witnesses if requested, by leave of myself. However, written communication to witnesses can only be provided via officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way.

Members of the media are to observe the following guidelines: cameras must remain focused only on the persons speaking; operators must not pan the public gallery, the committee or witnesses; and filming and recording must cease immediately at the completion of the hearing.

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

Ms HENNESSY — Thank you very much, Chair, for your warm welcome. I am delighted to return to the Public Accounts and Estimates Committee and to see some old friends, and I see Mr Morris nodding.

Ms SHING — We are delighted to see you.

Mr MORRIS — Not so much of the 'old', thank you.

Visual presentation.

Ms HENNESSY — Turning to the first slide, this is a very important budget for the Victorian health system. In total we have made a really significant investment, and I will talk more about this through the course of the presentation and inevitably as we answer questions. Our investments in health for the 2015–16 budget ensure that we are growing the very important health services that most Victorians rely upon. We are prioritising investments in areas where there is growth in demand for services, and that includes building very important and vital infrastructure. Most importantly, we are delivering on our election commitments, and that obligation has featured heavily within the budget decisions that have been made.

In total we are investing $20 billion in output funding in the portfolio of Health and Human Services in 2015–16. That includes an additional $1.38 billion over the next four years for health and hospital programs. It also includes more than $560 million for capital projects. When you look at that and compare it to last year's budget, we have increased output funding in acute health by 6.7 percent, and all up that is an extra $691.8 million.

We know that most Victorians will tell you that they are waiting too long in emergency departments and too long for elective surgery. To respond to that growth in demand for services we are investing an additional $970 million for the next four years. That increased funding will enable hospitals to treat an extra 40 000 patients in emergency departments each year. We are also injecting $60 million to tackle elective surgery waiting lists in the next year, and that $60 million will enable approximately 11 700 elective surgeries to take place in the next financial year.

Before the election we made a commitment to the people of Victoria that we would undertake a review of Victorian public hospitals — the most comprehensive one that has been done to date. We appointed Dr Doug Travis, who would be known to many members of this committee as a former president of the AMA and a highly respected surgeon. Dr Travis handed down his interim report in March, and he made recommendations to the government about how we should allocate the $200 million Hospital Beds Rescue Fund, based on what would represent best value and taking into account reducing waiting times but also looking at equity of access across the state.

We have accepted Dr Travis's recommendations. Those recommendations and the $200 million funding in this budget will see 101 new beds and points of care opened at 26 health services across Victoria. Another budget highlight is that this budget also includes $8.4 million to restore funding for the free whooping cough vaccine program for expectant parents and parents of newborns. That program ceased receiving that funding in 2012. We have reinstated that funding as we think it is an important investment.

We have also invested $28.7 million to establish 20 super pharmacies across the state — 15 in metropolitan Melbourne and 5 in regional Victoria. We have also made a commitment to invest $300 000 to undertake planning and support for the implementation of a real-time prescription monitoring system in Victoria.

The National Centre for Farmer Health does vital work in regional Victoria. It also provides assistance and education right across the country, supporting farmers and their families, and we are investing $4 million to ensure that they can continue to do this work.

We have also included in this budget $3.6 million to support Vision 2020, which is an important program which raises awareness about avoidable vision loss and blindness. Skin cancer, of course, is one of our most preventable forms of cancer. We are providing $15 million to run important education programs and to roll out sunshades at playgrounds, parks and beaches. This project also includes a million dollars for additional state funding for Quitline to help Victorians quit smoking. We have also provided funding for the community health program PRONTO!, which provides HIV rapid testing.

I would like to just talk about our investments in the budget around medical research. Victoria is leading the country. We absolutely punch above our weight when it comes to medical research, and this government is firmly and fiercely committed to maintaining and growing that. We will provide in this budget $25 million to the Melbourne Genomics Health Alliance over the next four years, and what that money will do is establish a statewide clinical genomics sequencing capability, a very important investment. Essentially what that will do is it will assist that alliance in helping diagnose Victorians, but particularly children, sooner. They will be able to identify treatments for them earlier, and it holds great hope when it comes to personalised medicine.

We are also continuing to fund the coordinating office for clinical trial research, streamlining preapprovals to make Victoria an attractive place for clinicians, researchers and scientists who conduct trials. I am also very pleased that we are announcing $2 million that we have committed in this budget to plan and support the establishment of the National Centre for Proton Beam Therapy at the VCCC. Proton beam therapy is one of the most cutting-edge treatments in the fight against cancer, and we feel very strongly about getting the work done to try to bring proton beam therapy to Victoria.

If I could now just go to some of our health capital highlight investments, in terms of assets, the 2015–2016 budget includes over $560 million total estimated investment in health assets. As you can see from the graph that is being displayed, that is more than three times what was provided in the last financial year. In addition to this, and subject to commonwealth contributions, we have funds in contingency for the Aikenhead Centre for Medical Discovery, and in the case of Maroondah Hospital some further consultation and planning works need to be undertaken. We are very committed to delivering both of those projects.

Some examples of our investment in health capital include $200 million to build the new western women's and children's centre. Melbourne's west is one of the fastest growing regions in Australia, and it is vital that we invest not only to meet current demand but to invest for future demand. Importantly that new hospital will alleviate some of the pressures not just in the west but in the north-west, which is also under significant population growth pressures. We are also investing $70 million to replace clinical services, hardware, IT infrastructure and medical equipment, and we committed prior to the election $20 million to expand Angliss Hospital and $16 million to expand Moorabbin Hospital.

The south-east is also another fast growing area of Melbourne, and we will be investing $106.3 million over the next four years to expand the Casey Hospital. We are also expanding the cardiac service at Ballarat Health. That is $10 million to build and equip a new cath lab. We have invested $15 million in initial funding for the Victorian Heart Hospital and also allocated $1 million for Goulburn Valley Health in Shepparton. We also have made a commitment of $85 million for the Werribee Mercy Hospital, and we are going to ensure that the helipad at the new Monash Children's hospital is built on the roof. There is $3.8 million allocated in the budget to that end.

We are investing $20 million in the Health Service Violence Prevention Fund. Our doctors and nurses, and indeed all of our health workforce — very dedicated professionals — do fantastic work caring for people when they need it. We have some significant challenges around occupational health and safety, violence and aggression in our health service, and that $20 million will go some way to attempting to mitigate those risks. We will also provide $20 million for capital infrastructure to our health services to make them safer for staff, patients and visitors.

Finally, there are some significant challenges ahead of us, and I do not shy away from those challenges. Our government is equal to that task. Members of this committee will be aware that in the last commonwealth budget there were some announcements, and they were forecast across the forward estimates of the commonwealth budget and then updated in MYEFO. That was not good news for the Victorian health system. We saw in last night's commonwealth budget that those cutbacks to Victorian hospitals, health services and programs are going to get worse. We initially had thought that that was going to impact on Victorian health services by around $13.6 billion over the next 10 years. The very disappointing news in last night's federal budget is that about $17.7 billion will be cut out of the Victorian health system at the hands of the commonwealth government, and those figures were announced last night.

Sadly the Abbott government has also cut other national partnership agreements that will impact upon Victoria. In particular the type of services that will be impacted upon include preventive health, dental health and Indigenous teenage sexual health, along with some funding that was targeted at Koori maternity programs, and so we are pretty disappointed about that. More generally we are concerned about attempts to cost shift to not just the state government but to Victorian patients when it comes to health care. That indeed is going to be a significant challenge in the future. Nevertheless, we will continue to make significant investments in health. We have started in the budget, and I think this budget evidences that. I look forward to talking with the committee more about those important investments.

The CHAIR — Thank you, Minister. I might kick off. In the context of the 2015–16 budget with respect to the health portfolio, can you inform the committee how the initiatives in the budget acquit commitments in Labor's financial statements?

Ms HENNESSY — I think first budgets are important for governments and acquitting election commitments. Getting a really important stake in the ground around election commitments is very important, and I am very pleased that we have made a really significant headway in terms of our pre-election commitments. To briefly step you through — and some of them I have referred to in the course of my presentation — this budget has in output funding our Hospital Beds Rescue Fund of $200 million; our super pharmacies commitment, $28.7 million; Melbourne Genomics Alliance, $25 million; the National Centre for Farmer Health, $4 million; the whooping cough vaccine program, $8.4 million; and SunSmart, which is both part in output and in capital, $15 million.

In terms of capital commitments that go to our pre-election commitments, Angliss Hospital, $20 million; the Ballarat cath lab, $10 million; and Casey Hospital will be receiving $106.3 million. For our Health Services Violence Prevention Fund there is $20 million; and Moorabbin hospital, $16.2 million. For the Victorian Heart Hospital we have made an allocation in this budget of $15 million, with the remaining funding towards our $150 million commitment to be dealt with in future budgets; and for the western women's and children's hospital, $200 million. In terms of capital contingency, we have $60 million for Aikenhead biomed facility; and $10 million for the Maroondah Breast Cancer Centre.

In terms of other pre-election commitments that impact upon the health budget, the Hazelwood mine fire inquiry reopened — that is being dealt with in the midyear budget update — and also 1000 defibrillators, which

is the responsibility of the Minister for Sport, but again, a very important investment in terms of the health budget.

In terms of future budgets, on the WorkSafe package that the government committed to before the election, that funding is due to flow beyond the next financial year in 2016–17.

All in all, we are really content that we have significantly progressed our election commitments. That has been the focus of our budget. It is no secret that we inherited a pretty difficult environment in the health care space, so we are doing what we can to make sure that we grow our broader investment in health as well as making significant progress on our pre-election commitments, and that is what we have done in this budget.

Mr MORRIS — Minister, welcome back to PAEC. I am sure you are greatly saddened that you only get 4 hours with us instead of the 56 that we got used to in the past.

Ms HENNESSY — I am under oath, Mr Morris.

Mr MORRIS — Minister, on budget paper 5, page 223, there is reference to the VCCC. Given that the 13th floor of the centre will no longer be able to be the Peter Mac Private, as you had announced prior to the budget, what are the permitted potential activities for that floor that will be supported by the state government?

Ms HENNESSY — The VCCC is a fantastic project; we are very, very proud of this project. In terms of the specifics of your question, the VCCC board has currently underway development of a proposal for government. We want the focus to be on medical research, on prevention and on research and education. Having recently attended a meeting of that board, I have been given an assurance that that is the work that is being done.

Mr MORRIS — Not public beds. Okay.

The CHAIR — The Deputy Chair on a supplementary question?

Mr MORRIS — In the context of your decision on Peter Mac Private, I understand that other public hospitals have been examining ways that they can initiate private hospital services as a way of generating additional income, obviously in order to enhance public services. In the light of the decision on Peter Mac Private, do you rule out any of those proceeding?

Ms HENNESSY — No, I do not, Mr Morris. The issue around the VCCC was the purpose and possibility of that building being very focused around not just clinical care for cancer, but cancer research and education, and that has been the focus and that will be the priority of that centre. Private hospitals play a very important role right across Victoria, and my department will always work collaboratively with both public and private hospitals that are seeking to explore a different model.

Dr CARLING-JENKINS — Thank you, Minister, and congratulations on your budget and your obvious commitment to health, which shines through. I note in your presentation that you acknowledge the contribution of Dr Doug Travis. I think that is really innovative that you had him come in and provide a report which has informed the budget. I am referring specifically to the beds rescue fund in budget paper 3, page 63, and there is a description on page 65. I note that Dr Travis provided an interim report providing 15 recommendations which led to this fund, and that Dr Travis's final report will be submitted by the end of June this year. This final report, according to the health department's website, will:

> … propose models of care that could be introduced to improve capacity in Victoria's public hospitals and innovative treatment delivery opportunities to enable better patient outcomes.

Is there flexibility within this budget to respond to the models of care which Dr Travis will recommend, or will Victorians need to wait for the next budget before receiving the full benefit of his analysis and expert opinion?

Ms HENNESSY — The Travis interim report is a really terrific piece of work, because it not only conducted an audit of where we had points of care that might be available, but also where we had demand and where we had capacity. Very clearly what Dr Travis has found is that we have a very strong mismatch between demand and capacity. In this budget we have $200 million allocated for the recommendations that Dr Travis has made. Hospitals and health services were invited by Dr Travis and his team to make an application around: if you had some money and you could redesign your emergency department, you could open up another oncology

day bed or you could open up another chemotherapy chair, what would make the most meaningful difference for you in terms of dealing with the demand of your local community and being able to improve the particular model of care? Emergency departments are a really good example where you make an investment and you enable, for example, hospitals to open up things like short-stay units. That actually enables better patient flowthrough. When a patient comes to an ED they are not necessarily ready to be admitted into an acute ward but they still require some ongoing treatment. These investments that we have announced are about demand and they are about making some improvements of those models of care.

The future work that Dr Travis will continue to do will be around: how else can we build models of care, given the increasing demand that we have got on our health services? We have also got interesting things happening amongst our community in terms of their preferred method of receiving health care. In the health system we talk a lot about this concept called 'patient-centred care', yet our walk is not yet matching our talk. Palliative care is a really good example. Many patients would prefer to receive palliative care in their home and would prefer to die at home, yet we have got to make sure that our model of care and our investment actually match where patients want to receive their treatment.

Dr Travis, in the course of doing his final review, is going to look at what some of these models of care might look like. We have this great challenge around greater expertise, which is a wonderful thing, but in particular geographic regions our rural and regional hospitals encounter great difficulty attracting a specialised medical workforce to those areas. Rural and regional hospitals are really terrific at coming up with different models of care, particularly around maternity where they might do the antenatal and postnatal care but they do not have the provision or the expertise to be able to do things like high-risk births, so they partner with other regional and subregional hospitals. It is about looking at how we can better align the services that people might like — those will inform our next budget.

One of the other really important recommendations that Dr Travis made was about the need for us to have a statewide health plan. We have got some good regional health plans that have been developed by different health services, but having a bird's eye view right across the state around the sorts of health services that we need can then inform things like where we actually need to invest around recruiting a stronger workforce, where we should be making investments around expensive high-value equipment — those sorts of things. That is a big body of work. But the model of care work — I would be hopeful that that will inform our next year's budget, but I do not want to do a disservice to those health services that have done some really hard work as they have bid for money from the beds rescue fund to redesign models of care to make sure patients get timely, effective and safe treatment.

Dr CARLING-JENKINS — I agree with you around patient-centred care. It is something that we very much need in our healthcare system. Just to clarify: with the $200 million there will be some flexibility to respond to the models of care that Dr Travis will be presenting in his final report but the bulk of his recommendations will be taken care of in the next budget — is that correct?

Ms HENNESSY — The $200 million has been acquitted in terms of the announcements that we have made in the budget. We have a list of all of the investments that Dr Travis has made around the beds rescue fund, because we know we could not wait for another budget before we did things like open up an additional renal dialysis chair or deal with the crushing demand that some emergency departments are under. Next is Dr Travis will provide us with his final report, which will talk about: how do we modernise our model of care in important senses?

Dr CARLING-JENKINS — For next year's budget.

Ms HENNESSY — The great challenge for me will be: how do we invest and fund it?

Mr DIMOPOULOS — Minister, I just wanted to ask you a specific question around acute health services, BP3, page 63, 'Elective surgery boost', 'Hospital Beds Rescue Fund' and 'Meeting hospital services demand'. I know you have touched on it in your presentation and in your answer just previously, but I want to get a sense of more detail about the investment in this budget to deal with the growth in demand for those services in Melbourne hospitals.

Ms HENNESSY — Thank you for your question, Mr Dimopoulos. Further to my answer to Dr Carling-Jenkins, we have made a really significant investment and one that our health services desperately

needed. We have inherited a health system that is under really significant challenge, particularly when it comes to emergency department waiting times, and elective surgery lists as well. We have made a really significant investment. We have put $970 million over the forward estimates to meet possible demand. That will mean an extra $248.8 million this year for health services, and it will also mean that hospitals will be able to admit about 60 000 patients and treat about 40 000 more patients in emergency departments.

We have also indicated the purpose of that fund by increasing our targets as well. You will see in budget paper 3 on page 225 we have proposed increases in activity for total hospital separations. The health system is full of language that is inaccessible to ordinary people, and a separation means a patient. I mean no disrespect to my wonderful colleagues here from the Department of Health and Human Services.

Ms WARD — No, I recall in a transcript you talking about us being humble politicians, and you are absolutely correct.

Mr DIMOPOULOS — A separation was — —

Ms HENNESSY — It means a patient. It effectively means a discharge — separating from the hospital. On page 228 that anticipates the increase in emergency presentations for 2015–16, and I think that demonstrates the really positive impact that that really big investment will make. The type of services that will benefit from that investment are not just emergency department presentations and elective surgery waiting lists. Things like maternity admissions, specialist clinics, palliative care, cancer treatment, dialysis — a really big growing in our health system — and subacute care, things like rehabilitation and the like. We have also allocated in that output an extra $60 million for an elective surgery boost for the 2015–16 year. It depends how you average it out, but on average that would enable about 11 700 surgeries. That would make a pretty significant dent in the hospital elective surgery waiting lists. That comes on top of course of our $200 million beds rescue fund. That will enable about 101 beds and points of care to be opened right across the state. There are about 26 different health services that will benefit from that. So all up it will be almost 20 000 patients who will benefit from that investment. That is a significant investment; that is a significant amount of patients, and we are very proud to have made those investments in our first budget.

Mr D. O'BRIEN — Minister, my question relates to public holidays and the impact of those costs on the hospital system. Budget paper 3, page 222, has the outputs for acute health services. Last Friday at this hearing the Treasurer explained that the cost for public hospitals was the responsibility of each minister to manage in their own department. Can I ask you how much has or will be provided to public hospitals to cover the additional costs of the 2015 Easter Sunday public holiday?

Ms HENNESSY — Thank you, Mr O'Brien. Funding for health services anticipates a whole range of labour inputs. They have all been put in to our bottom line wage costs. They are part of the normal base funding that is allocated to departments and they have all been included — all public holidays. The total cost of all public holidays varies each year, as some holidays fall on weekends, as Anzac Day did this year, where there is no additional holiday granted. When we come to negotiate with hospitals around this statement of priorities, labour costs are but one input in the WIES that is calculated.

Mr D. O'BRIEN — So is there a specific — —

The CHAIR — Is that a supplementary?

Mr D. O'BRIEN — I was trying to get an answer to the first question, Chair. I take it that there was no specific line item. My supplementary question, Minister, is for this year's budget, 2015–16, what is the cost of the new AFL Grand Final eve public holiday to the health portfolio?

Ms HENNESSY — Mr O'Brien, all of our labour costs and public holiday costs are allocated in the base funding. I do not have them disaggregated. We fund hospitals for activity and we fund them via WIES, and within that WIES labour is one of the inputs, as are things like laundry and meals and the like.

Mr D. O'BRIEN — But this would have had to have been included in your calculations for this year's budget, surely?

Ms WARD — On a point of order — —

Ms HENNESSY — All in our base funding — —

Mr MORRIS — It would be nice to get an answer to the first question — —

The CHAIR — Order! The minister is answering the question.

Mr MORRIS — The minister is not answering the question — —

Mr D. O'BRIEN — I guess the point is Labor — —

The CHAIR — Order!

Mr D. O'BRIEN — No. It is not anywhere near it.

The CHAIR — Order! The minister is seeking to answer the question. I ask members to let the minister continue without assistance.

Mr D. O'BRIEN — I think the minister might have finished — —

The CHAIR — Order, Mr O'Brien! The minister to continue.

Ms HENNESSY — Thank you. The funding of all the various price increases are always funded in our base. That includes all public holidays. It is all in our base. It will all be allocated in the WIES price that we negotiate for different activities with our health services.

Mr D. O'BRIEN — On a point of order, Chair, what we are trying to get to here is that there is clearly an additional cost to the budget bottom line for the additional public holidays, so much so that we have now asked, I think, three ministers — certainly two, the Treasurer and now the health minister — what the additional cost is of these. No-one is able to tell us, yet the Labor Party in its financial statement actually identified what the costs were — $91 million for the grand final eve public holiday. Where is that cost going to? Who is getting it?

Ms SHING — On the point of order — —

Mr D. O'BRIEN — Sorry, just let me finish, Ms Shing. We are trying to find out exactly where this cost is being borne and the answer we are getting is, 'Oh, it's built into the bottom line'. If the party in opposition could give a figure for the whole of government, I do not understand why departments individually cannot give a figure for the costs of these new public holidays.

Ms SHING — On the point of order, Chair, Mr O'Brien may not like the answer that he and the opposition — —

Mr D. O'BRIEN — It is not an answer, Ms Shing.

Mr MORRIS — We have not got an answer.

Mr T. SMITH — We have not got one.

The CHAIR — Ms Shing is on a point of order.

Ms SHING — — have received in relation to this question. However, as it has been explained on numerous occasions now, it is part of the normal base funding. The minister and previous ministers who have appeared in front of this committee have been crystal clear in relation to where this money sits and how it is actually dealt with as part of the overall base funding. I do not know what further clarification you are after, Mr O'Brien — —

Mr T. SMITH — A number would be great — —

Members interjecting.

The CHAIR — Order! Mr Smith, do you want to make a point of order?

Mr T. SMITH — I think we are seeking a number, Chair — a specific number. All we get is waffle. We want a number.

Ms SHING — Is that a question, Mr Smith?

Mr T. SMITH — It is a statement, Ms Shing.

Mr D. O'BRIEN — The point of order we are raising, for the benefit of the Chair, is that you have made it clear that ministers should be factual and truthful. I am not suggesting that the minister is not being truthful, but we are asking a fairly specific question that Labor could answer on a whole-of-government basis pre-election. I do not understand why individual ministers and departments cannot now provide this information to us. That is the point of order I am making.

Mr MORRIS — On the point of order, Chair, the minister is referring to future years. The allocations and the agreements have already been done for 2015, so clearly the cost of the grand final holiday, if nothing else, is an additional impost on hospitals, which was not part of the negotiations. So we are seeking that specific information, if nothing else. If the minister cannot give us anything else, then she cannot give us anything else.

Ms WARD — On a point of order, Chair — —

Mr MORRIS — This is an additional — —

The CHAIR — Order! You have made your point, Deputy Chair.

Ms WARD — My point of order is that the question now seems to have shifted and there seems to be a change in the question, and I ask that we go back to your original question and continue from there.

Mr MORRIS — The supplementary referred to the grand final eve, and that is the information we are seeking.

Ms SHING — On the point of order, Chair, this is not your question, Mr Morris. With respect, the question has been asked and it has been answered. The answer may not — —

Mr MORRIS — No, it has not. It has not been answered; that is the point — —

The CHAIR — Order!

Ms WARD — Mr Morris, this is not *Q&A*, where men regularly speak over women — —

The CHAIR — Order, Ms Ward!

Ms SHING — You may not like the answer to the question as it has been given to you, but the minister has indicated, absolutely clearly, that it is all part of the normal base funding.

Mr MORRIS — Base funding perhaps for 2016; 2015 has already been negotiated. This is an additional cost for 2015, which the minister is refusing to identify.

Ms SHING — Mr Morris, we can have these hearings — —

Mr D. O'BRIEN — On the point of order, Chair — —

Ms SHING — Just because you do not like the answer does not mean that you are entitled then to keep — —

Mr MORRIS — There is no answer — —

The CHAIR — Order!

Mr MORRIS — The minister is not presenting any information at all.

The CHAIR — Order!

Ms WARD — Don't be ridiculous — —

The CHAIR — Order! We have just started. We have got a long morning ahead of us. Mr Dimopoulos, on a point of order.

Mr DIMOPOULOS — On the point of order, I just wanted to clear the record from my perspective. What the Deputy Chair said in relation to it not being factored into the 15 budget, I do not think that it is what the minister said, so I do not think that is correct. The second thing is I think we need to come to grips with: the answer given is the answer given, and you have an opportunity through a supplementary to get another answer or more in-depth detail. Mr O'Brien had those two opportunities, and that is sufficient. That is how this process works. I also want to remind the Deputy Chair that he did caution all of us yesterday about speaking more than once on a point of order.

Mr MORRIS — I am just following established practice by other committee members. I will go with the flow.

Members interjecting.

The CHAIR — Order! I am going to rule on this matter. As the Deputy Chair and other members know, this hearing is governed by the standing orders of the Legislative Assembly. I draw members to standing order 58(2), which says:

> … a minister will have discretion to determine the content of any answer.

I believe that the minister has answered the question that was asked of her, and I am moving on to the next question.

Mr MORRIS — On a point of order, Chair, let us get this very clear. If you are going to use rulings like that to protect ministers who are not prepared to respond to direct questions from this committee, then we are going to have some problems — —

The CHAIR — I have ruled on this matter.

Mr MORRIS — That was a ruling that protected — —

The CHAIR — I have ruled on this matter.

Ms SHING — On a further point of order — —

The CHAIR — I have ruled on this matter, Ms Shing.

Ms SHING — On a further point of order, Chair, the Deputy Chair has just indicated and inferred that you are using this ruling to protect ministers — —

Mr MORRIS — Absolutely, I am.

Ms WARD — That is outrageous. You are outrageous.

Ms SHING — I actually see that as bringing the Chair into disrepute, and I seek that the member withdraw that comment.

Mr MORRIS — No, it was not a comment; it was a point of order.

Ms SHING — You said that the process was being used to protect ministers, Mr Morris.

Mr MORRIS — I made it very clear that if there is a desire by the Chair to accept non-answers — —

Ms SHING — 'Protect'; you used the word. 'Protect ministers' is what you said.

Mr MORRIS — Exactly, from the requirement that their answers be relevant to questions. The answer was not at all relevant to the question.

Ms SHING — Withdraw that comment. You are bringing the Chair into disrepute.

The CHAIR — Will the Deputy Chair withdraw that comment?

Mr MORRIS — It was not a comment; it was a point of order.

Ms WARD — It was a comment.

The CHAIR — We have got a long morning in front of us.

Ms SHING — Disgraceful!

Ms WARD — You know better than this. You have been in this position before.

The CHAIR — Next question — —

Mr MORRIS — The minister knows — —

The CHAIR — Order! I will refer to past practice as well. When you were sitting in this position, you had a rule that you would allow supplementary questions, but they were the gift of the chair.

Mr MORRIS — I agree.

The CHAIR — I will remind all members of that fact. Now we are moving on to our next question. Dr Carling-Jenkins.

Ms SHING — Walk the talk, Mr Morris.

Dr CARLING-JENKINS — Thank you, Chair.

Mr MORRIS — I am here to get information, not to debate.

Ms SHING — Do it properly then.

Mr MORRIS — We are not getting it.

The CHAIR — Order!

Mr MORRIS — We ask nicely, and we do not get it.

Ms SHING — We can go like this all day if you like.

The CHAIR — Order!

Mr MORRIS — We ask, we do not get it.

The CHAIR — Order! Look, the purpose of these hearings is to be able to cross-examine ministers and to seek information. We can keep the to and fro between the committee for the next couple of hours, and you will have no questions. Dr Carling-Jenkins.

Mr MORRIS — I have questions. I am not getting answers.

Ms WARD — Wait your turn.

The CHAIR — Dr Carling-Jenkins, on the next question.

Dr CARLING-JENKINS — Thank you, Minister. As representatives of Western Metropolitan I and my crossbench colleague in Western Metro have a particular interest in the hospitals in this area, and we are very happy, for example, about the expansion of the Werribee Mercy Hospital. Referring back to the hospital beds rescue package on budget paper 3, page 63, and also in reference to the media release dated Tuesday, 5 May, which I also note that you have attached to the presentation — and that is the table that I was going to refer to — this table allocates four new points of care beds to expand critical care for Western Health, which includes both Sunshine and Footscray hospitals. This is the only health service on the list where the allocation for each individual hospital is not separated, so I am just wondering: can the minister clarify how many points of care beds are allocated to Footscray Hospital and how many to Sunshine Hospital?

Ms HENNESSY — Thank you very much for your question, Dr Carling-Jenkins. I too am very excited about our investments in Melbourne's west because they absolutely need it.

Dr CARLING-JENKINS — Absolutely.

Ms HENNESSY — So when Dr Travis — and I might hand over to Frances in a moment to see what comments she has to make — went out to health services to ask them what it is that they wanted and by virtue of the fact that they have allocated funding for four additional critical beds in this year's budget, my assumption is that it will be up to Western Health in terms of how many they allocate at Footscray and how many they allocate at Sunshine. I know that Williamstown, which is another important campus of Western Health, would not be in scope for those two. But in terms of critical care capacity there has obviously been an expansion of critical care capacity at Sunshine recently, and I might see if Frances has any comments around her insights around the needs of critical care capacity at those two campuses.

Ms DIVER — The intensive care service at Western operates at two campuses: Footscray and Sunshine. Sunshine is a new service, and Western Health's management, in collaboration with the clinicians, are determining what is the appropriate mix of services across both campuses. The points of care that are being provided through the Travis review are for intensive care beds, which are at the most expensive end of the scale and also require a significant number of staff — more than five nurses for every bed to have an intensive care unit bed function 24 hours a day, 7 days a week. The recommendation is for that additional capacity, but it will allow management to determine the most appropriate mix in terms of staffing availability and the progress of shifting services between the campuses of Footscray and Sunshine. So it is a net gain of four intensive care beds to be opened over the next 12 months, with the local management determining the most appropriate location to meet the demands of the community.

The CHAIR — Dr Carling-Jenkins, on a supplementary question.

Dr CARLING-JENKINS — No, that was comprehensive enough, thank you.

Ms WARD — Good morning, minister. Can I say that your approach to PAEC is far more refreshing than your predecessor's. I refer to budget paper 3, page 63, and I am going back to what Dr Carling-Jenkins questioned you about before, which is in regard to the capacity of public hospitals across the health system. Can you expand on this and outline to the committee what initiatives you have committed in support of responding to this, with particular reference to the eastern and particularly the north-eastern region, which is of great interest to me?

Ms HENNESSY — Thank you, Ms Ward, for your question, and I know, as a representative of the north area, that they are also under significant challenges. More generally, right across the state we see different things happening in terms of patient demand, but extraordinary growth is occurring in Melbourne's west and in the north-west as well as in the north. In this budget I am particularly delighted that, as part of our $200 million beds rescue fund, we will open new beds and theatres right across Victoria, but in particular there will be additional funding for Northern Health, which will open up nine points of care to expand their emergency department capacity. Northern Health was awarded that funding through the beds rescue fund based on the recommendations of Dr Travis, and he provided those recommendations to us based on his assessment of where there was need but also on what hospitals said was their most pressing investment. ED presentations at Northern are a significant challenge, and so we are delighted that we have been able to make that investment.

Obviously the beds rescue fund will share investment right across the state. As I said, all up our investment will deliver about 19 848 patients. We inherited a very difficult environment; there was about a billion dollars taken from the Victorian health system over the last four years. I do not pretend for one moment that turning that around is going to be an easy exercise, but it is important that we continue to invest in the services, particularly giving attention to where there is growth. I am delighted about our investments in the west, and I am particularly delighted that we have managed to find some money in our beds rescue fund to ensure that we can deal with some of the pressing issues around emergency department presentations at the Northern Hospital.

Mr MORRIS — Minister, if we could go back to the VCCC reference at budget paper 5, page 223. I have with me a copy of a letter that you wrote on 26 March 2015, which outlines a $10 million shortfall in philanthropic funding, indicating that as a result of that shortfall the government has endorsed a $10 million scope reduction for the VCCC. Can you indicate to the committee what has been cut because of this gap?

Ms HENNESSY — Thank you for your question, Mr Morris. Upon becoming the Minister for Health I was briefed about this matter, a challenge that did not occur after the election of the Andrews Labor government. It

has been a challenge that was being discussed under the previous government. So the VCCC have talked about where else they could defer some of the refurbishment. I understand that some of that is going to be around administration offices and the like at the VCCC. It is disappointing, but certainly it was an issue that evolved under the previous government, and it was our unfortunate duty to have to progress that.

Mr MORRIS — I am tempted to ask for more detail, but I suspect that would be a waste of a supplementary. Can I move on slightly but still relate it to that subject. Of course with the Peter Mac Private not proceeding there is a further potential funding gap of $20 million. Has the scope reduction work commenced that would consider what the impacts of that decision are?

Ms HENNESSY — There is no $20 million cut to the VCCC, Mr Morris; it is not correct to assert that. When all parties signed up to the project — —

Mr MORRIS — I said it was a funding gap. I did not say a cut. I said a funding gap.

Members interjecting.

Mr MORRIS — No, I am not being verballed by the minister. I am — —

Ms Shing interjected.

The CHAIR — Order! The Deputy Chair asked a question, and the minister is in the process of answering the question.

Mr Morris interjected.

The CHAIR — Order, Deputy Chair. I will let the minister continue, without assistance.

Ms HENNESSY — There is no $20 million cut. Mr Morris is incorrect — —

Mr MORRIS — Funding gap.

The CHAIR — Order!

Ms HENNESSY — Mr Morris is incorrect.

Mr MORRIS — 'Funding gap' was the terminology.

The CHAIR — Mr Morris!

Mr MORRIS — I am not going to have my question reframed to suit the minister's prepared answer.

The CHAIR — As I previously advised, ministers are entitled to answer the question.

Mr MORRIS — Not rephrase the question.

The CHAIR — The minister is answering your question.

Mr MORRIS — No, she is not. She is referring to a cut; I did not refer to a cut.

The CHAIR — Order!

Ms SHING — On a point of order, Chair, in his supplementary Mr Morris referred to a $20 million cut that — —

Mr MORRIS — I referred to a $20 million funding gap.

The CHAIR — Order! Ms Shing has the call.

Ms WARD — Please stop talking over the top of people, Mr Morris.

Mr MORRIS — Funding gap.

The CHAIR — Order!

Mr MORRIS — Funding gap — two words, not one.

The CHAIR — I have already warned members to my left about depriving you of the right to ask a supplementary question. Please do not test me. Ms Shing, on a point order.

Ms SHING — Again, where Mr Morris is actually content to put that language on the table, he should be prepared to listen to the answer that the minister is giving, without interruption.

Mr MORRIS — Which was 'funding gap', not — —

The CHAIR — Order!

Members interjecting.

The CHAIR — The minister, to continue. The minister has the call.

Ms HENNESSY — I think not to antagonise Mr Morris unnecessarily, but should there be any inference that there has been a $20 million funding cut, it is an incorrect one.

Mr MORRIS — There was no inference; there was — —

Ms HENNESSY — It is an incorrect one.

Members interjecting.

The CHAIR — Order!

Ms SHING — How many interjections do we have now, Mr Morris? Are we in double figures yet?

Mr MORRIS — Can we count Ms Hennessy's interjections in the last Parliament?

Members interjecting.

The CHAIR — Order, Mr Morris!

Ms WARD — On a point of order, Chair, this is this PAEC, and we will proceed on the merits of this PAEC. I am not interested, Mr Morris, in your wasting our time — —

Mr MORRIS — I am not interested in — —

Members interjecting.

The CHAIR — Order!

Mr Morris interjected.

Ms WARD — Please let me finish.

Members interjecting.

The CHAIR — Mr Morris! Ms Ward! Ms Ward is making a point of order; she is entitled to make a point order without assistance from members to my left.

Ms WARD — Can I proceed, Mr Morris? This is our PAEC. We do not need to go back to past PAECs, where you may be paying back people for the way that they behaved previously.

Mr MORRIS — No payback. We are simply trying to get the question answered.

Ms WARD — You indicated — —

Members interjecting.

The CHAIR — Order!

Mr T. SMITH — On a point of order, Chair.

Ms WARD — That is not the way to proceed.

Mr T. SMITH — I was just seeking what the point of order was.

Ms WARD — That I would like us to proceed and listen to the minister without rude interruptions.

Mr MORRIS — If the minister does not rephrase the question, we will not have a problem.

Ms WARD — How about you let her speak, and you will find out what her words will be?

Mr MORRIS — A funding gap is not a cut. A cut was not mentioned.

Ms WARD — Move on, Mr Morris.

The CHAIR — The minister, to continue.

Ms HENNESSY — Thank you, Chair. When all partners signed up to this project, they signed up to a fundraising target. They will continue to do that work. There is no funding cut. All partners are continuing to do work in order to — —

Mr MORRIS — There was no cut asked about.

Ms SHING — On a point of order, the minister is within her discretion to answer the question as she sees fit.

Mr MORRIS — Not to change the question.

The CHAIR — Order! Mr Morris!

Ms SHING — It is unfortunate that you do not like the answer to the question; however, you are not in a position to continue interrupting and interjecting where the minister is making her answer.

Mr MORRIS — I do not mind the answer; I do not like the question being rephrased and an imputation applied that is not accurate.

Ms SHING — I am sorry that you do not find this process satisfactory, Mr Morris. Perhaps if you could actually phrase your supplementaries correctly in the first instance, we would not be heading down this path.

Mr MORRIS — The supplementary was correct. It has just been referred to differently by the minister — inaccurately by the minister.

Ms WARD — Mr Morris, this is descending into farce. How about you just let the minister complete her question?

Mr MORRIS — If the minister stops re-characterising a funding gap as a cut and sticks to the truth and sticks to the question that was asked, then let us move on.

The CHAIR — Order! Mr Morris!

Ms WARD — You are trying to — —

The CHAIR — Order, Ms Ward!

Mr MORRIS — No, I am not. I know what words I used.

The CHAIR — Order! Right, you have lost a supplementary for your next speaker. The minister is to continue with her answer.

Ms HENNESSY — The philanthropic contributors to the very important Victorian Comprehensive Cancer Centre project continue in their support, and those that are seeking ongoing philanthropic work continue to do that work, as our very important philanthropic foundations right across the state do for all of our wonderful health care services. Mr Morris's inference and imputation is incorrect.

Ms SHING — Good morning, Minister. Good morning, departmental officials. Minister, I would like to take you to BP 4 and a table on page 39, if I may. I would, to that end, welcome some further detail in relation to the Western Women's and Children's Hospital in terms of what this project will mean for families in the west and when construction of the project will actually be completed.

Ms HENNESSY — Thank you very much for your question, and I am delighted that there is a strong interest in investment in the western suburbs. Ms Shing, you join your colleague Dr Carling-Jenkins in her interest, and that is really terrific. As I have said, Melbourne's west is growing at extraordinary rates, and we do need to invest in health services in the west.

The maternity services at Sunshine Hospital continue to grow to meet increasing demand in the community. In Sunshine we now have the third highest number of births at any hospital in the state. That comes after some of the specialist women's hospitals, in terms of the Mercy and the Royal Women's. There has been a sharp increase in the births at Sunshine due to its location and its growing great reputation. It has a lot of really innovative midwifery programs. It does extraordinary things around engaging with really diverse communities. We now have great teaching, tertiary and referral and research capacity there, so it is a fantastic place, but we need to continue to invest in it if we are going to meet the demand.

Between 2005 and 2006 and 2012–2013 the number of births increased by a massive 70 per cent. By 2026 we know that the number of births projected to occur at Sunshine Hospital will exceed 7000, so it is vital that we are able to cope with that. We need to start to do the investment now. In some of the great debates around growth there is always a sense of infrastructure playing catch-up. It is absolutely important that, particularly when it comes to obstetrics and paediatrics, we are responding to what we know now will be the demands on those services.

What it will mean for many people living in the west is that they will be able to birth closer to home. It will allow an extra 2000 births per year, and it will ease pressure on the surrounding hospitals. We know that in some circumstances we have hospitals where if a person has a birth that is not complex, if you are not in early, then you do not get in and you then have to find another service. That is really an unacceptable state of play for expectant mums, in my view.

It will also provide obviously all of the associated support around Melbourne's west. It will free up beds and theatre spaces at Sunshine Hospital so they can perform more than 7000 operations a year. It will support other really vital services there, including cancer, subacute care and rehabilitation. The specifics of the new hospital: there will be 237 new beds; there will be a special care nursery with 39 cots; there will be four new operating theatres; there will be space for women's and children's clinics; and there will be preliminary work for the new hospital that is going to carry over into next year, with main construction to take place in the following year. We hope that the hospital will be completed by the conclusion of 2018.

The CHAIR — Before we go to next question, Minister, a document has been circulated, *Victorian Budget 15/16 — For Families*. The Deputy Chair was wondering about the status of that document. I am presuming that this is a public document?

Ms HENNESSY — Yes, Chair. That is a public document. It is a document that was part of the Travis review. It details how the $200 million beds rescue plan is allocated. It has been in public circulation for some time.

The CHAIR — That you for clarifying that, Minister.

Mr T. SMITH — Welcome, Minister. I refer you to budget paper 2, page 58: of the 1.45 billion outlined under funding from reprioritisation of existing resources, how much in each year relates to your health portfolio, and can you provide a list of the programs and amounts reprioritised?

Ms HENNESSY — Thank you, Mr Smith. I do not have that information to hand. I am more than happy to come back to the committee with that, but I am again more than happy to give the opportunity to Mr Wallace to see if he can provide some insight for you.

Mr T. SMITH — That would be appreciated, thank you.

The CHAIR — Okay, Ms Ward to proceed.

Ms WARD — Mr Wallace is going to speak to us.

Ms HENNESSY — Mr Wallace may be able to provide some insight.

The CHAIR — My apologies, I am getting ahead of myself. All of this excitement on a Wednesday morning!

Mr WALLACE — I do not have anything additional to add. I will take the question on notice, thank you.

Ms WARD — Thank you, Chair.

Mr T. SMITH — Do I get a supplementary?

The CHAIR — No, because of Mr Morris's behaviour. I said that at the time. I warned the Deputy Chair, and I indicated — —

Mr T. SMITH — Chair, that is a little —

The CHAIR — No.

Mr T. SMITH — With respect, I think — —

The CHAIR — No. I want to be really clear about this. Members here are entitled to ask substantive questions. Supplementary questions are — —

Mr T. SMITH — I just asked a perfectly reasonable question.

The CHAIR — Absolutely, but I did warn the Deputy Chair that if the misbehaviour were to continue, the opposition would lose a supplementary question. When that persisted I said, and Hansard recorded it, that you had lost your supplementary question for your next question.

Ms WARD — Your question is not the issue.

Mr T. SMITH — With respect, I do not think this decision reflects well on you.

Ms WARD — I do not think it reflects well on the behaviour of Mr Morris.

Mr T. SMITH — I simply asked a question.

The CHAIR — Mr Smith, can I characterise this to you in these terms: PAEC as it is constituted now is like a marathon, and I reckon where we are at the moment is about the 9-kilometre mark. I want to set the tone for the rest of the hearings. I want to make sure that we speak courteously and respectfully across the chamber. Of course there is an opportunity for robust debate, but I do not think that it is fair on members of the gallery or witnesses to see the sort of toing and froing that occurred just then. That is why, in this instance, I am not allowing a supplementary question. I do not propose to deprive you of any more supplementary questions; I am merely trying to make a point to make sure that we conduct ourselves in an orderly fashion.

Mr T. SMITH — Chair, I have asked a perfectly reasonable question, and I am seeking to ask a supplementary — —

The CHAIR — I agree. That was a perfectly reasonable question, but it came down to the way in which the behaviour was occurring beforehand.

Mr D. O'BRIEN — On a point of order, Chair, while I do not agree with your decision, I understand it. Could I ask for the same rules to be applied to the other side? The last little flare-up we had occurred when the minister was continuing to answer the question. Mr Morris made an interjection. It was not loud, and it did not stop the minister's flow. She was continuing to answer, and yet Ms Shing took a point of order and started the whole thing up. I simply ask in future that you rule those points of order out straightaway so that we can just get on with it, because we wasted 2 or 3 minutes there totally unnecessarily. We are allowed to make interjections on this side. There is no ruling against that. As I said, the minister was continuing; there was absolutely no purpose in doing that.

Mr T. SMITH — And quite often in committee hearings, Chair, both here and in Canberra and other places, there is an interchange between the witness and members of the committee. That is perfectly appropriate. It is not an interjection. There can actually be a conversation that can occur in seeking information. That is not inappropriate. What I tire of, Chair, is also having the question that we have just asked somehow edited by Ms Shing. It goes on all the time. If you are going to get stuck into us for arcing up —

Ms WARD — That was more than arcing up.

Mr T. SMITH — could you be a little consistent, frankly?

Ms SHING — Further to Mr O'Brien's point of order, Mr Morris made references in the last exchange including asking the minister to stick to the truth. He also inferred that the Chair was acting to protect ministers. In relation to the way in which this committee functions, it is my view that that sort of behaviour is not acceptable and nor does it actually assist with the committee's work. I do not disagree that there is capacity for some exchange, but when we have the sorts of exchanges that the transcript will reveal occurred on numerous occasions between Mr Morris and the minister because he was dissatisfied with her answer, it does not assist in terms of the committee getting its work done.

Mr T. SMITH — With respect, it also does not help either when Ms Shing decides that she does not like our questions and seeks to have them reworded. It is particularly irritating — —

Ms WARD — No. On a point of order, it is not about not liking the questions; it is the way in which they are asked. You know that.

The CHAIR — I have tried, since I have been in the chair, to be as even-tempered and even-handed as I can be in relation to my rulings, as the transcript would show and as the opposition would know. We have got a long way to go. Can we just try and play nice? Of course, Mr Smith, to take your point, there will be argy-bargy across the table. That of course is what happens in these hearings, but my point was that when I tried to bring the committee back to order those attempts by me were strenuously resisted by members to my left. That is why I made the threat and why I am now carrying through with that threat. It is not my preferred course of action. I do not want that. I do not want to deprive you of supplementaries, but I will if it is in order to try to ensure that this committee functions in an orderly fashion. Please make this the only time this happens between now and next Friday, and I will buy you a beer next Friday night.

Mr T. SMITH — I am just checking the Hansard recording.

The CHAIR — I am not misleading the committee or the house.

Ms SHING — It will be a light beer though, won't it?

Ms WARD — Minister, I am really glad that in your presentation you referred to whooping cough. I would like to direct you to budget paper 3, page 64, and the note that we are restoring funding for the whooping cough vaccine initiative. Can you please explain why the government is investing in this initiative and what it will achieve and deliver?

Ms HENNESSY — Thank you very much for your question, Ms Ward. The whole issue of immunisation is one that is very close to my heart. Whooping cough is a highly contagious disease, and it is incredibly dangerous. It is important that we take every opportunity to reinforce that with the community, particularly those who are opposed to vaccination. It affects the air passages and breathing. It causes severe spasms, often

haemorrhages, convulsions. It is a very, very serious illness, and it is not to be dismissed or treated lightly. In fact it is potentially a fatal disease, and we need to ensure that we treat it very, very seriously.

Babies are at risk of contracting whooping cough from birth. Children who are under six months old are at much greater risk of complications because they are not fully immunised at that stage. Because it is incredibly contagious, if parents are not immunised, they can pass it on to a newborn baby. With those kinds of alarming consequences, it is absolutely critical that we made the decision to reinvest in this project. It was cut in 2012, and we have made a commitment to re-fund it.

We have seen some very, very frightening increases in the rates of whooping cough in recent years. Notifications of whooping cough have increased by almost 58 per cent, so there is a really significant increase. As at 9 May this year there have been 1954 cases of whooping cough for all ages compared with a bit over 1000 at the same time last year. It is very alarming when you are in receipt of all of the notifications of these sorts of issues, and so we think it is absolutely critical to make sure that we take away any barriers around trying to get expectant parents and parents of newborn babies immunised. That is why we announced the reintroduction of the whooping cough vaccine for free for expectant parents and parents of newborns.

There has been an innovation internationally around when this vaccine can be taken. Vaccinating a pregnant woman in the last trimester, two weeks before she is expected to give birth, has been demonstrated internationally to have passed on antibodies to newborn babies that gives them much greater protection until they get to that six-month age where they can be the recipient of immunisation. So there are really significant challenges around this issue. I am not sure if Dr Brook has any reflections, but some of the projections around whooping cough and influenza for this forthcoming winter are moderately alarming and we need to continue to get the vaccination-immunisation message out.

I am delighted that we been able to restore this program, but we have to continue to make sure we take away barriers to immunisation and vaccination and we challenge some of the mistruths that are peddled around the consequences of vaccination.

Ms WARD — If a mother gets immunised two weeks before giving birth, that can then trigger it for the next six months for the baby?

Ms HENNESSY — That is right. The other issue around whooping cough is vaccination does not give you complete and perfect immunity. People often do not get boosters. It will last you for about 10 years. We need to keep talking to people about how important it is to go back to immunise and vaccinate. I do not know if Chris Brook may have some other reflections. He is one of our great experts in the department on this issue.

Prof. BROOK — Thank you. Through you, Chair, I would just like to reinforce a couple of the points that the minister has made so that everybody has a full understanding of this.

Whooping cough is entirely preventable, although immunisation does not always guarantee that people will not develop whooping cough, and the minister has made the point that immunisation does not last. It is perfectly understandable that women and men expecting children will not necessarily have protection themselves against whooping cough.

The science of this intervention has changed in recent years, and there have been some excellent large-scale studies that show that immunising the expectant mother roughly mid-third trimester, so that enough time is allowed for antibodies to appear in her bloodstream, is highly protective to children — about 90 per cent is the rate quoted by the biggest UK study. That is because the antibodies she produces crosses the placenta into the baby's blood and the baby is born with built-in protection. Babies cannot be immunised at the beginning of life because they simply cannot produce their own antibodies at that stage, and it is risky to do things like that.

This is, in a sense, a new program. It is certainly a reinstatement of every attempt to prevent whooping cough, sometimes called the 100-day cough, which gives you an idea of just how severe it can be in young adults and older adults. The minister's point about it being potentially fatal in children is extremely real. Children present quite differently to adults, and one of the most common presentations in children is they stop breathing for periods, and obviously that can be fatal at the end. With those comments I am just really fleshing out to make clear that this is a terrific initiative, and we look forward to its full implementation very shortly.

Mr D. O'BRIEN — Minister, my question is related to Casey Hospital. In budget paper 3, page 76, under 'Asset initiatives' it would appear that only $2.4 million of the 106.3 million for the Casey Hospital expansion has actually been funded. Could you confirm that is the case in this budget?

Ms HENNESSY — Thank you very much. The full 106.3 million is provided in the budget, and we will honour our election commitment. How funding is going to be allocated over the last two years is still to be determined, because final planning is underway. But the challenge around Casey Hospital, again obviously in the south-east, is the incredible population growth. We are building on the existing Casey Hospital, which is a terrific service, but that was a hospital that was built as a PPP. So through the internal processes of government some of the contract negotiations that will enable us to plan for the expansion need to be done. We are absolutely committed to building that hospital, Mr O'Brien, but some further planning work needs to be done. It is an area that desperately requires investment. Again there are very similar challenges to those in the west and the north-west in the south-east. We do know that this is a project that is going to take up to five years. It is a very significant project, and so we have got to get the planning and the detail right.

Mr D. O'BRIEN — My supplementary goes to that point, Minister. During the election campaign the Premier, in an article in the *Age* of 1 November, committed that the hospital would be completed by 2018 if Labor was elected. Now, as you have just said, it is five years, and in budget paper 4, page 39, it says that it will not be completed until the fourth quarter of 19–20 — in other words, 2020 — so why is it 18 months later than you originally said?

Ms HENNESSY — We would be hopeful, Mr O'Brien, to have it completed as soon as possible. The challenge around the Casey Hospital expansion really relates to the unique procurement method that was used around the primary hospital of Casey, and so we have got some unique challenges around the best way to procure. We will be getting on with that as soon as we possibly can. Making predictions around when a hospital is absolutely going to be completed are notoriously challenging things.

Mr D. O'BRIEN — So it would appear.

Ms HENNESSY — Weather and the like will intervene, but I do not step back from the fact that investing in the south-east is an election commitment. We are going to fulfil it, and that community absolutely deserves expanded health services.

Dr CARLING-JENKINS — I would like to talk a little bit more about palliative care. This is something that you mentioned in your last answer to me, so I would like to get a bit more detail on this. Palliative care is covered under 'Meeting hospital services demand' in budget paper 3, pages 63 and 225. Within the budget papers it mentions funding for palliative care beds. As you mentioned in your last answer and what was covered in the *Travis Review — Interim Report*, there was a highlight around the need for home-based palliative care services. I was just wondering if you could demonstrate to the committee the government's commitment to and funding of more home-based palliative care services.

Ms HENNESSY — Thank you, Dr Carling-Jenkins. I will talk a little bit about palliative care and our palliative care investment, and then I might ask Frances Diver to make a couple of comments. I think it is important that we continue to strengthen and renew the model of care that is used around palliative care. We fund about 54 agencies — some hospitals, some community health services and some NGOs and specialist services — to deliver palliative care across a really broad range of settings. Some of those are acute inpatient facilities, some of those are community, which are the home-based palliative care programs, and some are residential facilities. We know that in 2013–14 there were almost 15 300 people cared for by community palliative care and about 7320 in inpatient palliative care. So we can see the really stark difference in terms of where people's preferences are.

Our specialist palliative care clinicians are trained to manage often very complex symptoms of those with very life-limiting or terminal illnesses, and so there are often very disturbing presentations at ED as someone nears the end of their life for a person that sometimes has not got the kind of care that they require. We have some significant investments in the budget around palliative care. One of the things I have learnt travelling around rural and regional hospitals is that I will be walking through the hospital and they will say, 'That is technically our palliative care unit, but we use all sorts of different beds'. So we need to give health services that flexibility, but at the moment we see that where the great demand is is around palliative care at home.

I am hopeful that in our term of government we will be able to do some significant work around the model of care. There is some terrific work that is being done in other jurisdictions. The Auditor-General recently tabled a report on palliative care and was unusually complimentary to the directions that are going. That is not to say there is not significant work to be done, and we have also got to make sure we get funding models that incentivise community-based care. Having said that, I might ask Frances Diver if she has any comments or reflections specifically.

Ms DIVER — Palliative care funding is particularly welcomed by the sector for additional capacity. The process now that the budget has been handed down is that we will work with health services and NGOs — non-government organisations — where relevant to negotiate their budgets for the next year. Included in those negotiations will be working out what is the right mix of services. So there are some bed-based services that will require expansion, or there might be some community-based services that require expansion, or as the minister said, in some rural hospitals the use of acute beds or subacute beds for palliative care means that we need to provide specialist consultation and liaison services — so specialist palliative care staff to work with the regular hospital staff to ensure patients are receiving the appropriate end-of-life care.

The exact location and mix of services is now subject to the budget negotiation process with health services to make sure we get the right mix, noting that there is an increasing trend towards community-based services. That is appropriate, and that is taking pressure off acute hospital beds and taking pressure off acute palliative care beds, but recognising that we will also always need specialist palliative care beds for some patients who need a specific period in hospital for pain management or specialist care as part of their ongoing episode. But making sure that we have the right mix and the right balance between bed-based services and community-based services, and that is the negotiation we are about to head into with our health services and non-government organisations.

Dr CARLING-JENKINS — I appreciate your answer. That is great. Palliative care is something I am very passionate about, so I will try to be articulate here. I was very excited when the ALP document *Platform 2014* came out and it stated a commitment to expand palliative care services. Something that document said as well was to ensure that palliative care would be 'culturally and age appropriate'. I wonder if you could just expand your answer a little bit around how this new budget and these negotiations that you will be doing demonstrate this particular commitment to ensuring that palliative care is culturally and age appropriate.

Ms HENNESSY — Thank you. That is a terrific question. I might ask Frances to share some of her insights on this issue, but also to make the offer that we would also be more than happy to provide you with a briefing around some of the emerging directions in palliative care, because there are some terrific things going on. I am going to have to defer to Frances to provide some of those specifics.

Ms DIVER — Certainly there are some specialist palliative care services directed in particular towards children. If that is your interest, certainly the Royal Children's Hospital also provides specialty palliative care consultation and liaison into other agencies as well. So there is a mix of specialist children's services both in hospitals and in the community, and our expectation is that in the mix of the growth in palliative care services that services directed particularly to children will also grow as part of the overall system.

There is quite a lot of work that has been done in terms of cultural diversity and ensuring that particular cultural groups receive appropriate end-of-life care. That is a particular point in people's lives where the cultural safety, I suppose, of the care that is being provided becomes particularly important. Some of our palliative care programs have undertaken very specific work in engaging other culturally and diverse communities to ensure the services are appropriate. There is an enormous amount of work going on, and we would be very happy to provide a detailed briefing if that is required.

Dr CARLING-JENKINS — Thank you. I would appreciate that.

Mr DIMOPOULOS — Can I take you back to Casey Hospital? I for one do believe that it will be delivered, as will all the other commitments that this government made. In relation to budget paper 4, page 39, where it talks about the capital investment, I understand that it is the first intensive care unit in the rapidly expanding south-east suburbs. I want to get a sense from you about what the benefit or what the result will be in terms of how many people will be treated if that is actually true, that it is the first.

Ms HENNESSY — Thank you, Mr Dimopoulos, for your question. You of course would know the significant growth pressures out in the south-east, and we know that out in Casey we are going to have about 468 000 people by 2021. That is a significant amount of people. One of the other challenges for the health system is where and how you locate people so they are able to access things like intensive care and high dependency units when things like travel time have significant implications for their health outcomes. Last year Casey admitted about 38 000 patients, and they had 52 000 people present to their ED. Our investment in Casey Hospital is going to deliver a new eight-storey inpatient unit, four new operating theatres, a new surgery recovery centre. There are going to be an extra 96 beds, and there will be an intensive care unit.

Part of the challenge for Casey at the moment is that they do not have an intensive care unit and they do not have a high dependency unit, and that is a significant issue if you are critically ill, because you have then got to be transferred to Monash Health or elsewhere. All of those sorts of transfers obviously expand risk. We are also expanding the CT and MRI services there. There was a recent Auditor-General's report that talked about the mismatch of where high-value equipment is located versus where the waiting list for things like an MRI scan is, so I am delighted that we are making investments there that should help reduce some of the waiting lists for important diagnostic imaging services. Those investments should help reduce the waiting times.

The expansion will increase the size of Casey Hospital by more than 35 per cent. It will mean 12 000 more patients can be treated, 8000 more surgeries and 500 more births. We are delighted. We are very committed to that project. Having had the benefit of visiting that hospital to talk through this project, I know that all of the workforce are absolutely delighted.

Mr T. SMITH — I refer you to budget paper 3, page 64, and the Premier's comment in the *Australian* on 27 November 2014 regarding super pharmacies, stating that the allocated 28.7 million would provide for a night nurse and security improvements. Of the 28.7 million provided, what is the breakdown of what this funding will pay for — for example, nursing, security and other areas of cost?

Ms HENNESSY — Thank you very much for your question, Mr Smith. Our super pharmacy commitment is a really important one right across the health and emergency services sectors. We have this great challenge where we have demand made of our emergency services and of our acute services often because people cannot access other forms of health care. There is really interesting data around when people need and demand health care. For example, with things like Nurse on Call, the peak calls are always between 6.00 p.m. and 10.00 p.m., and often it is people coming home from work or you have been with a sick child all day, equivocating about trying to get to a GP or not. Then the cough gets worse and people catastrophise about whether or not they should go to an ED — is it transforming into something different? We think that 24-hour super pharmacies, that will include the provision of nursing between the hours of 6 and 10, are going to make a really significant impact on that kind of demand.

In terms of how this project is progressing, we have started the consultation process with all of the significant stakeholders. That includes pharmacies, nursing workforces, GPs, EDs, late-night clinics, and we will continue to do that work. We do not disaggregate in the form that you have asked because we are still in the process of developing the proposition. It will look very different in different areas. I know, for example, that in parts of rural and regional Victoria the pharmacist plays a really important role as a source of health care, where they have a significant distance to get to a hospital or they cannot necessarily access full-time GP services or out-of-hour GP services. The model is going to look very different depending upon where that pharmacy is going to be placed, and we will be working with all of those sectors to make sure we acquit ourselves of our election promise but we do so in a way that is also attendant to effectiveness and efficiency.

Mr T. SMITH — Would there be any possibility of getting that data on notice?

Ms HENNESSY — I put it to you, Mr Smith, the data does not exist at the moment. That is our funding allocation.

Mr T. SMITH — If it does, when it does — —

Ms HENNESSY — If and when it does, I would be more than happy to furnish the committee with additional information.

Mr T. SMITH — That would be terrific. In terms of emergency department visits that would be offset by trips to these super pharmacies, can you give us an indication of how many ED visits would be replaced by going to super pharmacies, for example?

Ms HENNESSY — Ultimately that is going to depend upon the location.

Mr T. SMITH — Roughly?

Ms HENNESSY — I am not in a position to speculate for you at this point in time.

Dr CARLING-JENKINS — I would like to refer to budget paper 3, page 65, and the reference to the elective surgery waiting list and the boost to that. I note that you referenced in your opening statement as well a commitment to $60 million, which would equate to around 11 700 surgeries, I think you said, over the next year. Could you please outline for the committee how effective this will be in reducing the wait times for elective surgery over the next 12 months?

Ms HENNESSY — Thank you very much for your question. Elective surgery is a really important part of the provision of Victorian health services, and most of the independent data as well as things like the Productivity Commission that reports on government services every year and that looks at things like wait times tell us the same story — that we have extremely long wait times and that we seldom meet our targets around this issue as well. So making a one-off $60 million investment in elective surgery is a really important part of our health budget in an attempt to also try to reduce the pressure on demand. Elective surgery is categorised into a number of categories. The pressure tends to occur — those who are waiting the longest are those who are in the higher numbered categories. Traditionally that reflects the urgency of the condition that they are seeking treatment for. I am going to ask Frances to make some comments as well, but the other really important input to elective surgery is also outpatients. Waiting lists for outpatient appointments are also incredibly long, and that is also the trigger for when a person then goes on an elective surgery waitlist.

Often the great frustration for people is that at the time they are put on a waiting list they might be category 3, but when you are waiting for 12 months for a hip operation you degenerate, your pain thresholds go, your level of immobility grows and you technically would be a category 2, which would get you up the waitlist, in a sense. So we are very concerned about the length of delay that all Victorian patients have. There are some particular areas where elective surgery waits are longer than others, and for certain particular conditions as well, that are of great cause for concern, but I might ask Frances to talk through the state of play around elective surgery at this point in time and what we hope our $60 million will deliver to Victorian patients who have been waiting for too long.

Ms DIVER — Thanks. There are two components to understand with elective surgery. There is both the waiting list and then there are the waiting times for surgery. The waiting list is often referred to as one list, but in fact it is multiple lists because it is multiple health services and multiple specialties within each health service. So there are actually multiple waiting lists. Then even within one health service you might have three or four groups of orthopaedic surgeons, for example, so you have got multiple lists. The increasing specialisation of some areas means that you have got some surgeons or specialties that are even more sub-specialty than that, so they might only operate on shoulders rather than hips. So even within the orthopaedic specialty, within a large health service, you have got these multiple queues.

So the waiting time for surgery is usually the most important thing to patients. That is what they care about, and as the minister mentioned, the waiting time for outpatients is also a significant component for some people who are ultimately going to have elective surgery. The increased interest and recommendations from Dr Travis's review about being more transparent about waiting times for outpatients will also assist in the community understanding of perhaps where they can seek their care to ensure that they have a shorter waiting time for outpatients. So having said that waiting times are important and that then there is the total waiting list, what we will now seek to do with the additional investment of $60 million, which we expect will deliver around 11 000 additional patients treated, is we will look to what the demand for elective surgery is — both the demand coming from outpatients, and we will also look at what the waiting times are in each of the individual health services and in the specialties and out of that negotiate the best outcome we can to ensure that we get the best waiting times that we can across the system.

Some of that funding will go towards giving additional capacity to treat the most urgent patients, but some of it, because of it being additional over and above the normal growth level, will allow us to target areas where there are significant long waits. So it will be a negotiation with health services to determine what is the best mix. In allocating that funding we will also have a mind to what their capacity is. So the Travis review has also provided important information for us to determine where there is spare capacity in the system — so where there are theatres we can open or beds or services that we can open to support undertaking that additional activity. That also lends itself to a kind of scale issue, so where we have efficiency in those public health services, then we might be able to deliver over and above the usual level of surgery because you have an efficiency involved in that.

I do not want to make it too complicated, but it is not one waiting list; it is multiple lists. Waiting times are probably the thing that consumers care about the most. The commitment and the interest in reporting outpatients is also an important component, and we expect to be able to improve our waiting times for elective surgery as a consequence of this additional investment.

Dr CARLING-JENKINS — Thank you for that explanation. I understand this is a very complex issue. I am just going to ask a very simple question, however. I am wondering whether you can quantify or approximate at least the difference this injection of funds will make. For example, do you think this will halve the wait times that people are experiencing?

Ms HENNESSY — I will get Frances to do the best she can in terms of making those kinds of projections — and that is no reflection on Frances's ability. As I said, the estimation that we have made of about 11 600 patients is an average because obviously things like the cost of ophthalmology surgery versus the cost of hip surgery are vastly different. We are confident it will make a significant difference. The wait list continues to grow significantly. We were very alarmed upon coming to office to look at that growth rate in terms of the elective surgery wait list. In terms of any forecast projections, I might ask Frances if she has some intelligent insight she can share with you.

Ms DIVER — The wait list has people coming onto the wait list and people coming off the wait list. One of the issues that the government is responding to with this investment is the increased inflow onto the waiting list. That is as a consequence of quite a lot of work that is going on in outpatients to try to improve and shorten the time at outpatients, which means there are more people coming onto the list at the moment.

Some of the funding will need to be directed towards just meeting our demand. So we have got demand from a growing population and an ageing population — more people need surgery. We have got demand because we are actually speeding up the time that people come through outpatients — there is a kind of a bit of a bubble coming through — and so we need to direct funding towards that. But we also expect to be able to direct funding to specific health services that have particularly long waits. There are a few specialties, but in particular urology and orthopaedics are two particular specialties where we expect to be able to deal with what we call the tail of the waiting list. Where we identify services that have got a particularly large group of long waits, we will try to direct some funding to that.

All of this funding allocation, on top of the outcomes of the Travis review bed rescue fund allocation, the elective surgery allocation, the budget negotiations — all of that mix — will then result in targets that will be identified for health services, and they will be published in the statement of priorities when they are published later in the year, which is the annual health service agreement between the minister and the board chair. Those agreements will detail the volume of elective surgery to be undertaken in each health service — that is where we will see it; it will be around 11 000 more — and then we will also be able to see the targets that we will be pushing services to in terms of improving waiting times. Not until I get to that point will I be able to make the intelligent comment —

Dr CARLING-JENKINS — Quantify it.

Ms DIVER — about exactly what the reduction in waiting times are.

Dr CARLING-JENKINS — Thank you very much. I look forward to that.

Ms SHING — Minister, my question relates to budget paper 5, page 181, and to your presentation this morning and a reference to the commonwealth cuts in the health budget. I note from your presentation that you

indicated that there would be numerous challenges for the state of Victoria under the national health reform agreement, and I was wondering if you could provide the committee with detail about this and some of the parameters used in developing this year's state budget and how that will be impacted in the forward estimates period by the commonwealth budget itself.

Ms HENNESSY — Thank you very much for your question, Ms Shing. Obviously the state budget is handed down before the federal budget, so there is a set of assumptions that are made. We were very disappointed with the outcome of last year's federal budget and the changes not just to the national health reform agreement but the deferral, and in some cases cancellation, of some national partnership agreements. That is going to cause a significant impact on some really terrific programs and services in Victoria. We will always do all we can to mitigate the harsh effects of those cuts, but we cannot stump up everything that the commonwealth government walks away from.

The great concern for us was based on last year's midyear economic and fiscal outlook, the MYEFO as it is referred to. We did some projections around what that would mean around the funding model for Victorian health services. We had forecast quite conservatively that that would mean we would lose $13.6 billion over 10 years, and that was incredibly significant. We note that that would mean that hospitals like Mildura would lose 135 million, Northeast Wangaratta would lose 123 million, Wimmera would lose 79 million, West Gippsland would lose 92 million. These are significant amounts of money that are being taken out of the health service. When you get to the bigger health services the impact is obviously larger but equally as significant. Hospitals like Barwon would lose 642 million. Right across our entire health sector there are significant impacts around the commonwealth government's decision to change the funding formula, which results in a cut to the Victorian health budget. I do not think it is one that we ought take lightly.

I am, to use polite language, very disappointed that in last night's federal budget the forecast projections have got worse for the Victorian budget. Some modelling that we have done now indicates that the deeper cuts and the additional year forecast in last night's federal budget indicate that that will now be $17.7 billion that will be cut out of the Victorian health system. This is a problem that is not going to go away. We remain open and willing for ongoing dialogue with the commonwealth about sustainable health funding, but we must not expect that you can cut $17.7 billion out of the Victorian health budget and expect that patients will not wait longer and that people will not get sicker. We are very concerned about this. That is not to say that we bring a closed mind to any ongoing dialogue with the commonwealth government about such matters, but every time there is a budget or a MYEFO things seem to get worse.

Mr MORRIS — Minister, if I can refer you to budget paper 3, page 222, which is the health output summary, as I am sure you are aware, there are a number of significant EBAs set to expire, and of course they will need to be renegotiated. The Victorian Public Health Sector (Health Professionals, Health and Allied Service Managers & Administrative Officers) Multiple Enterprise Agreement, the Nurses and Midwives (Victorian Public Sector) (Single Interest Employees) Enterprise Agreement and the Victorian Public Health Sector (Medical Scientists, Pharmacists and Psychologists) Enterprise Agreement — just to name a few — are all set to expire either in this coming budget year or the next. Given that your portfolio has been funded for 2.5 per cent per annum wage increases, are you confident that you will be able to negotiate all of the upcoming EBAs within your portfolio within the 2.5 per cent plus productivity, and if not, will you propose to make cuts?

Ms HENNESSY — A pessimistic outlook, may I say.

Mr MORRIS — Based on experience.

Ms HENNESSY — Certainly it is not the Minister for Health who actually conducts the enterprise bargaining negotiations, but I am not going to quibble with the semantics of your question; I understand the materiality point that you are making.

The Department of Health and Human Services is like every other department. We are funded for the assumptions made in terms of wages policy. We will negotiate within those parameters. The government will negotiate in good faith. I am not in a position to tell you exactly what productivity measure or improvement may be delivered, but our wage assumptions contained in this budget are the government wages policy, and those negotiations will unfold in due course.

Mr MORRIS — I appreciate the answer. It probably was not the clarity I would have preferred, but I appreciate the answer. It was implicit in your answer to the first question that the services intended in the budget could be delivered within the wages framework. How can you be confident that you can keep the cost of those wage increases within the 2.5 per cent plus productivity when clearly Labor could not do so for paramedics? Is it perhaps government policy that unions that have campaigned for the Labor Party will get better wage increases than others?

Ms SHING — On a point of order, Chair — —

Mr MORRIS — You disappoint me.

Mr D. O'BRIEN — She has got to think of something.

Ms SHING — It was only a matter of time before we ended up talking about the Labor Party and the paramedics in relation to enterprise negotiations. The minister has answered the question in relation to negotiations being undertaken in good faith. Again, if Mr Morris did not like that particular answer, then perhaps he should have asked his initial question in a different way. The minister has indicated that the negotiations will take place within the parameters of the budget as it has been allocated, so on that basis I am not sure whether there is a proper point of relevance for the supplementary.

Mr MORRIS — On the point of order, Chair, the question related to the early experiences within this government in terms of the ambulance officer settlement. It related to early experience and referenced the significant number of large and important enterprise bargaining agreements that are coming up for renegotiation, so I think it is an entirely legitimate question.

Ms SHING — Further to the point of order, Chair, the initial question did actually set out a reference to the 2.5 per cent per annum wage increases plus productivity, and it is the plus productivity bit which I think has led to his dissatisfaction with the answer to the primary question, being that once negotiations have taken place in good faith there may well be productivity line items that are built into any agreement which perhaps has led to the unfair categorisation of Labor deals in relation to the paramedics dispute amongst others.

Mr MORRIS — Are we going backwards and forwards on this?

The CHAIR — No. The kernel of the supplementary question was how confident are you that you can keep these costs within the framework? I think that is a fair question to ask the minister.

Ms HENNESSY — Mr Morris, I am afraid I can provide you with no political joy in this answer other than we will be applying the wages policy and we will negotiate in good faith. In respect of the ambulance dispute, I note we have got a terrific hour together on ambulances at the conclusion of the health hearing. Without wishing to sway out of this portfolio into that portfolio, the issue there was the wage offer was in fact exactly what the previous government had offered very close to last year's election.

Mr MORRIS — Perhaps the wages policy is not worth the paper it is written on.

The CHAIR — Order! You have had your supplementary question, Mr Morris.

Ms WARD — Minister, as you would expect, in the area I live in we have a high concentration of health professionals; a lot of my friends happen to be nurses. I ask you to turn to budget paper 4, page 39. I have been pretty concerned by the stories my friends tell me, as well as what I have read in the paper, regarding the violence that nurses and doctors all experience while undertaking their work. Could you outline to the committee the detail of the Health Service Violence Prevention Fund and how it is designed to improve safety for our nurses, doctors, health professionals and the other people who do an amazing job? Considering it was International Nurses Day yesterday, I think this is very relevant question.

Ms HENNESSY — Yes. Thank you very much for your question, Ms Ward, and it is an incredibly important one. Anecdotally and with some data insights we know that we have a significant issue with occupational violence and aggression right across our workforce. We hear it anecdotally. We have had the opportunity to look at different siloed data in respect of different segments of the Victorian workforce. It was an issue that was canvassed rather heavily on the ice task force, of which I was a member. It is not an easy issue to click your fingers and fix.

You may be aware that the Victorian Auditor-General tabled a report — I think it was last week; it feels like a long time ago — that also alluded to the scale of the problem. Part of the scale of the problem is we also think, even with the data that we have, that there is significant underreporting. One of the observations that the Auditor-General made — and certainly it is congruous with my anecdotal experience in terms of speaking with different parts of the Victorian health workforce — is that we have got a culture almost of, 'You just have to put up with it; that is what happens when you work in this particular workforce'. It is not acceptable, and it has incredibly awful impacts not only on people's physical wellbeing but also on their mental wellbeing. It has significant impacts on things like WorkCover premiums and the like.

It is an issue that we cannot afford to ignore. We have allocated $20 million as part of a hospital service violence prevention fund. That fund will be distributed by way of services making applications for innovations — and it might be a capital innovation or it might be a service innovation — that they can demonstrate will actually improve the occupational health and safety of their workforce. But I do not pretend that the hospital violence prevention fund in and of itself is going to eradicate this very, very difficult issue of occupational violence and aggression.

Culturally, as you alluded to, most people in the workforce are trained, professionally socialised and in fact have a legal obligation to provide a duty of care to people. The dilemma that many of them face, whether the setting is in the back of an ambulance, in public, in a health service or in an emergency department, is: what do I do when I am the subject of this behaviour? Do I put this person out on a street? Do I protect myself? What clinical risks am I then exposing the patient to? Those are all really significant dilemmas.

One of the recommendations that came out of the ice task force went to better training and supervision of people working in the drug and alcohol sector, and I am sure Minister Foley will provide you with great insight about some of the steps that are being undertaken there. But clinical oversight, as well, is important. Providing funding for supervision and training is essential. We also need stronger leadership, not just in terms of management and administration but peer-to-peer leadership around protecting people's wellbeing.

I know that out at Werribee hospital, for example, they have separate reception areas in order to deal with some challenging mental health patients — those that are coming into the ED. I know, having done an overnighter at The Alfred to get some insights firsthand as to how it manages really, really difficult clients, that part of the challenge is that upon reception in an ED many of our health services are not aware if a person is suffering from a mental health challenge, is having a psychotic ice episode or is deeply affected by alcohol. They have a range of clinical decisions that they have to make, depending upon the judgements that they make, but on the way through there is a whole host of people that are often subjected to unacceptably violent and aggressive behaviour.

That fund will go some way to helping mitigate risk. I personally am very strongly committed to trying to build a stronger sense of leadership across health services in Victoria about this issue. I will also be asking for better reporting in our health services. We have got under-reporting, we have got some transparency issues and we have got some cultural issues that are not easy to resolve. Those are all things that I am very deeply committed to progressing. But I am delighted that we have got some funds to assist with some health services that will have the capability to do something, whether it is just a small capital project or some better training and better clinical oversight, that may help in keeping our wonderful health workforce safer.

Mr T. SMITH — Minister, I refer you to budget paper 4, page 39, and the Premier's press release of 23 November 2014, titled 'Labor will build the Victorian heart hospital'. Your government has estimated it will cost between 300 and 350 million to build, to be jointly funded, with the state government contributing 150 million and project partners contributing the remainder of the total cost. Can you please confirm how much funding has been provided for this project in the budget and if there are any firm commitments yet of funding from the perceived project partners?

Ms HENNESSY — Thank you for your question, Mr Smith. Again, this is a terrific project. It will deliver the first stand-alone heart hospital in Australia. For those interested in international cardiac practice, there is a very exciting hospital about to open in Barts in the United Kingdom. Certainly some of our fantastic cardiac researchers and cardiac surgeons are very, very excited about this project. We have committed $15 million to plan and develop this very exciting facility in this budget. It is our view that this facility, when it is built, will provide the best cardiovascular care, research and training to Victoria. It is going to be about a 195-bed

stand-alone facility to be located at Monash University in Clayton, and it will treat cardiac diseases from early childhood to advanced adult life.

What we have done, Mr Smith, is we currently also have a process underway to renew and refresh Victoria's cardiac services plan and the role that the Victorian Heart Hospital will play in that plan. I am very excited about the work that is being done around how we provide cardiac services with a stand-alone heart hospital. We will commit $150 million for the Victorian Heart Hospital. That is our pre-election commitment, and we will deliver on that. In the process of the planning, we will secure our additional funding. Without wanting to disclose confidences, we know there is significant philanthropic interest. We have got significant partnership interests by a range of institutions out there, and I have got every confidence that the Victorian Heart Hospital will be built. It will be a fantastic day for cardiac services in the state.

Mr T. SMITH — Do you stand by your pre-election commitment that this hospital will be open by 2018?

Ms HENNESSY — Yes.

Mr DIMOPOULOS — Minister, my question relates to a facility not far from the one you have just described. I refer to budget paper 4, pages 39 and 42, in relation to a project that is close to my heart as the MP for Oakleigh — specifically, Monash Children's Hospital. As members would be aware, the helipad in relation to the children's hospital was an issue that was hotly contested locally, so I am really pleased to see funding in the budget. Can you outline for the committee the relationship between the reference on page 39 and the reference on page 42 under 'Existing projects' in relation to the helipad?

Ms HENNESSY — Thank you very much for your question, Mr Dimopoulos. I am very aware of the frustration that some of the residents in that area feel. I want to express my gratitude and appreciation to them for the inconvenience that they have experienced with the helicopter landing in Fregon Reserve, I know that has been a significant issue for residents, and I am very grateful for their forbearance.

I am delighted that this government has committed, I think it is, $3.8 million to ensure that we have a helipad located on the roof at Monash Children's. That has been a matter of some contest. It was taken out of the scope of the project under the previous government. I appreciate that it has been a really challenging and difficult issue in the local community because of, I suppose, the inconvenience and the noise to which they feel they have been subjected. We have taken some time to look at how we can do that to ensure that we are able to deliver this commitment. Monash are delighted with this commitment, and I am really happy that we have been able to allocate $3.8 million to make this a reality.

Mr MORRIS — Minister, if we could go back to VCCC. The budget paper reference is BP5, page 223. That reference particularly outlines the importance of the centre as part of the 2014–15 — —

Ms HENNESSY — Sorry, could you please repeat that? I did not hear Mr Morris.

Mr MORRIS — Sorry, yes. That reference outlines the importance of the centre as part of the 2014–15 investment program that is underway. I ask with regard to the 13th floor: can the government indicate to the committee, or can you indicate to the committee as the responsible minister, the annual cost of the lease of the 13th floor, and can you indicate to the committee that the full cost of the lease will be recouped under the revised arrangements that you referred to earlier?

Ms HENNESSY — Mr Morris, I obviously do not have the costings here and the state is the lessee of that space. I have got every confidence that the investment decisions that are made around that use will be money very well spent. I am unfortunately not in a position to make that announcement today because we still have some further government processes to go through, but let me assure you that with the vision of the VCCC, being incredibly important about research as well as clinical care, I think it is worth emphasising and making the point that we have a significant cancer challenge ahead of us.

When you look at the forecast around where the burden of cancer disease is going to fall, the investment in research and prevention and treatment is absolutely critical, and we will utilise the 13th floor to that end. Not to be too pessimistic about the future, but we have predictions that cancer is going increase by 43 per cent by 2024. Deaths are going to increase by 31 per cent. The number of cancer diagnoses is projected to reach about 150 000 by 2020. We have an urgency around making sure that we provide the investment and support for

cancer research and for the translation of cancer research because we are looking down the barrel of some incredibly frightening outcomes when it comes to the burden of disease. In terms of the specifics of your question, I am more than happy to take that on notice.

Mr MORRIS — And provide that information to the committee?

Ms HENNESSY — Yes, I will.

Mr MORRIS — That would be helpful, thank you. Minister, given the scrapping of Peter Mac Private at a relatively late stage, I ask: what is the total cost to the VCCC partners and to the government of scrapping those plans. Included in those costs would be the costs of the tender, the costs of the contract variations and any other costs that arose from scrapping those plans.

Ms HENNESSY — Mr Morris, I may defer to my departmental secretary, but there was no decision to scrap. Approval was not granted, just like final approval was not granted by the previous government. In any event, again I am not attempting to have a debate about the semantics of it, but the VCCC is proceeding as planned. In terms of some of the other subsets of your question, my departmental secretary may be able to provide some insights, but I think the assumptions of your question are not borne out by the facts. I respectfully say that, Mr Morris.

Mr MORRIS — We will have to disagree on that one.

Dr PHILIP — Through you, Chair, negotiations between Peter Mac and our preferred tenderer were just that: they were negotiations, always subject to the approval from government. That approval had not been provided prior to the election. It was always the case that any approvals for going ahead would be a final decision for government. So all parties were under pretty clear views that approval for the project through 2014 and into 2015 were always going to be subject to approval by government. Negotiations were only permitted between Peter Mac and a preferred tenderer under those conditions.

Mr MORRIS — The question related to costs rather than the arrangements. Are you saying, Dr Philip, that there were no costs incurred?

Dr PHILIP — I do not anticipate there being any costs associated to the government.

Dr CARLING-JENKINS — Thank you, Minister. As you said in your opening statement, there have been a lot of cuts from the federal budget which have impacted on the Victorian health budget, and this is something you also addressed in part in answer to Ms Shing's earlier question. I have a question which I ask on behalf of my fellow crossbencher who could not make it today, and it is around the health advancement section on page 246 of budget paper 3. I note that there is a line here that says:

> The lower 2015–16 target primarily reflects the cessation of the National Partnership Agreement on Preventative Health.

The question is in particular around something that was funded under this program, which was the Healthy Together Victoria program, which provided healthy eating advice and support, as you would know, in schools, workplaces and the community, including in local government areas with poor public health indicators, such as high rates of obesity, diabetes and heart disease.

Healthy Together Victoria has been recognised nationally as a flagship program and as a model example of how the state might tackle the growing obesity crisis. Over the past three years Healthy Together communities have worked directly with over 600 000 Victorians. They have apparently worked in 725 workplaces, 625 primary and secondary schools and 1265 early childhood centres in Victorian communities which were identified as being in most need. The question is this: with the government unable to provide ongoing funding for Healthy Together Victoria and the decreasing funding for health advancement in the budget, can the minister explain how her department will seek to tackle the crisis we face in the growth in obesity, preventable diabetes and heart disease?

Ms HENNESSY — Thank you very much, and that is a really terrific question. There is a reason that Healthy Together Victoria is lauded, and it is that it has had success. Often there are investments made in different health programs, and I suppose I always bring a very watchful and demanding eye around the outcomes that they produce. Because we have a shrinking pool of resources we are going to have to be very

rigorous around what we invest in, particularly not just at the acute sector but at the prevention and health promotion end as well. I know just how successful Healthy Together Victoria has been and particularly in regions it has become almost a nub of community development. I know in Ararat it has been a fantastic project. They are incredibly proud of their achievements. With that amount of money, to achieve the outcomes that they have is indeed pretty spectacular, I think.

Interestingly enough, I think it was the IP of Healthy Together Victoria that we have sold to New Zealand. There is international recognition for this program. So the funding history is a very sad and sorry one, but it is not one that I am prepared to let go yet. The very short, potted history is that the funding was going to be cut in last year's federal budget under the national partnerships agreement. Unusually, I will doff my hat to my predecessor, because he went into bat for the program.

Ms SHING — Hey, it is on the record! Do not say you never get anything from this process.

Members interjecting.

Ms HENNESSY — I do not wish to disappoint you, but it may be the only time. This is not a story that ends well though — let me adjust your expectations down.

Members interjecting.

Ms HENNESSY — But he did go into bat for the program. The then health minister, the Honourable Peter Dutton, gave undertakings, as I am advised, that the project would be continued, and so a request for tender was done for Victoria to evaluate the program and to continue its activity. That was signed off; the government changed; the federal health minister changed. I then pursued Minister Ley on this matter, both in writing and in my interpersonal engagements with her, because it is not just about the program — people's jobs are at stake here as well, particularly in local government areas where people have been funded for part-time jobs and the like. Minister Ley held out the federal budget as a potential source of hope. I do not want to put words in her mouth, but she said the matter would be dealt with in the federal budget — and of course that money has not been forthcoming. That is a matter of great disappointment to us.

We obviously have a range of health prevention activities that the department funds. I do not want to get people's hopes up around Healthy Together Victoria, but we will go back and look at what we could potentially rescope to soften the blow to see which of those programs or activities we could potentially continue, albeit in a modified form. I am very hesitant to step into spaces that we had agreements with the commonwealth government around funding, but this is a terrific program, and so for reasonably modest, in the grand scheme of things, amounts of money I want to see what can be done.

Ms SHING — Minister, I would like to take you to BP 3, page 64, if I may, and the initiative relating to proton beam therapy. Can you expand on the description included in the budget papers in relation to this specific initiative, which you also talked about in your presentation — how it works, what this will actually mean in relation to the fight against cancer in Victoria, which you have indicated will be a very significant challenge for us in terms of escalating numbers and presentations, and also any other benefits that may be associated with this therapy?

Ms HENNESSY — Thank you, Ms Shing. This is a topic very, very close to my heart — proton beam therapy and the power and possibility that it might mean for not just cancer patients in Australia but in the Asian region.

Chair, as a matter of course, I do not wish to incite the ire of committee members and I note the ruling of yesterday. I do have a handout. In terms of 'Can I publicly source it?', it is literally just a printout from the United States National Association for Proton Therapy, which is part of the Mayo Clinic. It is not politically contentious. It is a picture of what proton beam therapy looks like. I do not wish to transgress your ruling around documentation, but it is one of those health terms that can perhaps be alienating for people, and I do not want its absolute potential to be undermined by the language that is used.

Proton beam therapy is a cancer treatment and it offers really significant benefits to patients, particularly children, and we really want to explore the possibility of getting proton beam therapy in Victoria. The principle is that the treatment works differently. It splits a positively charged atom. There are tiny particles at the centre of

every atom, and the proton beam therapy splits off a hydrogen atom and those protons are accelerated to roughly two-thirds of the speed of light, and then they are beamed into the tissue where the cancer is.

If ever you are having a dull moment, can I highly recommend you look at some of the fantastic explanations and demonstrations of proton beam therapy online; they are really terrific. But essentially proton beam therapy and the research around proton beam therapy came out of, I suppose, the limitations of traditional radiation therapy, because proton beam therapy can target the diseased cancer tissue with increased precision and accuracy, producing less damage to the surrounding healthy tissues and fewer side effects. For a person who is on radiation therapy for long periods of time, there are long-term consequences of that. It is particularly valuable for children just by virtue of the size of an infant body, being able to use a proton beam to target cancer without damaging surrounding tissue. Very sadly, we have about 200 children diagnosed with cancer every year in this state, and we are really committed to seeing what other advancements in terms of treatment we can pursue.

I was really delighted last week during Parliament to see the joie de vivre around brain cancer support. Brain cancer, again, is one of those issues where using some of the traditional radiation therapies damages surrounding tissue, and proton beam therapy has significant potential for treatment around brain cancer. We want to acknowledge that this is a really important treatment, but we have to do significant planning around attracting proton beam therapy to Australia. There is currently none in Australia and there is none in Asia. We do have patients in Australia who get sent overseas to utilise proton beam therapy. That is subsidised partially by the commonwealth government, but it costs around $100 000 per patient to do that.

The other benefit of proton beam therapy is that it also provides fantastic leverage in terms of other medical research. We have a lot of clinicians in Australia who are very, very hungry to investigate the research potentials as well. I am really delighted that we have been able to make that commitment. As I said, there are currently no facilities in the Asian region, and we want to be able to bring together experts, many of whom currently travel overseas to utilise protein beam therapy for the purposes of bringing that to Australia. Whilst our motivation is indeed a health one, I do not underestimate the economic benefits of this. Obviously medical research is a really significant and growing part of not just the Australian economy but particularly the Victorian economy, and there will be significant economic benefits that I hope will be canvassed effectively through the planning process.

So if we are able to significantly progress this, it would be a terrific advancement in the fight against cancer and in providing better treatments for patients. It would attract the wonderful clinicians and researchers not just in Australia but also from overseas, particularly in the ASEAN region. Singapore is one of our great competitors when it comes to medical research. They are not using proton beam therapy yet. Oxford University has recently made a significant investment in this area as well. Oxford is also famous for having many fantastic Australian researchers there. We want to attract them back, and I am delighted that we have been able to make an allocation of some money to pursue this proton beam therapy investment. Again, I encourage you to, as part of your PAEC decompression process, perhaps at the end of the night, have a look. It is really exciting.

Ms WARD — We could have a movie night, David.

Ms SHING — I look forward to us all being able to get together to read about proton beam therapy.

Ms HENNESSY — I am suspecting cynicism here — not at all.

Members interjecting.

Mr D. O'BRIEN — We are not cynical at all, Minister. Just to again share with the committee, I just had an email noting that it is World Continence Week this week. It is appropriate that we have the minister here so that we could discuss that. That is something that I did not know we had a week of. Anyway, back to the question.

Minister, the rural and regional budget information paper has a map on pages 2 and 3, and under that map it highlights the key capital investments in rural and regional Victoria. The health ones are indicated by a little white cross in a blue circle. My question is: there is one little white cross in a blue circle representing Ballarat. Why is there only one rural and regional investment for health capital?

Ms HENNESSY — Thank you very much for your question. I will just get my papers organised.

The CHAIR — Which document is it, Danny?

Mr D. O'BRIEN — The rural and regional budget information paper. There is 10 million for the Ballarat cardiovascular thing.

Ms HENNESSY — Yes, there is.

Mr D. O'BRIEN — But there is nothing else; that is the question.

Ms HENNESSY — There is a $10 million commitment to the Ballarat hospital cardiac cath. lab. We think that is a terrific investment. The burden of cardiovascular disease in that particular region is the highest in Victoria. I cannot speak to who put what dots on which map there at all, Mr O'Brien, but I can tell you we have also committed $1 million to advance planning for the Goulburn Valley health service; $200 million in our Hospital Beds Rescue Fund — some of that will open new beds, significantly, in a lot of rural and regional locations; and obviously we are investing significant resources in our ambulance portfolio. I am always honoured and delighted to go to rural and regional health services, and particularly some of the smaller ones. I understand that often they are not just a health service; they are an important source of employment. They are often the important generator of community development and community programs as well. I look forward in future budgets to continuing to invest in both rural and regional health. Rural and regional health services will also benefit from our uplift in investment. But in terms of capital, in our first budget our focus has obviously been predominantly on our election commitments, and in future budgets I will look forward to investing in rural and regional health, let me assure you.

Mr D. O'BRIEN — Thank you, Minister. Perhaps that explains why there is not much, if it is on the election commitments. My follow-up question is related to the budget overview document. Page 7 lists the hospital capital spend, the $560 million. I wonder if you could outline to the committee what percentage of that goes to rural and regional hospitals?

Ms HENNESSY — I have not disaggregated that, Mr O'Brien, so I am not in a position to do that.

Mr D. O'BRIEN — I can help and say it is 1.7 per cent. If we add the Goulburn Valley, and I will be generous, it is still 1.9 per cent.

Ms HENNESSY — I do not contest your mathematical abilities at all, but certainly some of our beds rescue fund also goes to supporting rural and regional services; in fact many of them do. I would prefer the opportunity myself to make those calculations. But I do not walk away from my commitment, Mr O'Brien. I understand that capital right across the state in some of our health services is under particular challenge, and often the great dilemma is: capital or investment in the provision of services. We need to do both. We have inherited a really difficult environment. We are facing $17.7 billion cuts down. That does not mean that the people of regional and rural Victoria do not deserve levels of investment and support, and I certainly look forward in future years to be able to deliver that.

Mr D. O'BRIEN — I hope so.

Ms WARD — Minister, you have spoken at length on Sunshine Hospital and on the Northern Hospital, which have been fantastic investments, but I also would not mind if you could go to budget paper 4, page 39, and outline the $85 million investment in the new critical care unit at Werribee Mercy Hospital, what that will deliver and what it means for the amazing number of people who are moving into that area?

Ms HENNESSY — Thank you, Ms Ward. Again, I am very delighted about this announcement to commit $85 million across the Werribee Mercy Hospital. I have talked at length today — and I will not subject you to it again — about the growth in the western suburbs. I know in the city of Wyndham we are almost at 80 babies a week, so that is a lot of births and all of the on-flow in terms of infrastructure. Health care is critically important there.

The 85 million is part of our $560 million capital investment. What that particular investment will do is it will provide six additional operating theatres and support services, and 64 new inpatient beds, including 8 beds for a new critical care unit. Presently the great challenge around not having critical care facilities is that if a patient becomes unwell, they need to be transferred. They have either got to be transferred then into Sunshine or then

into town. Similarly there are great problems for those who are coming from down towards the Barwon region. Having critical care means that we can keep those patients there. It also reduces demand on things like ambulance transfers that put the pressure on our paramedic services as well.

This will completely open up the model of care that we are able to deliver out at the Werribee Mercy. It will also take significant weight off some of the other health services to which critical care patients get diverted. As I said, some of those in that catchment go from Barwon to Sunshine and into many of our tertiary hospitals in town. So reducing the demand in that area will be incredibly important. Werribee has also been the beneficiary of some funding from the $200 million beds rescue package, and that will also open up eight new acute inpatient beds, and that will treat another 925 patients per year.

One of the other really important issues is many of the clinicians who work at Werribee Mercy find it so frustrating to watch a patient they have been caring for deteriorate and to not be able to care for that patient there, even though they have got the workforce. The critical care unit is absolutely essential. Obviously many of these big hospitals in our growth areas and in what others term 'periurban' areas are critical sources of employment as well. They reduce the need for people to travel great long distances in order to get good-quality jobs. That will also be really significant in terms of providing employment opportunities for both the health and allied workforce in that area. They are delighted. I was there with the Premier last week, and I know this is not entirely on point, Chair, and the sight of politicians associating with babies is clichéd and predictable, but we met the cutest baby there last week on our whistlestop tour. It is one of the great delights of being the health minister, being able to meet — —

Ms SHING — You have just caused the ire of every other mother whose child you may have perhaps met earlier.

Ms HENNESSY — No, no, I walk very fast, Ms Shing! This was a six-month-old who was wearing a *Top Gun* T-shirt. He was particularly delightful and has impressed himself upon me.

Ms WARD — A six-month-old Tom Cruise.

Ms HENNESSY — Okay, this is now veering dangerously, Chair.

Mr D. O'BRIEN — Yes, digging a hole.

Ms HENNESSY — So I will conclude my answer. But we are really delighted, and the Mercy is really delighted. It was Sr Helen, for those of you who are familiar with the Mercy hospital right across the state. It was terrific to see her there, and the delight that community has about that commitment is something that I am very proud of.

Mr T. SMITH — Minister, I refer you to budget paper 3, page 63, as well as your press release from 5 May, titled 'Hospital beds to open with $200 million rescue fund'. Your $200 million bed rescue fund has opened 101 points of care, largely beds. In what time frame do you commit to open the other 1335 beds Dr Travis identified in his review?

Ms HENNESSY — Thank you, Mr Smith, for your question, and of course the context of Dr Travis's review is really important. The context was — and again I do not wish to conflate the right-hand representatives of PAEC with the previous government all of the time, and I do not come here to try to be deliberately provocative at all — that there were 800 promised beds that were not delivered by the previous government.

Ms WARD — Eight hundred? For four years of — —

The CHAIR — Order!

Ms HENNESSY — And this was not a fishing expedition. We sincerely wanted Dr Travis to go out and tell us where there was capacity but also potentially where there was demand. So, for example, in some areas of Victoria there is capacity but not demand and in some other areas there is demand but there is not capacity. Dr Travis makes a range of really significant points in his report, and that is probably the clearest one he makes — that governments have an obligation in terms of investment. Again, with a billion dollars taken out of the Victorian health system and $17.5 million of cuts coming, we have got some really significant challenges ahead of us.

Mr MORRIS — On a point of order, without wishing to raise the temperature any further than the minister has already done, the question was pretty clearly about the time frame for opening a further 1335 beds. It was not about a history lesson or the rewriting of history. That aside, if we could have an answer to the time frame, it would assist certainly the members on this side of the room.

Ms SHING — On the point of order, I think the minister is providing a valuable context and relevance for the Travis review and what that has led to, and I think the history of the predecessor government is directly on point in relation to the shortfall we are currently facing.

Mr MORRIS — Tempting as it is to use that as an opportunity to engage in debate, I will simply seek an answer.

The CHAIR — I think what the minister is doing is trying to set some context. The question was asked at 11.44; we are now at 11.46, so I think the minister was trying to put the question within some context. But I am conscious of time, and I ask the minister now to look at addressing the question that was asked by Mr Smith.

Ms HENNESSY — Dr Travis has made a recommendation around a state health services plan being developed, and that is critical because the point is that in some areas where there is capacity there is no demand and there are other areas where there is demand but no capacity, and so there is a mismatch between those two things.

As a government our record speaks for itself in terms of our investment in health, and this budget demonstrates that, and we will continue to invest. But our investments need to match where there is demand, and Dr Travis clearly identified a mismatch between those things. We will continue to invest in health services while we deal with the very difficult environment we have inherited and the one coming federally, but we will also be guided by future work around a state health services plan that will make sure we match. It is not just a matter of beds and funding; we have got capital issues that colleagues have canvassed, we have workforce issues in certain parts of Victoria. We have actually got to plan these things properly. They need to be invested in, and that is what this government will do.

Mr T. SMITH — We seek an answer to the question, with respect.

The CHAIR — What I heard the minister say was that she was providing some background and context and she indicated that there is an additional outlay that has been identified in this year's budget but that further work will be done to inform a future allocation. That was my understanding of what the minister was seeking to do in answering your question. But you have a supplementary question.

Mr T. SMITH — I do have a supplementary, but on a point of order we were seeking a specific time frame for these new beds.

Ms HENNESSY — They are not all new beds.

Mr T. SMITH — Other beds.

Mr MORRIS — The reopening of the 1335.

The CHAIR — I think the minister is giving you some background and context in terms of providing an answer to the question you have asked.

Mr MORRIS — But no answer.

Ms SHING — We are still looking for your 800.

Mr T. SMITH — I have let the minister provide that context, and I am now seeking the time frame.

Mr MORRIS — Perhaps some time in the future we will get the answer.

The CHAIR — Does the minister wish to elaborate further on the answer she has provided?

Ms HENNESSY — I have answered the question. We have made an enormous investment in health care in this budget. Our record speaks for itself. We will continue to make those investments. But I do not want to

mislead the committee, nor do I want the committee to miss the very central point that Dr Travis makes, which is that demand and capacity and capability are currently mismatched in this state, and in order to have a quality health service that needs to be addressed.

Mr T. SMITH — On 5 May you said you had adopted in full Dr Travis's recommendations about how the 200 million bed rescue fund could be allocated. Do you commit to support all the other 14 recommendations he made in his report, which you released in April this year?

Ms HENNESSY — Yes.

Mr T. SMITH — All 14?

Ms HENNESSY — We have indicated that we support all of Dr Travis's recommendations.

Mr MORRIS — Support and implementation are two different things.

Ms SHING — Asked and answered already.

Mr DIMOPOULOS — Minister, I have been reading these budget documents, obviously, more so because I am on this committee; it was a broader reading than what I would normally have done as a parochial state MP.

Ms Shing interjected.

Mr DIMOPOULOS — It is fascinating. I came across the Aikenhead Centre for Medical Discovery. You also referenced it in your opening remarks. It is in BP3, page 109. But specifically my question is around why the funding is held in contingency listed under 'Outstanding capital commitments' on that page. Can you explain a bit more about that and also what you expect the project will deliver?

Ms HENNESSY — Thank you. Again, this is another terrific project, and the leadership of St Vincent's, both in this state and nationally, on Aikenhead is something we should all feel very proud of. Before the last election, Mr Dimopoulos, we made a commitment to the Aikenhead medical discovery centre. It is essentially around biomedical engineering, and I will talk you through that, if that is your wish, in a moment. But it is poised to begin. It is a shovel-ready project. Our $60 million we have put in capital contingency — BP3 109, as you have referenced — and $60 million is also required from the federal government for that project. The other project partners' money is almost fully raised. Both I and St Vincent's have lobbied and advocated to the federal government around this project. We see it important in terms of not just the medical research agenda but also employment capability. They will be taking down the corner of Victoria Street and Rathdowne Street very shortly, and it is a fantastic project. Essentially it provides a great opportunity. Biomedical engineering is essentially about medical devices in a sense, and the medical device industry is a really critical and important part of our economy.

This would be the first biomedical engineering research centre. We know the wonderful history we have in this state around the cochlear implant. Medical device companies are a significant part of our economy. We have got a good export story to tell on this front. So this is a really significant project for not just our economy but for the future of actually improving things like prostheses and all of the other wonderful things that biomedical engineering delivers.

We are very strongly committed to this project. Our 60 million is in contingency. I have obviously not had an opportunity to work through the federal budget to see whether or not that 60 million is in there. I certainly met with federal minister Sussan Ley about this matter, and I know St Vincent's have as well. I do not want to unequivocally say the federal government has let us down, because the money may in fact be in there; I certainly hope it is. This is a fantastic project, and, if the money is there, we will look forward to getting on with that as soon as possible.

Mr MORRIS — On a point of order, Chair, I refer to the minister's response to the question from Mr O'Brien about regional Victoria. When Mr O'Brien politely interjected some figures, the minister indicated that she preferred to do her own calculations. Can I ask that those calculations be done and that that information be provided to the committee on notice?

Ms SHING — On the point of order, Chair, again, I think the minister was responding to Mr O'Brien's assertion that those figures were to be taken as gospel, and I think the minister was actually indicating that she would prefer not to be verballed and would rather rely upon her own information, having that available to her. There was no further request at the time the question was asked. On that basis, I think that holding her to the letter of that ignores the spirit in which that comment was delivered.

Mr MORRIS — The minister can always decline to provide information on notice, but I am simply asking for it.

The CHAIR — Would the minister be prepared to provide that information on notice?

Ms HENNESSY — I am more than happy to come back to the committee on that, Chair.

Mr MORRIS — Minister, when I first entered the Parliament I finished up on the Drugs and Crime Prevention Committee, and I say finished up because I really had not much part in getting myself there. But nevertheless because part 1 occurred in the previous Parliament, I found myself embroiled in part 2 of a review of the abuse of particularly prescription drugs and the need for prescription monitoring. Budget paper 3, page 64, refers to 'Real-time prescription monitoring' and provides a sum of only $300 000 for what is beyond doubt a potentially life-saving reform. Do you commit to implementing real-time prescription monitoring, and, if so, what is the intended time frame?

Ms HENNESSY — Thank you, Mr Morris. I too am very concerned about prescription-related deaths, and, as a follower of this issue, you would be aware that over the last years there has been coronial recommendation after coronial recommendation after coronial recommendation around this very issue, so I do not disagree with you around its import at all.

Upon coming to government I had a look at what steps needed to be taken in order to progress real-time prescription monitoring. Again, some of last night's announcements may shift this, and so if I can just reserve my rights as I do not intentionally want to mislead the committee. But upon coming to office, I think Victoria was the only state that had not signed up to the electronic recording and reporting of controlled drugs system, which is called the ERRCD system, and that is the national platform around this issue. That work had not been done. I signed on to that platform just recently, but, as I said, there were some announcements in this space last night by the commonwealth government, so that may in fact progress things indeed. The purpose of having national cooperation on this issue is really self-evident in a sense, but that is the platform. The $300 000 is around getting some planning going on that. It may be that we can expedite that subject according to the details of what was in last night's commonwealth budget. It is a matter of big concern, but it is not something that I can come into government, snap my fingers and have in operation.

Mr MORRIS — I understand that the pharmacy guild is advocating for real-time monitoring for some non-schedule 8 drugs. Codeine is one that has been mentioned. The planning that will proceed this year, is that intended to be restricted to prescription pharmaceuticals or will it go broader than that?

Ms HENNESSY — More broadly. I am going to have to defer to one of my departmental representatives, because more broadly there is some discussion and debate around the classifications of various scheduled drugs and the prescription regulation that flows from it. I cannot off the top of my head, Mr Morris, remember if codeine is included. If one of my departmental representatives is unable to provide you with that clarity here today, I am more than happy to take that on notice and report back to the committee about it. We will take that on notice.

The CHAIR — I am conscious of the time. We are due to wrap up in about 46 seconds and then we have a 15-minute break, so I would like to thank the witnesses for their attendance today: the Minister for Health, the Honourable Jill Hennessy; Dr Pradeep Philip, Mr Lance Wallace, Ms Frances Diver and Professor Chris Brook.

In relation to questions on notice, I think there was a question around reprioritisation of funding that was asked by Mr Smith, there was a question about the breakdown of the allocation for super pharmacies, there was a question in relation to the lease costs for the 13th floor, there was a question on notice in relation to the breakdown of capital investment in regional and rural Victoria, and now there is a question on notice in relation to prescription drugs. The committee will write to the witnesses shortly and ask that if that information is available readily, that it be provided within 21 business days of the request being received. Obviously some of

those matters might take a little bit longer, so when they become available, if they could be provided to the committee, that would be great. I declare this session closed.

Witnesses withdrew.