T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Budget Estimates 2018–19

Melbourne — 17 May 2018

Members

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

Witnesses

Ms Jill Hennessy, Minister for Health,

Ms Kym Peake, Secretary,

Mr Terry Symonds, Deputy Secretary, Health and Wellbeing,

Mr Nick Foa, Deputy Secretary, Housing, Infrastructure, Sport and Recreation,

Ms Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management,

Ms Anne Congleton, Deputy Secretary, Community Participation, Health and Wellbeing,

Mr Greg Stenton, Chief Finance Officer, Corporate Services,

Dr Margaret Grigg, Executive Director, Health Service Policy and Commissioning,

Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, and

Mr Robert Fiske, Chief Executive Officer, Victorian Health and Human Services Building Authority, Department of Health and Human Services.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2018–19 budget estimates.

All mobile telephones should now be turned to silent.

I would like to welcome the Minister for Health, the Honourable Jill Hennessy, MP; Ms Kym Peake, Secretary of the Department of Health and Human Services, Mr Terry Symonds, Deputy Secretary, Health and Wellbeing; Mr Nick Foa, Deputy Secretary, Housing, Infrastructure, Sport and Recreation; and Mr Greg Stenton, Chief Finance Officer, Corporate Services. In the gallery are Dr Margaret Grigg, Executive Director, Health Service Policy and Commissioning; Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management; Anne Congleton, Deputy Secretary, Community Participation, Health and Wellbeing; Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria; and Robert Fiske, Chief Executive Officer, Victorian Health and Human Services Building Authority.

Any witness who is called from the gallery during this hearing must clearly state their name, position and relevant department for the record.

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, any PowerPoint presentations and handouts will be placed on the committee's website as soon as possible.

Witness advisers may approach the table during the hearing to provide information to the 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 must remain focused on the persons speaking. Any filming or 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. And by way of background, we will be breaking at 11.12 a.m. for a 10-minute break. Minister.

Ms HENNESSY — Thank you very much, Chair, and good morning to all of the PAEC committee members. By way of overview of the 2018–2019 Victorian budget, this is a fantastic budget for health. There is $1.2 billion in capital expenditure funding for hospital redevelopments — which I will go through — upgrades and expansions right across metropolitan Melbourne and regional Victoria. The budget also allocates $2.1 billion and that essentially supports the 1.96 million patients that we expect to be admitted to our hospitals over the course of the budget year and the 1.84 million patients that will be seen in our emergency departments this year. The budget also includes $24.3 million investment essentially in the areas of prevention, in recognition of our need to create healthier communities. Essentially our investments will mean that we are able to upgrade our hospitals and that we are able to undertake important infrastructure work, purchase better equipment and provide better and faster care for Victorians.

If I just now go to the acute health budget output there, in this you will see the history of investment in the acute health budget output, and the investment in 17–18 represents a 7.5 per cent increase on the funding provided in the 16–17 budget, which was also an additional 10.5 per cent on the 2015–16 budget. So you will see a significant increase in the acute health budget output growth there. By way of comparison, that represents over the last four budgets a 37.3 per cent increase on acute health expenditure.

We go to strengthening access to public health services. Essentially there is a $2.04 billion package for hospitals in this year's budget build on our commitment of $1.67 billion in additional funding that was made available last year. With this funding, essentially more than 207 000 Victorians will be able to get surgery with an

additional $217.6 million elective surgery boost. That is the biggest elective surgery boost in Victorian history, which is part of the $36.2 million package over four years, which is essentially targeted at cutting wait times and waiting lists. That is the equivalent of 14 370 hip replacements. Obviously they are not all going to be spent on those, but in terms of scale that is an incredibly significant investment.

There is a $50 million winter blitz package. That is to support Victorian hospitals to open more beds, to hire more doctors and nurses, to treat more patients this winter following one of the worst flu seasons on record. Twenty-five million dollars has been provided for the better care innovation fund over the next two years to grow innovation and the capacity of our hospitals; and $6.5 million is being delivered to support the implementation of the voluntary assisted dying reforms in Victoria. Also $2.1 million will be spent on more rural and regional patients to access transport through the Victorian Patient Transport Assistance Scheme as well.

We go to creating healthy communities. Chair, could I just ask if there is a time clock available? No? You will just give us the indication?

Ms SHING — The Chair is the time clock.

The CHAIR — Yes.

Ms HENNESSY — Fantastic. This year we are investing $10 million for the Olivia Newton-John Cancer Wellness and Research Centre to establish a centre of research excellence. That funding will also assist with the infrastructure and support researchers that need that additional investment to continue the groundbreaking work that they are doing in the cancer space.

There is $6.1 million to support the influenza vaccination program and $5.5 million to deliver a Healthy Heart Initiative in the Loddon Campaspe Regional Partnership area and a prevention lab for the Central Highlands Regional Partnership area, which will support key health prevention projects.

The budget also invests $2.1 million to support research into rare and hard-to-treat illnesses — so, for example, bone marrow failure. There is research investment via the Maddie Riewoldt's Vision organisation; and $700 000 to support child and youth vaccination to offer meningococcal ACWY vaccine to all year 10s and 15-year-olds not at school during the 2018 school year.

The next slide is essentially an overview of the investments in regional Victoria: a $1.2 billion investment in health infrastructure. Half of that funding, $627 million, is being allocated specifically to rural and regional hospital redevelopments. In particular there is a $461.6 million investment to redevelop the Ballarat Base Hospital. There is $115 million to expand Wonthaggi Hospital, again an important project that will deliver 345 jobs as well during construction, and a $50 million boost to the Regional Health Infrastructure Fund, taking that fund to the largest ever Regional Health Infrastructure Fund of $250 million. In essence that means that over the past four years our state government has provided $1.062 billion to regional-specific capital projects. Indeed funding for rural and regional hospitals has risen by over 35 per cent over the past four years.

If we could go to the next slide: this budget is also delivering $396 million for Australia's first standalone heart hospital. It is supporting a $123.8 million electronic medical records project across the Royal Melbourne, Peter Mac and Royal Women's hospitals, and that will absolutely help save lives and contribute to medical research. There is a $72 million investment to deliver key technology, medical equipment and infrastructure programs so that our clinicians are supported with the kind of infrastructure and equipment that they need to do their work; $69.5 million for infrastructure upgrades at the Alfred hospital; and $29.6 million for an expansion and reconfiguration of Sunshine Hospital's emergency department, which will create a separate space for children and their families and absolutely help make an important investment in an area that is under the pressures of incredible growth in demand. The budget has also set aside funding — obviously we have not disclosed the figure in the budget papers — to purchase land for the future new Footscray hospital as well.

Chair, if I could take you to the slides, you can see on the slides — perhaps you will more easily be able to see on the document in front of you given how small that writing is there — that absolutely investing in health has been a very strong priority of our government since day one. We have made a massive investment in hospital upgrades and equipment to support all of our hardworking health workforce do what they do so well. As the

map shows, there has been $1.2 billion in capital expenditure that will be invested in hospital expansions, improvements and rebuilds right across the state.

If I could take you to the next slide, Chair, the final two maps demonstrate our very demonstrable commitment over the past four years when it comes to infrastructure. Aside from the major capital investments that we have made in health in the 2018 and 2019 budget, over the past three years we have committed considerable funds, including to the Joan Kirner Women's and Children's Hospital, the Casey Hospital expansion, the Werribee Mercy Hospital expansion, ambulance station upgrades, vehicles and equipment of $40 million, the Goulburn Valley Health redevelopment, the Regional Health Infrastructure Fund, the Northern Hospital expansion, the Monash Medical Centre expansion and upgrade and the Royal Melbourne Hospital critical infrastructure works. So there has been a very strong investment in hospital upgrades, and overall our investment in health and ambulance infrastructure over the past four years has been $3.2 billion. That compares to the four years before of $1.6 billion, so we have almost doubled the investment in four years compared to the four years prior to taking office.

The final slide simply provides some more legends to demonstrate and outline where those investments have been. This has been a really important budget not just to continue to invest in the very important operational demands of our health services and our health system but to make important investments in the area of health and medical research and in the important area of equipment that is, because of changes in technology, becoming increasingly more important in our health system. But when it comes to capital this is a very, very significant budget with a very significant capital investment that is not only good for the rebuild of hospitals but fantastic for the generation of construction jobs during the build and fantastic for the purposes of generating health-related jobs once the build has been completed — and obviously health and community services is one of the fastest growing areas of the economy.

With that overview, Chair, I might now move on to questions.

The CHAIR — Thank you, Minister. You would be pleased to know that was 10 minutes precisely. Minister, the budget paper reference is budget paper 3, page 229. My question relates to the health complaints commissioner. Are you able to outline to the committee the work that that the health complaints commissioner is doing in terms of promoting quality and safety?

Ms HENNESSY — Yes, I am. Thank you very much for your question, Chair. The health complaints commissioner was established by way of legislation through Parliament in 2016. Essentially the genesis or the need for the establishment of new powers of the health complaints commissioner was that we found that we had many areas of potential health regulation falling between the cracks of health law and consumer law and examples where we had practitioners that were not necessarily regulated through the national law, which is the foundational regulatory place for registered health practitioners. So those particular powers were expanded through legislation for the health complaints commissioner that took effect in 2017. Since that time we have seen three prohibition orders laid against three practitioners and proceedings against one. Of these two were for cosmetic services — that is a growing area of interest for us — one was a massage therapist and the fourth was a drug and alcohol counsellor. There was a drug and alcohol counsellor that was convicted just in April this year in respect of the drug and alcohol counselling services that were being provided. Those services were in breach of a ban that had been put in place in South Australia. That provider had picked up shop, moved to Victoria essentially and, in breach of that ban, had started to provide services. He has been ordered to pay a fine of $10 000 and $4000 compensation to that complainant.

Importantly the health complaints commissioner has the powers to take action in respect of health services, and that is reasonably broadly defined — services that are intended or claimed to assess, predict, maintain or improve a person's physical, mental or psychological health or status are captured by their powers — which cause harm. That means essentially that the health complaints commissioner can take enforcement action essentially regarding harmful health services that were previously unregulated or subject to extremely light oversight.

A very compelling example of that that previously has not really been the subject of significant regulatory interest has been in the field of gay conversion therapy. Certainly both the health complaints commissioner and I have been the subject of a range of largely anonymous correspondence from people that have been, in my view, deeply harmed and hurt by their experiences. So with that in mind we have asked the health complaints commissioner to undertake an investigation. It is a really difficult issue for people to talk about, and providing a

platform for them to be able to talk about their experiences as well has been something that we have been asked to do by those that have been in touch with both myself and the health complaints commissioner. We know that some of the proponents of those practices continue to cause harm, particularly to the LGBTI community, and we have secured some additional staffing resources from the Department of Health and Human Services to provide to the health complaints commissioner in order for her to conduct that inquiry. We look forward to seeing what is established in that space.

It is also important to emphasise the health complaints commissioner does not often operate independently. The commissioner operates along with other health agencies. There are certain powers that the Department of Health and Human Services has. As I said, AHPRA, the national regulator, has certain powers, and an important part of the reforms that we put in place was enabling those organisations in order to share information and to work collaboratively and cooperatively.

As I said, one of the areas of strong interest for us is in the so-called 'cosmetic appearance industry'. That has traditionally been under-regulated, and, as I said, one of the geneses for these reforms was that ordinarily someone might not be a registered health practitioner but is providing a particular service, so you could not complain against them under the national law because there was no jurisdiction there. They sometimes would go to consumer affairs to kind of argue that it was misleading and deceptive conduct, or services that were not fit for purpose, but did not often get to the nub of the health issue or the particular danger or damage that offering therapeutic services that are not therapeutic services can have. But we have seen some very concerning cases of people that have been providing treatments in the cosmetic appearance industry that they are not properly qualified or not properly authorised to perform.

We have seen in New South Wales, for example, a death at a cosmetic clinic. In New South Wales of course some of the imports that are made of products that purport to be Botox and other kind of similar products are not in fact that, so that is a very strong area of our focus. Also, we are very keen to continue to try and take swift enforcement action. We again changed the law in 2017 so that all facilities where surgery or general anaesthesia take place are regulated, and they are held to the same standard from a regulatory perspective and a reporting perspective as procedures that might occur in a private or public hospital. So that means that smaller cosmetic clinics which provide surgery will be held to the same standard. Those regulations spelling out those details are going to come into force on 1 July.

So the health complaints commissioner was essentially part of the suite of reforms that we put in place, and there is a growing area. Unfortunately there are many people who hold out the false promise of a whole range of treatments, whether that is about how you look, and particularly in the cancer space we have seen a lot of rogue operators as well. Those people are very firmly on the radar and there are a number of active investigations underway.

The CHAIR — Are you seeing cultural change occurring as a consequence of the work of the commissioner, in terms of across the provision of health services in Victoria?

Ms HENNESSY — Look, I think so. It is probably a little bit early to tell and I think there is great room for improvement. But what we do notice — and this is just the nature of regulation — is when you regulate an area or government leans into an area, you will see the rogue element of that industry reform, so offering services that are known to be unregulated or being performed by unauthorised people. It is not that people do not hang the shingle on their door or advertise in the *White Pages* anymore; it is about actively scanning social media platforms to identify where people might be purporting to provide health services that are in fact very dangerous. That was our experience around solariums as well. People would try and avoid and evade the laws. Rather than it being for money and it therefore being a commercial transaction it would be 'for 25 bottles of wine you can come and use my backyard solarium', so we have just got to keep responding to the ways in which people are trying to avoid the regulation, whilst at the same time having a sensible approach to regulation as well. Fundamentally it is very difficult to regulate for common sense, so we use those other platforms available to us about the dangers of some of those procedures, and the old adage of 'if it sounds too good to be true it probably is'.

The CHAIR — Excellent. Thank you very much, Minister. I was going to ask you another question about colonoscopies. I note the investment that was made in the budget, but in the interests of time I might hand over to the opposition and we will come back to that.

Mr D. O'BRIEN — Good morning, Minister. I would like to start on the heart hospital if I could, which you referred to. Ahead of coming to government in 2014 the current government said they would contribute $150 million to the project and project partners would contribute the remainder of the 350 million total cost. In June 2015 you said you were going to work with the philanthropic community and the private sector and other researchers to raise the additional funds. Why have you not been able to raise any additional funds for this project?

Ms HENNESSY — Essentially, Mr O'Brien, we committed to the delivery of the heart hospital for all of the very obvious reasons. Cardiovascular disease is the biggest killer in our country. We were obviously keen to try and attract some commonwealth funding, and we have not been able to do that. It is a matter of great frustration for our capital program that less than 0.3 per cent of the commonwealth capital contribution has been dedicated to Victoria. We have done some significant work with our project partners, both Monash Health and Monash University, and part of an important piece of that work was the economic analysis that was done by Monash University that also demonstrated that the Victorian Heart Hospital would generate over $400 million of additional activity.

In essence we decided we wanted to get on with the project, and that is why we have made the additional funding allocation in this year's budget so that we can get on with the project. The nature of the design of the heart hospital is such that it has been designed so that in future years, should there be additional investment attracted, there is the capacity for extension and expansion. There is always ongoing discussion and deliberation, as there continues to be, with, for example, the philanthropic sector. People make their contribution in a range of ways — sometimes that is about equipment, sometimes it will be around medical research that is being done there. But essentially we made the decision that it was of such economic and health importance that we have made the additional investment in this year's budget.

Mr D. O'BRIEN — The principle is I am sure sound, Minister, but I guess the question is really: why is no-one else wanting to come on board with this — whether it is the commonwealth or any other partners?

Ms HENNESSY — I would love an answer to that question from the commonwealth government. As I said, it is really a nation-building project. I know that that is a cute word that is thrown around — Mr Morris is giving me the eye — and it is a very utopian word. In terms of the great heart hospitals of the world — Texas heart, Barts in London — it is absolutely an essential project for the purposes of not just cardiac care, but medical research and medical devices with a really significant economic impact where there is a national employment cluster out at Monash University. We would have loved to have attracted commonwealth funding, but we have not been successful.

Mr D. O'BRIEN — You talked, Minister, though, about philanthropic and research institutes and the like. Why are they not interested in this?

Ms HENNESSY — We are continuing to talk to those research institutes. Often that philanthropic funding comes in the form of not a capital investment but an equipment investment as well. That is often the nature of the way in which philanthropy makes a contribution. We have simply made a decision as a government that the heart hospital is such an important project that we are putting in the additional money to make it happen and to make it happen sooner rather than later.

Mr D. O'BRIEN — Secretary, I might just ask you: the minister stated in December last year that:

> Project partners are leading an ambitious fundraising campaign to support this.

Since that statement was made and the government committed to fully taxpayer funding the hospital, have any additional funding partners been identified and signed on, and if so how much?

Ms PEAKE — Certainly the feedback that I have had particularly from Monash University is that the government commitment to this project is a critical precondition for the attraction of that sort of partner input. Of course in terms of partners, there have been contributions from both Monash University and Monash Health. Monash University has itself contributed I think in the order of $44 million and Monash Health around $12 million. They now have the basis for those further discussions with research institutes and other philanthropic partners for what they might be interested in contributing to the project.

Mr D. O'BRIEN — When were those commitments made by Monash uni and Monash Health?

Ms PEAKE — In terms of Monash University, I think we covered some of this in the hearing in February around the contributions that Monash University was making, which includes in-kind support in terms of the land as well as other input. I do not have a specific date in front of me, Mr O'Brien. I am more than happy to provide that.

Mr D. O'BRIEN — Since December, though, have there been any other contributors?

Ms PEAKE — As I have just indicated, the feedback, particularly in my discussions with Monash University, was that the announcements in the budget were critical for them to be able to pursue those conversations.

Mr D. O'BRIEN — So no is the answer I take it, Ms Peake?

Ms HENNESSY — There are a number of active philanthropic conversations occurring, and of course people do not necessarily like putting those — in terms of giving you a straight answer to your question, this is a government-Monash Health-Monash uni investment at the moment, and the philanthropic conversations look very promising in the same way that we saw —

Mr D. O'BRIEN — That is fine, Minister. The question was whether any had come on board since December, and the answer is no. Secretary, can I just ask about the fundraising campaign that was referenced earlier. What has been spent on that by the department?

Ms PEAKE — Sorry, the fundraising? We have not contributed to a fundraising campaign. There has been work that has been done, as I mentioned, by Monash University. They released a prospectus that, as the minister has indicated, identified the broader economic benefits of the project as well as the health benefits, and they are continuing those discussions with potential partners.

Mr D. O'BRIEN — Can I continue, Secretary — how many private beds will there be in the 195-bed heart hospital?

Ms PEAKE — Certainly the partnership that Monash Health has with its own private partner is part of this project, but I might just ask Mr Symonds or Mr Foa to step through the actual breakdown of those 195 beds.

Mr FOA — The new hospital will contain 195 beds, which will do 2000 cardiac surgeries, 13 500 cardiac cath lab procedures a year and 108 000 consultations. It will also significantly host 300 undergraduate students, 260 postgraduate students and 20 PhD students. In terms of the additional scope that has been brought forward in this project, there are an additional three operating theatres and one procedure room that will do 2000 cardiac surgeries a year, and the cardiac diagnostic facility with imaging equipment will have another 4000 MRI scans annually. Additionally, it has got a helipad, 6000 square metres for Monash University and 600 underground car parks. The Jessie McPherson centre that is operating is the private hospital element of Monash Health, and Monash Health are going through their clinical plan at the moment about how many of those beds will move across.

Mr D. O'BRIEN — So it is 195 public beds, secretary?

Ms PEAKE — The project is for 195 beds. I am happy to take the question on notice and provide what information is possible, but, as Mr Foa has indicated, the work on the actual service planning is underway currently, so it will be a period of time before we can provide a fulsome answer to your question.

Mr D. O'BRIEN — So we are confirming that there are going to be private beds in the hospital?

Ms PEAKE — It has always been part of this project that Jessie Mc is part of the project.

Mr D. O'BRIEN — Mr Foa, you just mentioned the helipad. The helipad is part of the project?

Mr FOA — Yes, that is correct.

Mr D. O'BRIEN — Do you have a breakdown of the cost of the helipad?

Mr FOA — No, I have not got that with me, but I am happy to take that on notice.

Mr D. O'BRIEN — Is anything that was in the business case not being proposed in the final project, secretary?

Ms PEAKE — So, in terms of the business case, the commitments that have been made in terms of the services provided are in this project. There will always, as the Minister has indicated, be opportunities to grow, whether that is teaching, research or additional services in the future.

Mr D. O'BRIEN — Can I just go back to the question I asked about the fundraising campaign. You said there is no government money in it. Is there any money from Monash at all in terms of helping to fundraise?

Ms PEAKE — I think we know the answer to that question. Monash University has a significant philanthropy unit that works both for the university and other projects that they have, and they are the ones that have been leading the philanthropy efforts in respect of the Victorian Heart Hospital.

Mr D. O'BRIEN — Thank you.

Ms PEAKE — Mr O'Brien, just coming back to your question about the breakdown of beds, I can inform the committee that of the 195 beds, 48 are Jessie Mc private beds. That is the intention, but as we have indicated, obviously that will be confirmed and firmed up as the service planning is completed.

Mr MORRIS — Ms Peake, can I just ask you some questions about bullying? Last year you told us there were 90 reports of work-related harassment and/or workplace bullying at DHHS. How many reports were made in 2017?

Ms PEAKE — Thank you, Mr Morris, for your question. I think when we talked about this last year it was also in the context of the significant effort that we are putting into increasing both the messaging to staff about the zero tolerance approach that we take to this and —

Mr MORRIS — Sorry, we are relatively tight for time. It was a pretty up and down answer.

Ms PEAKE — I just want to put it into that context. We have been seeking to increase reporting of bullying and harassment incidents. In terms of 2017, the data that I can give you is that there were 22 per cent of staff within the department who reported, in the People Matter survey, having experienced bullying in the 12 months to May 2017, which was down from 24 per cent in 2016. I think last year we talked about the workplace facilitator that we had created to provide an avenue not only for reporting bullying and harassment but for concerns that staff had around behaviours in the workplace.

Mr MORRIS — So, just in terms of getting comparative figures there were 90 reports in 2016; how many in 2017?

Ms PEAKE — I can only provide the feedback that I have had from the People Matter survey. I am happy to take the number on notice.

Mr MORRIS — I am talking about actual reports.

Ms PEAKE — The 24 per cent was reduced to 22 per cent. That is the data that I have got, but I was going to just going to give you more specific data in relation to the workplace facilitator, if that would be of interest — reports to them?

Mr MORRIS — There are a series of questions I would like to ask you. I think we are going to run out of time. We will come back to it if you cannot tell me now — on notice, perhaps. There were 90 reports in 2016. How many in 2017, and how many staff were terminated as a result of disciplinary outcomes in 2017? Do you have that sort of information available?

Ms PEAKE — I am happy to take the question on notice, but I did just —

The CHAIR — Order! We will come back to that.

Ms PENNICUIK — Welcome Minister, secretary, deputy secretaries and everyone who is here today. Thank you for coming. Can I just start by welcoming your announcement today for the inquiry by the health commissioner into so-called gay conversion therapy, which I know many people in the community have been

very concerned about for many years and have been calling for, including the Greens and others in the Parliament. I think it is good to have a proactive inquiry rather than relying on people having to come forward, necessarily —

Ms HENNESSEY — A complaint-based inquiry, yes.

Ms PENNICUIK — Yes. If I could refer you to budget paper 3 and also to your presentation. In your presentation you mentioned the $6.5 million to support the implementation of the voluntary assisted dying framework. That is there on page 72, but above that is also a very large allocation of funding for meeting hospital service demand, which includes palliative care, and also, on page 86, there is $50 million, just for this financial year, for a Regional Health Infrastructure Fund boost, which also includes palliative care. The government has announced, I think, $62 million under those headings, but it is a bit difficult to unpack where that $62 million is. Is it over the forward estimates? Certainly the amount that has been called for by the sector is around $65 million per year. I wonder if you could provide a bit more detail on the two things I have mentioned, particularly palliative care.

Ms HENNESSEY — Thank you, Ms Pennicuik. I can. You are right. For all the obvious reasons that palliative care is providing in a whole range of different settings, it does not appear as one line item as well. So, as you have identified, there is $6.5 million for the VAD implementation task force. Recurrent funding for palliative care services has increased year on year: four years ago, 116; 2018–19, $144.7 million. In March of 2017 there was an additional $5 million put in for equipment and infrastructure grants for community palliative care agencies. In November 2017 there was a $62 million package of extra support for palliative care services, with funding over five years

So that is 2017–18 — that would have appeared in last year's midyear budget update — through to 2022. That is essentially a package that was comprised of $19.9 million to support home-based palliative care across regional and rural Victoria to provide care for an extra 1215 people and $6.25 million to establish a 24-hour expert advice line to provide access to after-hours palliative care. That tender has recently gone out, so that work is underway to support carers and generalist health services to address gaps for people living in rural areas. There is $19.5 million to better respond to demand and patient complexity by providing additional palliative care physician or nurse practitioner positions in the regional palliative care consultancy services, $10 million in one-off grants for end-of-life auxiliary support services to assist people, family and carers to manage the day-to-day activities associated with caring for someone with a terminal illness at home, and $6.35 million to support the families of people who have accessed VAD as well.

There is of course additional money in the acute health services budget output, but that is at the acute section of palliative care. The money I have just talked about is predominately community-based palliative care. We also have the funding review that is currently on foot. That is looking at what some of the funding anomalies may be. Some of the figures that you referred to in your question also relate to commonwealth funding, so on top of that there is some commonwealth funding that comes into the sector as well.

Ms PENNICUIK — Thank you for that comprehensive answer, Minister. I wonder if there is any more detail around those things — I am trying to write them all down. You mentioned family support of $6.35 million. What does that actually entail?

Ms HENNESSY — The VAD implementation task force will be working to help identify what particular activities that money is invested into. That comes from a commitment also that Mr Jennings made in the course of the upper house debate as well during the VAD process. So I am happy to provide you with a breakdown of what we think that money will be spent on, but as I said the work of the implementation task force is currently on foot and underway and making great strides. I would be very happy to offer you a briefing in respect of where that money is going and what it will be spent on specifically.

Ms PENNICUIK — Thank you, Minister. I would certainly take you up on that. But I think in terms of the answer you gave there is probably more detail to those particular initiatives that you ran through that I think the committee would be very interested in if you were able to provide it.

Ms HENNESSY — I am happy to undertake that for the committee. There have been enormous amounts of work and a really significant increase in the investment. There are two critical pieces of work that are not yet complete as well, but there is a very, very long list of investments, along with the workforce reform, because

one of our great challenges, particularly in rural and regional Victoria, is getting people 24-hour access to GPs while a pal care nurse may be supporting a family with a loved one dying at home. So there are enormous amount of work going on. These are the figures. I have given a bit of a quick run-through of what some of those figures relate to, but I would be happy to come back to the committee with a more detailed outline of where those investments are and what those activities are.

Ms PENNICUIK — Just in terms of the total amount that I touched on in my question, the sector has been calling for something like $65 million per annum that is needed, and the government is investing $62 million over four years. I wonder if you have got any comments about that.

Ms HENNESSY — That figure — and I am aware of the document from which that figure comes — includes commonwealth funding, and the figures that I have not spoken to do not include the commonwealth funding. So there is commonwealth funding in that figure. As I said, our recurrent funding is at 144.7 plus a lot of the capital and things like cars, equipment, shower stools — all of those kinds of things are absolutely critical. So we have —

Ms PENNICUIK — Minister, sorry to interrupt you. I really hate doing it, but I know I am going to run out of time. You mentioned that commonwealth funding. Perhaps in the information you provide the committee could you include that so that we get a full picture of —

The CHAIR — I would be happy to.

Ms PENNICUIK — Thank you.

The CHAIR — Minister, just in my previous bracket we started talking about colonoscopies, and the budget paper reference is budget paper 3, page 226. I note that there was an announcement of $12 million to tackle the rise or the surge in demand for colonoscopies. Can you outline to the committee just in relation to the public reporting of colonoscopy performance and how this $12 million investment will assist that?

Ms HENNESSY — Yes, I can. Thank you very much, Chair. We have seen significant changes in the demand and a really significant increase in the demand. That has largely been generated out of the fact that we have got an ageing community, where we start to see the peaks in particular age cohorts. When the national bowel cancer screening program was initially introduced in 2006, it was for a much smaller cohort. Only those aged between 55 and 65 were eligible for the kits, and the testing was only once every five years. In that time we have seen some significant changes. The screening regime is now for Australians aged between 50 and 74, and people are now sent a free test kit in the mail every two years. Of course people do a self-test at home looking for traces of blood in a person's faeces, which might be a sign of a precancerous growth requiring a check, and if you get a positive result, you are asked to see your doctor. Your doctor will then make a decision around the referral, and the next step is usually a colonoscopy.

When initially the national bowel cancer screening program was put in place, if you think of the cervical cancer screening program, it is quite an accurate analogy. It was announced that the commonwealth government would establish a bowel cancer screening register, and that was going to be covering both cervical and bowel cancer screening. That was supposed to be functional by 1 March last year and the cervical cancer screening by 1 May. They subsequently then made a decision that they would not do them both — that the commonwealth would go for the cervical cancer screening as a priority. That is also because there has been a change from going once every two years for a Pap smear to a human papilloma virus check once every five years. So as the clinical data and nature changes, so does the demand. We are very lucky that we have got a cervical register here in Victoria because the commonwealth register, unfortunately we are still waiting for it. Similarly we do not have a national bowel cancer screening register.

What we do know about national bowel cancer screening is right across the country we have got much variance in the approach to how we categorise, how the risk stratification for those tests is done. We have engaged the Royal Australasian College of Surgeons for the purposes of developing proper colonoscopy risk stratification practices so we can get consistent application of who requires a colonoscopy and when. We are very, very conscious that there is growing demand, and that is why we have put a lot of additional investment in. Myself and all other health and territory ministers have also called upon the commonwealth government to make an additional contribution as well.

This was the subject of a resolution and discussion at the most recent health COAG meeting. It is about infrastructure, it is about operational funding, but it is also about some of the other workforce challenges — getting gastroenterologists into rural and regional areas. So we are doing the work for the purposes of ensuring that we are getting consistent application of referral, consistent categorisation. We have got the lowest median wait time in the country, but we are still not where we should be, and that is why we are making the additional investment. I am not quite sure if —

The CHAIR — In terms of Victoria relative to the other states and territories, we are clearly a positive outlier in terms of colonoscopy?

Ms HENNESSY — We are, but there is still significantly more work to do and, as I said, at the most recent health COAG it was really significant. This is a great national challenge for many people.

Ms SHING — How does that interface, Minister — sorry, just to interrupt on this theme — with the population growth and the fact that we have an ageing population? Because the increased demand that we see is only going to continue to increase all the time.

Ms HENNESSY — This is a problem that is not going to get better; it is going to get worse. That is why we made such a significant investment. But at the moment you cannot even get a very accurate picture from the data because we have got different approaches, whether that is in the public health system or the private health system. So getting national categorisation is really essential. Whilst the commonwealth have agreed to do some of that work, they are a bit shy about putting in some more money. But every state and territory is in the same boat on this issue. We cannot go from screening a small amount of people in an ageing population to more regularly screening a large amount of people without there being a really significant increase in the demand. That is all a good thing, but you cannot commit to screening on the one hand and then not make the other investment about supporting it. So that is the work that we are currently doing. There are new guidelines that will be in place as of 1 July in Victoria to that end.

The CHAIR — Minister, I just might change topic and theme. The budget paper reference is budget paper 4, page 65, and I am looking at the 'National Proton Beam Therapy Centre' in Parkville. I am just curious about the funding profile for this initiative. If I look at total estimated investment, there is $50 million, there was $5 million estimated expenditure to 30 June of this year, but there is no projected expenditure for next year and there is a 'tbc' against the estimated completion date. Can you just outline to the committee the rationale or the back story, I suppose, to that funding profile?

Ms HENNESSY — Sure. Thank you very much for your question. What you have said is broadly correct because the government has already committed $52 million as an initial contribution towards the proposed national proton beam centre in Parkville. There was $2 million in planning in the initial 2015–2016. This is obviously a project of national significance. We are very interested in ensuring that we are able to provide a service that would be able to meet the needs of Australians as well as Victorians, and so we again are very focused on trying to get a commonwealth contribution to turn this from a hope into a reality. Certainly the Premier has raised the matter with the Prime Minister on many occasions, seeking their support.

There is a contribution that the commonwealth say that they have made to South Australia, but we are not quite sure what the status of that is. It seems to have been a promise made in the course of crossbench negotiations while Senator Xenophon was still in the federal Parliament. But one of the reasons that we feel frustrated with the position of the commonwealth is that initially of the $44 million that the South Australian government has put in $30 million of that is just to move a signalling room, so it is not going to build much. The preparatory work seems to be quite unrealistic. We understand that the company that they were looking at getting to build it has filed for Chapter 11 bankruptcy in the United States. I know the commonwealth wrote to the South Australian government in September, demanding a business case. We have a business case; we have put our money on the table. The South Australian government does not have a business case, and certainly the investment that has been outlined today will only deliver one beam, which is really not a sustainable model.

The other issue we have, I suppose, with that potential investment is of course it is not being co-located with a hospital, and the whole power and promise of proton beam is particularly for paediatric cancers, particularly paediatric brain cancers. In order to use that, you need to be located close to or at a hospital because all of that work is done under anaesthetic. So this does not look like a great plan that is emerging. The commonwealth

now seem to be kind of conscious of that, so we are going to continue to advocate for that for those very reasons.

The CHAIR — So the commonwealth has not really responded positively or negatively to the proposal; it has just been —

Ms HENNESSY — Look, they have referred to their interest in South Australia, but of course the South Australian proposal does not appear to be one that is going to deliver benefits to all Australians, and it is unlikely to be able to attract all of the things that are so positive about proton beam therapy, which is not just being able to utilise it for paediatric cases — which is why it is predominantly used — but for other difficult cancers like lung cancers, where you do such significant damage to other parts of the organ. But for paediatric treatments you require an anaesthetist and an anaesthetic, and I do not think you are going to do that outside a hospital setting. So we are continuing, and the Premier continues, to advocate to the Prime Minister about our centre. There is much hope, particularly amongst all of our clinical researchers in the Parkville precinct as well.

The CHAIR — Thank you very much, Minister. I think it is just a fantastic initiative. It will be wonderful for it to come to realisation.

Mr MORRIS — Back to the secretary and back to bullying. With regard to the 2017 survey you told me that 22 per cent of respondents said they had experienced bullying in the last 12 months. How many staff said they were currently being bullied?

Ms PEAKE — Yes, certainly. So 7 per cent of respondents reported that they were currently being bullied, which was consistent with the year before. I was going on to just inform you of the reports that have been made to the workplace facilitator — concerns that have been raised. Since the workplace facilitator commenced in February last year 256 staff have raised issues. They are not all about bullying. They are also about receipt of performance feedback and how that is provided, and also about the sorts of things that would improve their experience in the workplace. In the first quarter of this year 46 individual staff members have come to see the workplace facilitator. As a result of that feedback to the workplace facilitator, there are a number of actions that we have taken. Over 2900 staff — so nearly 3000 staff — have participated in training about what constitutes bullying, and 427 managers have commenced participation in a people leadership capability program, which really goes to that second point about both managing behaviours they see in the workplace that are inappropriate but also in particular providing performance feedback. And the plan is to reach over a thousand managers in that program by the end of 2018.

Mr MORRIS — How many staff disagreed with the statement 'I rarely think about leaving this organisation'.

Ms PEAKE — I am happy to take that to provide you with feedback, and of course this year's survey is open at the moment.

Mr MORRIS — Could the committee receive on notice a copy of the aggregated People Matter survey of 2017, which I believe has gone to you?

Ms PEAKE — I am happy to look at what is available — to take that on notice. I am happy to take that on notice.

Mr MORRIS — I will leave that with you, so if you take that on notice. Thank you. Can I move on and ask you about cladding. There is $10 million in the budget for rectification works. What buildings will be rectified with the funding, and how much for each building?

Ms PEAKE — Certainly. I will commence this answer and, if there is more detail that can be furnished to the committee, I will ask Mr Foa to supplement. But in terms of the health buildings that have been identified for rectification, I think earlier in the year there was material that was provided publicly about non-compliant cladding on nine hospital buildings, with more extensive assessments being conducted on another 11 hospital buildings, so there are 20 hospitals spread over 15 sites. In the program of work that is underway in terms of the removal of non-compliant cladding, the Royal Women's Hospital replacement works commenced in September last year, and just for the committee's information, Lendlease is paying for the works, so there is no cost to

government for those works — again, just to emphasise, there will be no impact on hospital operations or patients. So they are exterior works.

Mr MORRIS — So that is outside the 10 million?

Ms PEAKE — So that is outside the 10 million, but just so that you are aware of that work that is going on. The $10 million is now underway for more detailed planning work and rectification works to start. I will just confirm actually with the head of our building authority which of those works are underway.

Mr FOA — We are just about to start work on the Sunshine lower floors, Sunshine Hospital, so level 1 of that hospital, as well as some of the high-risk areas around Geelong hospital, so not all of that hospital has cladding. There is the special nursery extension building at Casey Hospital, Werribee Mercy and the north wing expansion at the Royal Melbourne Hospital.

Mr MORRIS — Can we get some detail on what we expect each of those projects to cost? I am happy to take it on notice if you do not have it with you.

Mr FOA — Sure.

Mr MORRIS — How about the VCCC? Where is that at?

Mr FOA — The VCCC has compliant cladding.

Mr MORRIS — Right. There was an issue. Who paid to rectify it?

Mr FOA — Plenary, who are the operators of the building.

Ms HENNESSY — Before the building opened, Mr Morris, that was identified and removed at Plenary's cost.

Mr MORRIS — Yes. We have had this conversation before. I think this time last year, while there was an expectation that the department would not be paying for it, that was not yet confirmed.

Ms HENNESSY — I see.

Mr MORRIS — That is what I am trying to —

Ms PEAKE — It is now the case.

Mr T. SMITH — Minister, if I could follow on from the Chair about questions about the colonoscopy funding — budget paper 3, page 226 — I am interested to know where in the budget is the 12 million that you announced on 1 April. Is it new output funding?

Ms HENNESSY — That was put in the 17–18 expenditure because it was a commitment that was made before this budget — I am happy to seek the advice of Mr Stenton — and of course there is funding in the output funding more generally that would be used for colonoscopy among many other things as well. But that additional $12 million was a 17–18 expenditure and flowed from then. I will just invite Mr Stenton to identify —

Mr MORRIS — Sorry, just on that, was that a reallocation?

Ms HENNESSY — Pardon me?

Mr MORRIS — If it was 17–18, it would need to have been a reallocation.

Ms HENNESSY — It was an internally identified source of funding provided and then put into — allocated to — our health services. I will just ask Mr Stenton to confirm because I do not want to give you incorrect information.

Mr STENTON — As the minister said, we funded that $12 million internally. It was through efficiencies in the department, and it continues to be in the output base of the department's funding and has been allocated as an ongoing source.

Mr MORRIS — Where was the money previously allocated?

Mr STENTON — It was unallocated, if you like. In the departmental budget arrangement we hold some funds for contingent purposes, and —

Mr MORRIS — So it has effectively been funded out of contingencies, although not identified as contingencies in the budget.

Mr STENTON — Yes. We obviously, in a budget of 25 billion, hold small amounts of money for risk issues, and when we get to certain points in the year, if those risks do not eventuate we have conversations about where we can best allocate those funds, and this is one of those instances.

Mr MORRIS — Can I just pursue that for a second? If this amount was funded out of that source last year, what is the quantum for the source in this year's budget?

Mr STENTON — For that allocation?

Mr MORRIS — No, for contingencies, effectively, within the output.

Mr STENTON — The contingency amount varies year on year, so it is —

Mr MORRIS — I am asking for 18–19.

Mr STENTON — We have not got to 18–19 yet in terms of what our total capacity is and therefore what we would be able to hold as contingency.

Mr MORRIS — Even though we are currently inquiring into the 18–19 budget, we do not know what the contingency is going to be.

Mr STENTON — Yes. We know the absolute quantum of the budget, but the way the process works, we work through the allocations to all of our service providers and at the end of that process if there are contingent amounts — if there is anything left over, if you like — we hold that in contingency.

Mr MORRIS — I must say I am rather surprised that we actually have got a quantum in the budget that we are expected to tick off on, but what you are essentially saying is you are not exactly sure what it is going to be spent on yet.

Mr STENTON — No, sorry, I may have misunderstood the question. The 12 million allocated for palliative care —

Ms HENNESSY — Colonoscopy.

Mr STENTON — Sorry, colonoscopy, has been allocated to health services.

Mr MORRIS — But we have gone slightly away from the colonoscopy funding in that you told me it was effectively funded out of contingencies, although not labelled as that, in 17–18. I am saying: what is the quantum for contingencies in 18–19? If I am not mistaken, I thought you said it is basically what is left over once we know what we are spending on everything else.

Mr STENTON — Perhaps I will go back a bit. The quantum for 18–19 of funds available for risk will be determined in our budget build for 18–19. We are working through that process at the moment.

Mr MORRIS — So we have got the figure for the output, but the budget is not put together yet?

Mr STENTON — Correct.

Mr MORRIS — Okay; thanks.

Mr STENTON — But in relation to the colonoscopy amount, that is an ongoing commitment now in our budget, so it will not be re-funded, if you like, from contingency.

Mr MORRIS — I understand. Sorry for butting in, Mr Smith.

Mr T. SMITH — No, at all, Deputy Chair — your prerogative. Which health providers will receive the funds and over what period — this is the 12 million?

Ms HENNESSY — I might have to invite Mr Symonds to talk about the process of allocation because, as I said, some of that is additional funds and some of that is already built into the existing base. Terry, I invite you to talk to that.

Mr SYMONDS — Sure. Thanks, Mr Smith. I will take this question on notice in terms of which actual providers got an allocation from the funds. We talked to all of the providers of colonoscopy to work out which ones had available capacity —

The CHAIR — Order! Ms Patten until 10.42 a.m.

Ms PATTEN — Thank you, Chair. Good morning, Minister and secretaries. I wanted to turn to dental health on page 244 of budget paper 3, particularly regarding those performance measures. We know that dental health and lack of affects people's diets and certainly social stigma. I note that the wait time has increased from 15 months to 22 months. I see that you are sort of expanding what that measure is, but 22 months seems to be an awfully long time for people to be waiting for dentures. I was wondering if you can expand on that, please.

Ms HENNESSY — Thank you very much, Ms Patten. That is a really, really important question. Our great challenge around dental — and I will invite the secretary to talk around the construction of the wait times very shortly — has been significantly impacted by the commonwealth reducing their funding for adult public dental health care by 30 per cent. We have done our best to continue to put additional investment in because of things like it is a leading cause of avoidable hospital admissions for kids under 10 and the indignity of access to things like dentures, particularly for older people. The way in which the waitlist is constructed with dental essentially is a triage system, so the most urgent person goes first. I might invite Kym to talk. We have put additional money into dental, and we will continue to do so, but again, there is growing demand and we have been really buffeted by the commonwealth cutting 30 per cent out of the commonwealth dental funding.

Ms PEAKE — There is a bit of a technical answer as well as a policy answer to your question. The technical answer to the measures and estimates in the budget papers is that we are expecting to maintain performance compared to last year, both in terms of the volumes of people who are able to access a service and those wait times. We are conservative when we provide the estimates and the data that we had earlier in the year, but on most recent information we do think we can maintain effort. But to the minister's point about the impact of the changes in the national agreement, obviously the state itself has maintained its funding position, but the commonwealth reduced its previous NPA contribution by 30 per cent in January last year. What we have done is continue to target the available funding to really vulnerable groups: children, pregnant women, Aboriginal people, refugees and asylum seekers, and people defined as homeless or at risk of homelessness. They are not on waitlists. We also make sure that people who have got a really urgent dental need are fast-tracked within 24 hours.

Ms PATTEN — Thank you. Certainly in 16–17 we were looking at 15 months, and I appreciate the loss of funding has changed that. Is it possible to get a breakdown, because I think that is interesting that some people are not on these measures because they are not on those wait lists? If I could get a little bit of further information about that, that would be great.

Ms PEAKE — Yes.

Ms PATTEN — Just in the time I have got remaining, I would like to turn to end-of-life care and the $6.5 million allocated. It is great to see we have got the implementation task force, and I am assuming that that will be doing a lot of education and training with the various organisations. I would also be conscious that there will be a number of organisations that will not be coming on board with this scheme. Do you have any sense of how many organisations the task force will be working with as opposed to the organisations that most likely will not want that training or need it?

Ms HENNESSY — Thank you very much, Ms Patten, for your question. I am furiously just trying to find my notes here on that issue as well.

Ms PATTEN — And while you are doing that, the supplementary on that would be are there any time lines for the programs that you have mentioned, being the task force and the establishment and operation of the review board?

Ms HENNESSY — Indeed. So the implementation task force is up and running. The important work that is being done around medications is very well advanced. We are close to the appointment around the voluntary assisted dying review board being put in place. Part of the work that the implementation group is doing is working with clinicians around the establishment of the clinical guidelines. We have an assurance, particularly for those who do not wish to participate organisationally, that they do not, and I suspect that comes as no surprise to you.

I do not really want to identify those at this point in time that are actively participating, but we have got strong participation, particularly in the development of the clinical guidelines and the drug development issues. We also look to the experience overseas where there were a number of services that came on after the introduction. We have got a June 2019 introduction. I am not sure, Terry, if you have got anything further to add, or if, Ms Patten, you have got a specific task that we can help you with?

Ms PATTEN — I appreciate not wanting to list them for obvious reasons. Is there a special component for the GPs? Obviously sometimes, apart from our specialists, GPs will be on the front line in the conversations that we start. Is there a component and have we seen GPs coming on board or requesting information?

Ms HENNESSY — The AMA is represented on the implementation task force, as is the Royal Australasian College of GPs. There is certainly a very strong GP interest in being involved in the implementation panel and certainly, without wanting to disclose or breach any confidentiality, strong GP interest in being involved in the review board as well. I get the sense that those that may have been, and I do not want to use a pejorative term, agnostic during the debate are now increasingly showing much stronger interest as well. That is why using the implementation task force, those existing bodies and the development of the clinical guidelines that is currently underway, I do not know, Terry —

Ms PATTEN — Just in the last few seconds, just to clarify, the guidelines and I guess that training for GPs will be implemented through the AMA and through the royal colleges rather than directly from the department?

Ms HENNESSY — It will be, that is correct. It will be starting reasonably soon; like, it is all systems go.

Mr DIMOPOULOS — Good morning, Minister and officers. Agnostic is not pejorative, it is a great word. It is authentic, it is filled with humility.

Ms HENNESSY — I was trying not to be provocative, Mr Dimopoulos.

Mr DIMOPOULOS — I know what you meant, Minister; I was just having a bit of fun. I just want to go back to your presentation. There were so many numbers, Minister, because there is so much investment in this budget for health. I want to clarify the elective surgery component. You talked about, I think, 14 000 procedures as an example of what the investment would buy. Specifically bringing you to budget paper 3, page 72, the investment is 217.6 million. I just want to get a sense and a bit more detail about what elective surgery categories it will cover and how the investment will impact the performance measures later in the budget document on page 230. Can you take us through that?

Ms HENNESSY — Thank you very much, Mr Dimopoulos, for your question. As you say, there is that $217.6 million investment in elective surgery for the 2018–19 year alone, and over the forward estimates there is a $362.2 million investment. We came in and, just to put that in stark contrast, the investment that had been made in elective surgery in the last financial year before we took office was $45.4 million.

Mr DIMOPOULOS — That is extraordinary.

Ms HENNESSY — We are at 217.6, so the desperate need —

Mr DIMOPOULOS — From one year to the next?

Ms HENNESSY — From their last year to our investment this year. So that is almost four times the investment that was made. So obviously more investment is going to have a positive impact on our elective

surgery performance going forward. We think we have done a pretty good job but there is always more work to do is essentially the story. We have delivered the lowest wait time for elective surgery on record two years in a row. We are keeping very focused on the investment to ensure that our hospitals keep delivering. Obviously last year's flu season kind of buffeted us about because many elective surgeries had to be cancelled simply because every intensive care unit was full, every high-dependency unit was full and we could not have more patients in one room because of the infection risks et cetera. So that has certainly had an impact. With the additional investment we think that we are going to continue to try and keep up with the very dramatic demand.

As you can see on page 230, 100 per cent of category 1 patients were treated in time. For category 2 patients we are aiming 0.3 per cent higher than what we projected to achieve in 2017–18 whilst maintaining a strong 95 per cent performance for cat 3 patients. In every budget we have continued to invest in elective surgery, but it is an incredible struggle because we have got population growth occurring very significantly in our state. It is a good thing, but that is not the only input into what drives demand. Utilisation for people — that is essentially people that have one, two, three, four chronic diseases, for example — really is what drives the demand on our health system. But we have kind of gone from under the previous government having an elective surgery waitlist that blew out to 50 000 to some of the lowest wait times on record, but we have also got to continue to make sure that we continue to invest. And having learned the lesson from last year's flu season, I now know how significant events like that can really impact upon your performance.

Mr DIMOPOULOS — Minister, can I just unpack a bit the historical benchmarks, I suppose, because they are pretty profound and I want to understand them a bit better. This may be a question that Ms Peake might be able to answer. The minister referred to on record. When did records start being collected?

Ms HENNESSY — My instinct is it was about 17 years ago, I think. Is that right?

Mr SYMONDS — Yes.

Mr DIMOPOULOS — Sorry, Minister, I should not have presumed that. You would not have known that — going to the officers. But 17 years. So two years in a row it is the lowest wait time on the waiting list for elective surgery —

Ms HENNESSY — On record.

Mr DIMOPOULOS — On record.

Ms HENNESSY — Yes.

Mr DIMOPOULOS — So almost 20 years, or 17 years at the very least. In terms of the investment, the $45 million you referred to in the last year of the previous administration, that was matched with the 50 000 waitlist; is that right?

Ms HENNESSY — It blew out to $50 000.

Mr DIMOPOULOS — And was that the highest on record?

Ms HENNESSY — I am not sure. Yes, it was, I am being advised.

Mr DIMOPOULOS — So the highest on record, and within a period of three years, effectively, we have achieved the lowest elective surgery waitlist on record?

Ms HENNESSY — That is correct.

Mr DIMOPOULOS — It is an extraordinary achievement, given the population growth. It is not as if the variables were static. They were climbing at the same time as we were investing and we still achieved a far better result.

Ms HENNESSY — No, and they continue to. The nature of elective surgery waitlists is that they kind of go up and down during the year. You get hit by winter. You are hit by things like when clinicians take leave, so at Christmas the waitlist gets a bit longer. One of the really strong focuses that we have put on is that group of long waiters, those that have been waiting for extraordinary lengths of time, your category 3 patients. What we did

last year through the statement of priorities, which is essentially your contract with hospitals or your service level agreement of sorts, is that we put a formula in there that essentially meant that people had to focus on their longer waiters as well, because you could go and do a gazillion tonsillectomies but it is the long waiters with really complex issues that may not be category 1 or category 2. Anyone that is waiting for a surgery, every day is a day too long for them, but the clinical categorisation of these things is all done nationally, based on medical evidence. I see lots of correspondence from people that might be waiting, both directly and via MPs on behalf of their constituents. Sometimes while you are waiting you can degenerate or your hip might start to cause more pain. We are always at great pains to say to people, 'It's your GP, essentially, that writes the report —

Mr DIMOPOULOS — The reassessment.

Ms HENNESSY — for the assessment', and if there is any change in that, that people should go back to their GP.

Mr DIMOPOULOS — Minister, linked to the growth in funding, the population growth and the investment is obviously the workforce. You cannot deliver this, obviously, without the workforce. Budget paper 3, page 72 also has a line item about meeting hospital service demand. I just wanted to see if you could tell the committee a bit more about the growth in frontline health services in this budget and also over the last three years.

Ms HENNESSY — Absolutely. The growth in demand and the growth in activity also, you cannot do any of that without a growth in all of the employment and labour costs as well. It goes without saying that our clinicians, nurses, volunteers, allied health staff and the people that change the water and the flowers — essentially those are our hospitals. It is not the infrastructure. So there has been a really significant growth in the medical workforce in order to support the growth in demand, demand that we have enabled to be met by making additional investments. There has been an additional 1500 full-time doctors. That is quite extraordinary when you think about it. There are 2900 more full-time nursing positions and more than 5000 additional frontline full-time health care roles. And I know we will talk about paramedics later on, but there has been a really significant increase in the number of paramedics.

Making the investments to support our workforce is also really important. We have tried to do that through some of the less tangible things in enterprise bargaining agreements. It is not all about money. Things like refurbishing tearooms and other things that I have learned through the process of doing a number of really big enterprise bargaining agreements are incredibly important to staff. The nature of some of our clinical staff here in Victoria is a bit different to some other states because we have a lot of what are called VMOs, visiting medical officers. So they might work at the RMH for three days a week and they might work at the Epworth for two days a week, which also means we have got to invest a lot around things like quality and safety standards, not having a variance as well.

Mr DIMOPOULOS — Minister, you mentioned the EBA. Did that address concerns previously expressed by junior doctors about being overworked?

Ms HENNESSY — Look, it did — well, it did to an extent. There are such incredible demands on our clinical staff. I am not a 'We have fixed it' kind of gal. We are always just on a steady path to trying to improve, but of course the two most recent doctors enterprise bargaining agreements were with senior doctors, the junior doctors and doctors in training. The really significant issues for doctors in training are about the length of shifts, the break between shifts and of course the dangers of driving home when you are exhausted and coming back.

The flip side of that is you have got to make sure that you are giving doctors every chance to be trained and to be supervised well, but essentially the significant achievement — other than a well-earned pay rise in the doctors in training enterprise bargaining agreement — is the additional regulation around their terms and conditions because of the risk that they suffer from long shifts, to themselves and to the quality and safety of patients, and the demands on their time to be able to study as well.

It is a really, really tough gig, and I am delighted that we have been able to land an enterprise bargaining agreement that goes some way to addressing those issues, but I do not want to pretend that it is a walk in the park for any of our clinicians, who work extraordinary hours. Then when we see things like, whether it is Bourke Street or thunderstorm asthma or any of those really significant events, people are just there and they are there for days and they will do whatever needs to be done to care for people. It is incredibly humbling.

Mr DIMOPOULOS — The commitment is enormous. Thank you, Minister.

Mr T. SMITH — If I could just quickly pick up some of the comments from Mr Stenton with regard to contingencies. What was the contingency in the 17–18 budget?

Mr STENTON — The contingency — 'contingency' is an interesting word, but —

Mr T. SMITH — Total contingency.

Mr STENTON — Yes, so the contingency varies over the course of the year, and the way we achieve contingency is through efficiencies, mainly in departmental operations. So to further explain on Mr Morris's question: we start the year with an estimate of how much contingency we have available and generally it runs in the order of about 0.1 to 0.2 per cent of total budget, but it varies over the course of the year depending on other efficiencies. So it is not something that we budget for per se; we estimate —

I see you raise your eyebrows, Mr Smith. It is an estimate at the commencement of the year, and as we go through particularly the first quarter of the year, there is an allocation of funds, and we are much surer of what contingency funds we have available. And as I said earlier, they are predominantly for risk. So issues will arise in the Health and Human Services system during the course of the year, and those funds are allocated to address those issues.

Mr T. SMITH — So it was 0.2 per cent of the total health budget?

Mr STENTON — It is 0.1 to 0.2 per cent of the department's budget.

Mr T. SMITH — All right. If I might follow on to the minister with regard to colonoscopy waiting lists, you said in an FOI that DHHS does not have any documents or data relating to colonoscopy waiting lists, and many health providers have not collated their own waiting lists. How long will it take you to identify where this money will be spent, and why don't you keep that important data on waiting lists for colonoscopies?

Ms HENNESSY — Thank you, Mr Smith. I may invite Mr Symonds to also comment in the course of our answer, of course. There is a national guideline that sets out what constitutes an elective surgery. That is then what goes to what is reported centrally and what is not, and because, among other things, that national guideline identifies colonoscopy as not an elective surgery — so therefore that is measured locally.

What we know, as I have answered in previous questions, is that there is significant variance between how colonoscopies are categorised, and that is why important work is being done to address that issue with the college of surgeons in order to identify that. Our ambition is to get consistent, accurate data being set across our health services, and then we are happy to work towards greater transparency of that data, but it is not classified as an elective surgery.

Mr T. SMITH — Colonoscopy is not classified as an elective surgery?

Ms HENNESSY — There are national guidelines, and there are common procedures not considered elective surgery. So there is a national guideline of what constitutes or what is classified as elective surgery and what is not, and colonoscopy is not classified as an elective surgery.

Mr T. SMITH — So we can see that colonoscopy is vitally important, and we can see that bowel cancer has been and will continue to be a massive issue for public health in this country, yet you do not keep waiting list data on colonoscopies.

Ms HENNESSY — No, waiting list data is kept at a hospital level, and if I could invite Mr Symonds to talk about where and how we are reforming that, but the reason that is the case —

Mr T. SMITH — Can you provide that data per hospital for colonoscopies that people are waiting for?

Ms HENNESSY — Sorry, I cannot hear you.

Mr T. SMITH — Can you provide that data per hospital to us, please?

Ms HENNESSY — I am happy to invite Mr Symonds to talk about where the data is at.

Mr T. SMITH — I would be delighted to hear from Mr Symonds talking about all sorts of things, but I would like to know: can you provide the data per hospital for people who are waiting for colonoscopies?

Ms HENNESSY — I am happy to see what I can do, but as I said, we do not hold the data currently and therefore cannot provide it to you.

Mr T. SMITH — Well, you run the hospital system; why don't you have the data?

Ms HENNESSY — Because, as I said, it is not classified as an elective surgery. Nationally it is not classified as an elective surgery.

Mr T. SMITH — Would you consider changing it?

Ms HENNESSY — Absolutely. We are absolutely looking at reform to that system.

Mr T. SMITH — I am intrigued, though, given what you have said previously to other members of the committee — and I completely agree with you — that it is a very important screening measure, and bowel cancer will become an increasingly big issue as our society ages. Yet you do not have the data. I find that incredible.

Ms HENNESSY — Hospitals have the data, and if I could also refer you, Mr Smith, to the national change program that is underway that was agreed to at the most recent COAG, because all states and governments and territories are in the same position. That is why a new national standard in respect of this issue and its classification was requested — at Victoria's behest, might I say. If I could invite Mr Symonds to talk about the work that is being done that goes to the points you have canvassed in your question.

Mr SYMONDS — The data is not completely and consistently collected, even at hospital level. It is collected and kept in a mixture of diaries, sheets of paper in consulting rooms; some is mixed up in electronic systems for recording elective surgery patients. It is collected in a range of places and stored in various forms at hospital level in such a way that it cannot be easily transmitted, and many hospitals cannot even consistently report it. So the work required is to develop a national agreement on what the definition is, exactly, and on what data fields are required to be collected, and then for services to put in place systems to capture that data and transmit it in a way that they have done for decades for elective surgery.

Mr T. SMITH — I am delighted to hear about COAG processes and all the other very interesting issues you have raised in your evidence just then, but I am asking about Victorian hospitals and Victorian data. If hospitals are collecting this data as you have articulated — sometimes in a haphazard sort of fashion but it is being collected — why is it not being centrally collated so the minister can inform the committee and indeed Victorians how many people are waiting for a colonoscopy? This is not that complicated, surely.

Mr SYMONDS — I guess our experience with developing new collections for things like waits for outpatients is that it is more complicated than any of us expect. It has taken years to get consistent collection of data for patients waiting for specialist clinics, and it has taken years of discussion to get even some airtime around collection of data for colonoscopies at a national level.

Mr T. SMITH — The minister has already spoken about elective surgery waiting lists, so clearly quite a lot of data is collated around other procedures, just not this one.

Mr SYMONDS — There is a lot of data collected at hospital level, but it is not collected and collated consistently across hospitals in a form that could be reported to the department now and then reported to the public.

Mr T. SMITH — Why not?

Mr SYMONDS — Because colonoscopies, I guess, like a lot of other procedures — procedures in radiology suites, diagnostic procedures — have not had the attention that elective surgeries have nationally. Every state and territory —

Mr T. SMITH — Sorry, can you repeat that? I did not quite hear that.

Mr SYMONDS — Elective surgeries nationally across every state and territory have had the attention and investment in data reporting systems that allow every state and territory to report it consistently. That has not been the case for procedures seen as being, once upon a time, on the fringe of core hospital procedures, and that applies to colonoscopy, it applies to cath lab procedures for patients with heart disease. We do not collect it. Hospitals do not collate consistent information either about those conditions, but they are also very serious. It reflects how health care has changed that our reporting systems need to catch up with health care so that —

Mr T. SMITH — So you can see that your reporting systems are not where they should be?

Mr SYMONDS — No state and territory in Australia —

Mr T. SMITH — I am not interested in other states and territories.

Mr SYMONDS — Sure.

Mr T. SMITH — I am asking about Victoria.

Mr SYMONDS — I would agree with you. The whole industry needs to catch up so that colonoscopies and cath lab procedures get the attention, collection of data and reporting that they deserve to tackle the issues you have addressed.

Mr T. SMITH — So bowel cancer is, what, our second biggest killer?

Mr SYMONDS — Yes, I have heard that.

Mr T. SMITH — Yes. So should we not perhaps speed up this process so —

Ms HENNESSY — We are doing that work, Mr Smith.

Mr T. SMITH — Well, when will it be concluded, Minister?

Ms HENNESSY — The new guidelines that will be in place around categorisation will be 1 July. There are other important pieces of work that go with that, and I do not know if Mr Symonds —

Mr T. SMITH — Like what, Minister? When do you think we will have accurate data about the number of people waiting for colonoscopies?

Mr SYMONDS — I could not give a time frame for that. The Australian Institute of Health and Welfare provides the definitions and consistent reporting —

Mr MORRIS — Can we stop talking about national standards and national bodies?

Ms SHING — It lies at the heart of this issue.

Ms HENNESSY — But that is how the entire categorisation occurs. It is how the entire funding occurs.

Mr MORRIS — The commonwealth does not run a single hospital. We have been through this, I think, Minister, when you were a member of this committee. Data needs to be relevant to the task at hand, not something to satisfy the bureaucrats in Canberra. Yes, you have to jump through those hoops, and yes, we appreciate it. The question that is being asked here is that we have something that is that second biggest cancer killer and we are not collecting data so we know what the picture is across the state. That is what is being asked: why not?

Mr SYMONDS — If I could add, as the minister said, that Victoria is the first state. We are not waiting for the commonwealth to provide guidance around consistent categorisation —

Mr T. SMITH — Stop talking about the commonwealth. You run the hospitals.

Mr MORRIS — This stuff is hardly news.

Mr SYMONDS — I am giving you an example of where Victoria is not waiting for the commonwealth. We are the first state to provide guidelines around the difference between urgent and non-urgent colonoscopy so that we know what we will get when it is recorded.

Mr T. SMITH — So how many people are waiting for an urgent colonoscopy?

Mr SYMONDS — I have explained to you why —

The CHAIR — Order! Ms Pennicuik until 11.12, and then we will break.

Ms PENNICUIK — Minister, I would like to return to a subject we have discussed many times before, which is the Footscray Hospital, which you mentioned briefly in your presentation. If you look at budget paper 4, pages 62 and 64, page 62 with regard to new projects has got TBC, TBC, TBC, and on page 64 there is, in terms of planning and critical infrastructure, some $17 million allocated. I remember last year there was $50 million that had been allocated to the planning for the new hospital, and we had a bit of a discussion around some other funding — I think it was $61 million — to Sunshine and Footscray, and there was $17 million in that discussion. Is that this $17 million. You answered me last time, and I think Mr Foa was involved as well, that the $17 million was for works on the south —

Ms HENNESSY — North and south wards, which, as you would know, are —

Ms PENNICUIK — Yes. Has that been completed? Is that $17 million this $17 million?

Ms HENNESSY — I might just have to check with Mr Foa so I can give you —

Ms PENNICUIK — And while we are at it, there was $17 million for which it was not clear whether it was coming out of the 50 or the $61 million, which was allocated last year to Footscray and Sunshine. If you could explain what is going on here with Footscray Hospital and with works at Sunshine and Footscray; is this the same money or is there new money and were the works completed?

Mr FOA — Thank you for the question. So obviously with Footscray, with the announcement of a new Footscray Hospital, we are doing the urgent works required on required spend obviously to keep the existing hospital going as much as we can and to address really urgent issues, so that work is ongoing, and we have allocated that 17 million for that —

Ms PENNICUIK — It was allocated last year but it is reallocated now, so are you saying none of it has been spent?

Mr FOA — Well, the 17 million this year is enabling us to keep moving forward with the planning, building on the 50 million from last year. The idea of the new Footscray Hospital is that we have enough money to continue our planning. As the minister has mentioned, we are not forecasting a land purchase amount in the budget papers because that is subject to wanting to participate in a market and not forecast a land payment amount. So the work is progressing. We are currently undergoing some community consultation around both sites and elements of the hospital that the community would like to see. We have run some volunteer workshops, we have run staff workshops and we have had two engagement sessions at the Maribyrnong Aquatic Centre. So the works are proceeding apace and we are addressing those urgent elements of repairs and maintenance as they are required within the south and north blocks.

Ms PENNICUIK — We knew that had to happen; it just does not appear from the budget that it has happened. Is it completed or is it still underway?

Mr FOA — It is still underway.

Ms PENNICUIK — And what is the expected completion? Is it the end of this year?

Mr FOA — We are staying ahead of elements as they are required, and obviously with the south block in the condition it is in it will continue to throw up challenges, so it is all ongoing.

Ms PEAKE — It might be helpful for the head of our building authority to give you a bit more detail about the 17 million as opposed to the 50 million — the 17 million for the urgent works as opposed to the 50 million

that is really helping us with the planning for the new build. Can I just ask Robert to give you a bit more of a breakdown on that.

Mr FISKE — There have actually been two amounts allocated for urgent infrastructure upgrades. In the 16–17 budget papers there was the original $15 million, and then in the 17–18 budget papers there was another amount allocated for urgent infrastructure. The total amount allocated was 25 million. The way that is being managed — just building on my colleague Nick — is that the hospital is identifying infrastructure and the risk assessments for that infrastructure and will commit the funds at the point in time when they think that the risks posed by the infrastructure are actually too great and will impact the hospital, so they will actually do it as it breaks.

Ms PENNICUIK — I understand that. That is good; thank you. Just in terms of time, if you could go back and have a look at the figures we discussed last year — the 61, the 17, the 50 and now there is the 25 — and perhaps just clarify how all that works for the committee in terms of Footscray and Sunshine, because some of it was for Sunshine, and you mentioned that before.

Ms HENNESSY — Yes, it was. It was 61 last year, I think.

Ms PENNICUIK — Just a clarification of where we are with that would be good. And just in terms of the new hospital, it is a new hospital, and we had a discussion — is it a brownfield site or is it a greenfield site? Perhaps some information from you, Minister, about what is intended and some sort of a time line?

Ms HENNESSY — I am not in a position to announce which site. As Mr Foa outlined, both the existing site and two other sites are being actively looked at and the community are being consulted about those.

Ms PENNICUIK — Sorry, how many?

Ms HENNESSY — Two other sites, and the community are being consulted about those. Depending upon which ultimate block of land we buy, which money is provided for in this budget, that will then go to how then you phase and build a hospital. As you would know, one of the great challenges in the west is the remediation work that is required to be done on land, often, as well, so that is another important input that is being looked at. Whilst I do not rule out a rebuild on the Gordon Street site, it is a very challenging site to build on, and decanting a hospital where you have got extraordinary population growth and a growth in demand while you knock down and build would present a significant challenge, so the other two sites are being given very serious consideration.

Some of those would have consequences. One, for example, would involve the compulsory acquisition of a couple of houses as well. There are other issues around locations and co-locations with university facilities and access to transport. So those are the issues. I have got to say that there are swings and roundabouts with both of those options. The reason that we have not disclosed the number is that the moment you disclose the money the cost goes through the roof —

Ms PENNICUIK — But are you envisaging coming to some decision soon?

Ms HENNESSY — I would hope so.

Ms PENNICUIK — This year?

Ms HENNESSY — I do not want to make a commitment that I cannot necessarily keep, but I know how desperately need that rebuild is.

Ms SHING — I would like to just pick up on the answers to questions that were given in relation to contingencies, and the efficiencies that are achieved within the budget more generally. Mr Stenton, you have given evidence that between 0.1 and 0.2 per cent of the budget is understood to potentially be used for contingency, but that that varies throughout the year in question. Has that process of allocating contingency and operating within that framework changed at all in the last four years?

Mr STENTON — Thank you, Ms Shing. No, not at all in the last four years. In my experience, which is rather lengthy in the department, it is partly prudent financial management. All good CFOs will look for efficiencies, and when I use the word 'contingency', we continuously look for ways to improve our productivity

and efficiency in the department, and that then allows us to harvest some efficiencies that we hold prudently to manage risks in the portfolio.

Ms SHING — Which is indeed the evidence that you gave around the way in which that envelope that was paid for within the existing operational budget could be met as a consequence of those internal efficiencies; is that correct?

Mr STENTON — Indeed.

Ms SHING — You indicated that you have been with the department for some time?

Mr STENTON — Yes. Would you like me to reveal how long?

Ms SHING — I would in fact like you to reveal how long in the context of the prudent financial management that you have just referred to in the context of contingency.

Mr STENTON — So my son is turning 30 shortly, and I started just before he was born. There you go. I was 12 at the time.

Ms SHING — Wow. Unless he was born in a leap year, I can probably do the calculations about how long you have been there. Now, by reference to contingencies and the way in which reporting may have changed, has that changed at all in the last eight years, to your recollection?

Mr STENTON — No, it has not.

Ms SHING — No, okay. So there is no variation there.

Mr STENTON — Yes. As I say, all prudent financial managers will tell you that you need to do two things. You need to continuously look for productivity and efficiency improvement, and you use those funds to manage risks and to allocate back into future efficiencies.

Ms SHING — So it is nothing new, in other words?

Mr STENTON — No, nothing new at all.

Ms SHING — Thank you very much. I would also like to return to earlier questioning in relation to Mr Smith's line of inquiry on colonoscopies and the guidelines that have been spoken about that will be finalised from 1 July, I think you said, in Victoria. Now, what I would like to get very, very clear is an understanding of the significant variance between how they are characterised at a hospital level and the extent to which, if at all, that impacts upon the delivery of colonoscopies per se. Because what it sounds like we are being invited to conclude is that because data is collected in various ways there is somehow a correlation between that and a failure or an inability to treat the second greatest cause of mortality in terms of this diagnostic framework. I would like to step back from that a bit and to understand the extent to which that reasoning holds up or not, because these sorts of claims are easy to make, but we need to unpack them in the context of the way in which that variation occurs — the characterisation on the one hand and the way in which treatment occurs on the other. Mr Symonds, I am happy for you to answer that or for the minister to, based on the fact that you have both addressed the subject matter.

Mr SYMONDS — I guess our interest in consistent guidelines is to ensure that the most urgent patients are treated quickly to address any risk of cancer. You will appreciate that many colonoscopies are undertaken for diagnostic purposes as follow-ups to earlier concerns. Simply looking at the total number of colonoscopies waiting or booked might not be the best guide to who actually needs treatment soonest.

Ms SHING — Is that the sort of variation that was referred to earlier in the evidence that the minister gave?

Ms HENNESSY — Yes.

Mr SYMONDS — That is right, and there is variation within health services about how much diagnostic information is held about the patient that would allow a decision to be made about how soon they should be treated. If I compare it to elective surgery, where we have guidelines around what procedures should be categorised as 1, 2 or 3 — that is, ideally treated within 30 days, 90 days or a year — we do not or have not had

previously those kinds of guidelines for colonoscopy. The guidelines that we have got now, that are now publicly available — they are on our website — refer to having to combine single symptoms, such as rectal bleeding, altered bowel habits, diarrhoea, constipation et cetera, with other factors to understand who should be treated soonest. We have categories there for treatment ideally within 30 days, 60 days and 180 days, and for each of those, examples of the kind of combination of symptoms that might guide clinicians and ensure that an urgent patient in this health service we understand to be the same as an urgent patient in that health service. Or within one health service, a patient seen by one clinician and understood to be urgent is equally as urgent as a patient seen by another clinician, because ultimately they have to get booked within the same procedure rooms with the same overall resources.

That is the kind of variation we are trying to address, and the simple global number of colonoscopies, many of whom will not necessarily even be symptomatic or have the kind of symptoms that require urgent treatment, does not help us understand —

Ms SHING — You are talking more within the diagnostic space?

Mr SYMONDS — That is right. It does not help us understand necessarily the time frames in which people have to be treated. Our concern here is to make sure that the most urgent patients are treated soonest. That is what is at stake in the variation we are talking about.

Ms SHING — When we look at variation and we look at urgency, that categorisation of 1, 2 and 3, as you alluded to earlier, is also something that is akin to people who may actually have otherwise been on a 'long waiter' sort of classification. To go back to the earlier evidence that has been given in the context of trying to address long waiting and the formula that meant that people had to focus on longer waiters as well — I think that was the evidence that the minister has given, because long waiters have complex issues that might not just be at category 1 or 2 — do colonoscopies fit within that matrix around getting hospitals to be more attentive to people in the context of that sort of diagnostic or other treatment using the colonoscopy process?

Mr SYMONDS — The minister's comment might have been about elective surgery in the context of long waiters.

Ms SHING — But there can be an overlap too in the context of where a colonoscopy might be needed for a diagnostic purpose versus the elective surgery process that a patient might need. Is that correct?

Mr SYMONDS — Of course.

Ms HENNESSY — That is correct.

Mr SYMONDS — People can be waiting too long for colonoscopies and for elective surgery. I guess what we are trying to do, in the case of urgent elective surgery, urgent colonoscopies and urgent procedures of any kind, is make sure those patients are seen quickly and immediately. For those patients where the condition they are being treated for is not life-threatening and does not require urgent treatment, then we think the length of time they have waited should be a more important factor in terms of when they are treated. So for less-urgent patients, treating, if you like, from the back of the list, then the longest waiting first is a good principle, if they can afford to wait. But if those patients have symptoms that require urgent treatment, they should come first, and that applies equally to colonoscopies and elective surgeries.

Ms SHING — So if I am understanding the evidence that you have given, along with the evidence that the minister has given, urgency is the prime factor in determining the way in which assistance is provided, irrespective of how that assistance may be provided, including through diagnostic colonoscopies.

Mr SYMONDS — And that is true of emergency departments as well. It is true of our health system overall. The most urgent patients are treated first.

Ms SHING — So there is nothing new in that, is there, Mr Symonds? No, Minister?

Ms HENNESSY — No.

Mr SYMONDS — We have not had previously guidelines to understand which patients fall into those categories, whereas for emergency departments and for elective surgery there are longstanding means of understanding and comparing that.

Ms SHING — And that is then part of the broader continuous improvement framework around the guideline that comes into effect from 1 July.

Mr SYMONDS — That is right.

Ms SHING — Yes? Excellent. Thank you very much for that.

Mr T. SMITH — Before we move on, Ms Peake, can you please take on notice and provide to the committee a list of all waiting lists that hospitals have the data for but is not provided to the department centrally?

Ms PEAKE — I am happy to look at what we can provide, yes. And, Mr Smith, if it is helpful, just on your previous question on the services that receive the $12 million —

Mr T. SMITH — We can take that on notice, that is fine. Yes, that would be great.

Ms PEAKE — I have got that list too.

Mr T. SMITH — Thank you very much. Ms Peake, referring to budget paper 3, page 226, under 'Public health', which includes funding for medicinal cannabis, it was stated in a media release on 17 January 2018 that 29 children had been offered an imported medicinal cannabis product and that the number would be expanded to 60 children. How many are accessing medicinal cannabis product currently?

Ms PEAKE — Thank you, Mr Smith, for the question. Obviously the children receive at a point in time, so it is not an ongoing list. There is a list that is current at a point in time. At the moment there are 29 children who are receiving medicinal cannabis. That does not mean it is the same 29 children as it was in the data that you refer to in your question.

Mr T. SMITH — So, again, at this point in —

Ms PEAKE — At this point in time, there are 29 children.

Mr T. SMITH — Twenty-nine at the moment, and how many children in total?

Ms PEAKE — I might just ask Ms Skilbeck if she has that overall data available today.

Ms SKILBECK — Yes, I do. It is a total of 34. We have had 13 patients discontinue their own participation in this compassionate access scheme. This is the scheme with which we provide medicinal cannabis that is imported. They have largely discontinued participation due to a lack of clinical response, either initially or after a period of time. It is not dissimilar to what we are seeing in some of the interstate clinical trials for persistent epilepsy in children.

Mr T. SMITH — Is that 34 on top of the current 29 or five on top of the current 29?

Ms SKILBECK — The number I have, as at May of this year — so literally yesterday — is that there are 21 children on treatment; 13 have discontinued. That means 34 over the journey since March 2017.

Ms HENNESSY — As the secretary pointed out, largely children with epilepsy are treated by a paediatric neurologist, so at different points in time, depending upon how other treatments might be going, paediatric neurologists make a decision about whether or not they wish to apply. I am certainly aware of one lovely little girl who passed away from the underlying condition who was on the trial. Without wanting to verbal any of the very insightful paediatric neurologists and those that are far more across the research that I, in the early days one of the informal or anecdotal pieces of advice that I was giving was that for about a third it did not make a difference, for about a third it improved their quality of life and for about the other third it was kind of like the jury is out. That is, in essence, how I think about the effectiveness.

Mr T. SMITH — Thanks, Minister. I do not mean to cut you off, but we are running out of time. When do you expect to get to 60 candidates for your trial?

Ms HENNESSY — I will ask Ms Skilbeck to provide you with that advice.

Ms SKILBECK — We are expecting a significant increase by the end of this month and thereafter. The specialists to which the minister referred have been implementing more formal clinic arrangements within each of the three hospitals involved.

Ms HENNESSY — That is at the Austin, the Monash and the RCH, where the three clinics are being set up.

Mr T. SMITH — So, is this at the end of this financial year?

Ms SKILBECK — No, it is this month of May.

Mr T. SMITH — Thank you. Have you estimated what the cost per patient is to supply them with imported cannabis or even how much was the total cost of importing cannabis in 2017?

Ms HENNESSY — There is a complicated answer to that simply because of the fact that it depends upon which product you are using. The cost is also determined by things like the weight of the patient. More generally there is a really significant cost between whether or not you are talking low-THC cannabidiol or high-THC product.

Mr T. SMITH — Have we got a number?

Ms HENNESSY — Ms Skilbeck might be able to provide you with an average perhaps.

Ms SKILBECK — I am afraid I cannot. I do not have it with me, but we can get —

Mr T. SMITH — Could you take that on notice?

Ms SKILBECK — Yes, we can get that information.

Mr T. SMITH — And how much was the total cost of importing cannabis?

Ms SKILBECK — Total cost, or per patient?

Mr T. SMITH — What was the total cost of importing cannabis in 2017. On notice?

Ms SKILBECK — Certainly.

Mr T. SMITH — Thank you very much. How much are patients currently being charged?

Ms SKILBECK — Zero.

Mr T. SMITH — How many applications have been assessed by the Office of Medicinal Cannabis?

Ms SKILBECK — Yes. One moment. As at 14 May we have assessed for schedule 8 — so these are the products with the greatest amount of THC available — and we have issued 62 treatment permits. This is after the much larger number that the Therapeutic Goods Administration in Canberra will have assessed because of course we only engage in the schedule 8 treatment permits, not schedule 4. For example, the program that we were discussing for epilepsy in children is a schedule 4 medicine, not a schedule 8.

Ms HENNESSY — I think there are 123 on schedule 4s.

Mr MORRIS — Sorry, just on that, Ms Skilbeck. There were 62 issued. Can you tell us how many applied?

Ms SKILBECK — I will have to take that one on notice, I am afraid.

Mr MORRIS — If you could, that would be helpful. Thanks.

Mr T. SMITH — In 16–17 and 17–18 there was $5.1 million each year, 10.2 million in total, for access to medicinal cannabis. Did all of the 5.1 million in 17–18 go to DHHS for medicinal cannabis? Has all of the money been spent; if not, how much has?

Ms SKILBECK — In 17–18 thus far we have not spent the entirety of the 5.1 million. I am afraid I do not have the estimated carryover to hand. But it is difficult to estimate the total number of patients and therefore, as was earlier noted, the flow, but we can provide that information.

Mr T. SMITH — On notice. Thank you very much.

Mr STENTON — Mr Smith, if I might, in the department's total appropriation that initiative is certainly part of what has been allocated to the department, and the carryover process is a timing question. So in the case of medicinal cannabis, where we simply are not able to allocate the funds because there are processes, we carry those funds forward.

Mr T. SMITH — Okay, so could you perhaps on notice take down a breakdown of how much has been spent on each of the component costs of running the scheme?

Mr STENTON — Sure.

Mr T. SMITH — And what is your advice on when the scheme will be expanded to include other cohorts?

Ms HENNESSY — Can I answer that? All other cohorts can now access it — can make an application to access medicinal cannabis. As I said, we know that there were 123 applications for med can in Victoria. The changing position of the commonwealth — and some of that has been a decision of the commonwealth, some of that has been around the politics of a disallowance motion that has been in the Senate that was originally put in, then it was voted down, then the then Senator Lambie changed her position — has then affected what access schemes are available. As at this point in time you can go to your doctor or your specialist if you have a condition or illness, and your doctor can make an application under SAS, scheme 1 or 2 — Melissa, is that correct? — and they can either approve or deny that application. If that is a schedule 4 medicine, it is processed immediately. If it is a schedule 8 medicine, it is processed within 24 hours by us. We do that for schedule 8s — not just med can, but all schedule 8s, so other opioids and things like that.

Mr T. SMITH — Minister, taxpayers are currently paying for current users of the scheme. Is that going to be expanded to other cohorts?

Ms HENNESSY — Our subsidisation is restricted to paediatric patients with severe intractable epilepsy for whom other interventions have not worked. That is essentially the threshold of what we as a state subsidise.

Mr T. SMITH — And so what is the cost?

Ms HENNESSY — That goes to the questions you have been asking Melissa.

Mr T. SMITH — So other cohorts will not be subsidised in any way, shape or form?

Ms HENNESSY — They are not. We say that that is the role of the commonwealth PBS. Well, there is one product, Sativex, which is used for multiple sclerosis, that is currently on the PBS. That is kind of state-subsidised or commonwealth-subsidised, for want of a better term, but the limits of our subsidy, as we have previously said, are limited to paediatric clients.

Ms PATTEN — Thank you, I would like to continue on that.

Ms HENNESSY — I am sure you would, Ms Patten.

Ms PATTEN — I actually appreciate some of the questions that Mr Smith answered. I was interested that we do not really have —

Ms HENNESSY — Asked, Ms Patten.

Ms PATTEN — Asked. Pardon me. It is question time, not answer time, anyway. The only real mention I can see about medicinal cannabis is that the schedule 8 acceptances, for want of a better word, have been rolled

into the general schedule 8 measures. Given that we are trying to expand our medicinal cannabis patient cohort in Victoria and we are trying to produce our own medicinal cannabis here, is there any reason why we have not got medicinal cannabis as one of the outcomes or measures in the budget?

Ms HENNESSY — Simply because, I suppose, the fact that the shape of the law and the world has changed so radically over the past three years, largely because of the change in appetite on this issue by the commonwealth and the changing role of their approach. The other angle that I also know you are interested in is of course the industry development angle as well. I am not quite sure if there are any output measures there, but that is also one of the other important reasons why we as a state remain involved despite the fact that the commonwealth, at the time that our legislation was brought into the Parliament, were saying, 'Never on our watch will we move on this', and now we have got a scheme where they are completely being very helpful, the regulation has changed. We have again recently —

Ms PATTEN — I would question 'very helpful'.

Ms HENNESSY — Helpful is always a relative term. Also at the most recent Council of Australian Governments there was an agreement for there to be work done on a national scheme. If you are in Tasmania, for example, you are required to have a specialist, as opposed to in Victoria where it can be a GP or a specialist. So there are just different hurdles or barriers in different states. The approach we have taken has been, 'Let's strip all of the regulation back and rely on the commonwealth scheme', because otherwise we would have been putting an additional layer of regulation in. We remain involved from both a clinical access and medical research perspective and production, which Ms Pulford will be able to talk to you about, for that cohort of patients with severe intractable epilepsy and Dravet syndrome and conditions like that.

Ms PATTEN — Thank you. I think that is an interesting segue into access to medicinal cannabis. While the state has now removed really any involvement in that access with the exception of —

Ms HENNESSY — Our paediatric —

Ms PATTEN — the children, the numbers are pretty small. In the government's own document it expects that there are 83 000 potential patients across Australia. Now, given that, say, a quarter of those are in Victoria, that is a potential 20 000 patients, and so far about 100, maybe 150, Victorians have been able to get access to it. I am wondering in what ways the Victorian government can assist with access. I have been informed by your department that it is a constitutional matter, but where there is a will there is a way of increasing that access. By 2021 we hope to be supplying 20 000 patients in Victoria, and at the moment 100 are getting it legally; thousands and thousands are obviously accessing it.

Ms HENNESSY — Beyond the boundaries of the law —

Ms PATTEN — Yes.

Ms HENNESSY — and you and I might not see eye to eye on that issue, but to try and go to the nub of the question, research is one obvious way. We are involved in some research and can always do more. I think the other really significant issue, and where this is changing at a kind of, I do not know, pharmacological level, is the changing in the dosage and the composition and what we know about the resins and what we know about the intellectual property of all of the different strains — work that Ms Pulford's office is working out, because you do not have venture capitalists and public listing of companies investing in medicinal cannabis because they think they are onto a bad investment. So I think there is the industry component.

The real challenge, however, is around the more we learn about composition, the requirements to comply with things like the Office of Drug Control regulations strengthen. Some of the advice that we have had, particularly around the paediatric end, is if you were to do that and apply all of the cost that the state had incurred you would end up with a product that costs around $1200 a week because it is so finely manufactured and purified. For your other medicinal cannabis that might be used for cancers and chronic pain or wastage associated with HIV you are probably looking at about $100 to $300 a week, ultimately getting the clinical evidence to a point where there is a compelling argument for the PBS to perhaps say, like they have with Xanax and MS, there may be an argument for us to subsidise some of this, because cost is the other issue.

Ms PATTEN — I take that point, but I would challenge that somewhat. When you look at the cost of medicinal cannabis in every other jurisdiction, it is not that amount and is not being subsidised. I think Canada is a good example. I was there recently and Aurora is saying $1.20 a gram to produce a dried flower. Now, you will need more than 1 gram to produce an effective medicine, but if the state can help with scale then those costs will come down, and with one in five Victorians in chronic pain, with the opioid issues, I just wonder if there are any initiatives that the Victorian government is exploring as to how they can increase access for Victorians, putting aside the special access scheme and whatever is happening up there in Canberra.

Ms HENNESSY — Yes. So, with 1 minute to go, I think inviting Minister Pulford to talk about that work that is underway —

Ms PATTEN — Yes, I will do.

Ms HENNESSY — Some of that work is commercially sensitive, so that is why I am cautious about leaning in on that issue, because I am not quite sure where the limits or limitations of that are.

The second issue, I think, around cost is about particular Australian regulation, and that is that one of the requirements, for example, that have been put in place for the good manufacturing process of medicinal cannabis that is locally produced imposes tests, and we do not have the capability or the means to do those tests to test for toxins. So part of what is driving the cost is the standards that are in place. Standards are a good thing when it comes to the production of medicine, but when we do not have the capability to test for some of those toxins we have then got to invest to develop the capability to do that.

Mr DIMOPOULOS — Minister, I just want to bring you back to this incredible slide on acute health budget outcomes, which shows extraordinary growth in 2014–15, and specifically budget paper 3, page 226, and the VCCC. There is a component obviously in that acute health funding line that goes to the quarterly payments for the PPP for the VCCC — all these acronyms. I understand that the initial proposal for the VCCC, back in 2009, was for eight floors for the northern section of the facility, which is the Royal Melbourne Hospital component of the development. I also note that commentators have had views about Melbourne Health's proposed use of the eighth floor. I wanted to ask if you could give some background about that history of the eighth floor and what the VCCC and the departments are doing to deliver the best possible health care and medical research for that funding in the budget.

Ms HENNESSY — Thank you very much for your question. Look, just to go to the nub of your initial question, there has been some misinformation put in around the activities of the eighth floor of the VCCC. The facts of the matter are that in 2010, essentially the VCCC on level eight of the RMH, there was an inpatient unit and that inpatient unit was going to be used for cancer beds. In 2011, however, there was a descoping of that, and I am happy to table the documents that demonstrate that. I know there has been some commentary asserting that that has been something done at the behest of our government. That is simply not the case.

Mr DIMOPOULOS — In 2011, was it?

Ms HENNESSY — It was in 2011 when the project was descoped and those beds were removed. Subsequently RMH, through their own investment, have delivered a stroke unit there. They are doing fantastic work all across the VCCC. Both the RMH and Peter Mac are doing quite extraordinary work. There is very exciting medical research that is emerging from there. There is greater access to clinical trials occurring. There is fantastic work being done on rare cancers in that area. RMH is doing extraordinary work in the stroke space as well. You know, of course, we have made significant contributions to establish endovascular clot retrieval services that are delivering amazing clinical outcomes.

People that would ordinarily walk away with a significant disability from a stroke are walking away 24 hours later without any adverse effect whatsoever. We have obviously combined that with the fact that in many areas we have, through our ambulance services, been enabled to give drugs that mean they thrombolyse patients. They can get very, very granular readings. They can immediately get that to one of the 24-hour stroke specialists either at Monash or at the RMH, and they can get them to a hospital if they are eligible for the clot retrieval. Literally it is making a world of difference. I do not have it at my behest, but in our stroke survival and disability rates you just see the data, and it is quite extraordinary.

Mr DIMOPOULOS — Minister, thank you. It would be great if you could table that document —

Ms HENNESSY — I will.

Mr DIMOPOULOS — because it clarifies a lot of this information, in fact not just for the recent past but for the last couple of hearings in the last couple of years. Thank you for that. I take you to budget paper 2, page 61. You mentioned earlier, in either a previous answer or your presentation — I cannot recall — what you see as a problem for the commonwealth funding model proposed. Can you elaborate on the deal a bit further and what the impacts would be for Victoria?

Ms HENNESSY — Sure. It has been a very long and challenging process to try and ensure that Victoria gets its fair share of funding from the commonwealth. That has not occurred when it comes to dental. Dental should not be treated as the poor cousin of general health, because it is so integral to people's general health. But the new kind of cost cuts that have been imposed by the commonwealth have reduced the amount paid per unit of activity by about 30 per cent. Health is full of all these acronyms that perhaps do not shed any further light on it, but a DWAU is a dental-weighted activity unit. In effect the commonwealth previously provided $848 per unit of activity. Under the new scheme they provide $578 per unit of activity. About 68 per cent of clients in the public system are priority or emergency clients, and they are not entered onto waiting lists because they are immediately triaged for the next available appointment.

So the magnitude of those dental cuts, plus the fact that we have got population growth and the priority that we give to people that are experiencing significant disadvantage with high needs, means that people will be waiting longer for dental care. That is going to have all sorts of impacts on people's general health and wellbeing. They attempted to do it initially through legislation. The commonwealth were unsuccessful, or failed to pursue that, and then unilaterally just decided that they would put out a different national partnership agreement and that that was what they were going to pay, and that was that. We have put some more money in, but the demand on dental and the fact that people's dental health is an insight, really, to people social and economic status, often, has incredibly meaningful impacts on their quality of life as well.

Mr DIMOPOULOS — And, Minister, it is an insight because it is treated differently, because it is not —

Ms HENNESSY — Yes. As I said, there are avoidable hospital admissions. If you go down to an emergency department over a weekend, you will find people in horrific pain because of the fact that they have not been able to access affordable dental treatment. People do a fantastic job, but the 30 per cent cut hurts. It will really hurt patients.

Mr DIMOPOULOS — Just one more question, unrelated to dental health: on budget paper 3, page 73, it refers to 'Health and medical research for bone marrow biology'. You have mentioned in your presentation, I think, the investment in the Centre for Research Excellence in Bone Marrow Biology, with their Maddie Riewoldt's Vision. I also saw a recent funding announcement. I think you also mentioned it was Olivia Newton-John in fact in this very room, and I think she was here in the last sitting week. That is presumably covered in 'Decisions made but not yet allocated' under general government contingencies, in budget paper 5, page 30. Is there anything else we have missed in terms of what the government is doing to invest in health and medical research in this budget that may be under those brackets?

Ms HENNESSY — Look, we are doing enormous amounts of things, but obviously on bone marrow failure, I think there are about 160 diagnoses of bone marrow failure per year. It largely affects people aged between about 16 and 40, and about half of them die. Very sadly, Maddie Riewoldt was one of those people. There is not a lot known about bone marrow failure. It is really kind of about the biology of the bloods. Again, with other blood cancers and leukaemias we have come some way, and organisations like Snowdome Foundation do an extraordinary job. We have got wonderful clinicians, but a lot of that information has not been transferable to bone marrow failure. Why there has been a particular challenge around bone marrow failure is that it is not technically classified as a cancer, and because of that it means that that particular stream of medical research has not been eligible to access medical research funding, for example.

So I am delighted that we have been able to make that investment. Obviously there is the investment for the ONJ wellness centre and the MRI-Linac as well, which again will be a really extraordinary piece of equipment able to be used for treatment without harming other parts of people's biology. I know that I am running out of time. Perhaps we can talk about the EMR shortly. But again that is not just important for patients; it is absolutely critical for research for organisations as well.

Mr DIMOPOULOS — And a different example but on a similar theme is the location of the heart hospital at Monash University, for the exact same reasons.

Ms HENNESSY — Precisely.

Mr DIMOPOULOS — I think, while employment is a second-order issue in relation to the first-order issue of saving people's lives, it has an enormous employment aspect.

Ms HENNESSY — Economic impact — biggest growth area of jobs in the state. The fact that we see so many —

The CHAIR — Order! Mr O'Brien until 12.10 p.m.

Mr D. O'BRIEN — My question is now to the secretary, relating to Ballarat Base Hospital. Secretary, can you tell me when the master plan for the Ballarat Base Hospital redevelopment extension was completed?

Ms PEAKE — I am actually going to ask Mr Fiske to give you the details on that.

Mr FISKE — We actually have an existing master plan, but we are actually going to need to reprosecute that master plan as part of the next phase of the full hospital's redevelopment. We are about to commence some review of our service planning, which will lead into another master planning exercise. One of the issues of redeveloping the Ballarat hospital is how we actually account for the decanting space to allow the full hospital redevelopment to occur, so that means we are going to have another look at the master plan.

Mr D. O'BRIEN — You said you have an existing master plan. When was that done?

Mr FISKE — It is several years old. It is about two or three years old; I would have to check on the exact date.

Mr D. O'BRIEN — On that basis, then, perhaps a question to the minister: Minister, how can we be allocating $462 million when we are doing a whole new master plan?

Ms HENNESSY — The master plan is being refreshed. The master plan has been in existence for a long period of time. We have got significant demand growth at Ballarat Base Hospital. There is an absolute need for us to redevelop that hospital. I am aware that other hospitals would have liked to have received capital funding in this budget. I would point to the fact that we have doubled the amount of capital investment over the course of our term in government. Ballarat is desperately needed, and like all builds and all master plans that are done, as people wait for capital money to be made available there is always usually a need for a refresh before the build commences.

Mr D. O'BRIEN — Secretary, the government provided $1 million last year to plan for Ballarat's future needs, including the fit-out of the shell space at level 1 of the Drummond Street building, which was funded by the previous government. How much does the fit-out of this space cost?

Ms PEAKE — Again I am going to turn to Mr Fiske to give you the details.

Mr FISKE — The fit-out of that shell space we envisage will actually be part of the full redevelopment and will actually be used for decanting space. We estimated that the full fit-out would be approximately $40 million as part of the early phases of the redevelopment. As the minister has pointed out, though, as part of the master planning process we will actually need to relook at some of the feasibility aspects of the technical approach to the delivery of the infrastructure, and that may adjust that figure.

Mr D. O'BRIEN — When will that begin, or is that not going to begin until the full redevelopment?

Mr FISKE — No, we are actually commencing the early phase planning, which will start with service planning imminently, leading to probably master planning at the back end of this year.

Mr D. O'BRIEN — What has happened since the announcement in February last year of $1 million for that planning?

Mr FISKE — That initiated service planning, so as part of the redevelopment we are going to actually —

Ms HENNESSY — Input into the redevelopment plan.

Mr D. O'BRIEN — A lot of planning. Can I move on to bush nursing centres. Minister, I am sure you are probably aware that the nursing EBA agreed between the government and the ANMF has resulted in significant costs on bush nursing centres, which are struggling with that. It is an effective cut. The reason that the bush nursing centres will not sign up to the EBA is because of this significant threat to their financial viability, so why haven't you fully funded the bush nursing centres for the costs of the EBA?

Ms HENNESSY — I am going to have to take that question perhaps on notice and come back to you. Bush nursing hospitals, as you may know, have a separate relationship to the department because many are kind of independent organisations — that is, it is like a not-for-profit hospital that is not a public hospital. Certainly a funding offer has been made to all of those bush nursing hospitals to fund any increase in the EBA, but I make the point that they are different.

Mr D. O'BRIEN — How much was that funding offer, Minister?

Ms HENNESSY — I cannot tell you. I am happy to come back to you. We appreciate the very unique position of bush nursing because they do operate like not-for-profit entities and because they are not public health services, so when they have come to us to say that they needed some support we have said that we are happy to help provide that support. In terms of the granular detail of that, I will take that on notice and bring that back to the committee.

Mr D. O'BRIEN — I understand, Minister, that the total costs of the EBA from 16–17 through to 21–22 are estimated to be $2.5 million. You have got a $26 billion health budget. Why can bush nursing centres not be adequately compensated for that EBA?

Ms HENNESSY — I do not necessarily accept your first figures, and I know that we have had some documents put through this committee whose veracity has been contested, but my point to you, Mr O'Brien, is that we are supporting the bush nursing centres. I do not see any reason why a patient in a bush nursing centre should not get the quality of care through nurse-patient ratios that we see in other public-funded hospitals.

Mr D. O'BRIEN — Have you met with Leading Age Services Australia, which represents the bush nursing sector?

Ms HENNESSY — I have certainly had correspondence with them.

Mr D. O'BRIEN — I believe they have been asking to meet with you.

Ms HENNESSY — I am not aware of that, but I do not manage my diary through this issue through committee. Mr Stenton is trying to whisper something in my ear. If you would permit me, he may be able to cut to the chase. I do not intend to make funding commitments here through the PAEC. As I said, bush nursing hospitals are independent, not-for-profit entities that operate in the state of Victoria. Mr Stenton, are you able to add anything to my response to Mr O'Brien?

Mr STENTON — I am happy to, Minister. Mr O'Brien, we did do some estimates for each of the bush nursing centres based on the EBA outcomes. They are at various stages of signing up to EBAs. We have provided a written offer that we think covers the full cost of the EBA.

Mr D. O'BRIEN — How much was that?

Mr STENTON — In total I would have to take on notice, but we have written to each individual bush nursing centre based on their workforce profile as we understand it to cover the cost of the EBA.

Mr D. O'BRIEN — For the record, I understand the offer is a total of about $515 000, and the —

Ms SHING — How would you know that if you just asked what the funding is?

Mr D. O'BRIEN — Because that is what the bush nursing hospitals have been told, Ms Shing. It is a $2.5 million shortfall out of a $26 billion budget. Anyway, can I move on. Can I just go back to the Ballarat —

Ms HENNESSY — Again, just to make the point, we are happy to do what we can to help, but these are independent, not-for-profit entities —

Mr D. O'BRIEN — But it is your EBA, Minister.

Ms HENNESSY — and the cost per hospital is going to be different depending on what they provide. The nurse-patient ratio changes according to the level of acuity of care that you are providing.

Mr D. O'BRIEN — And it is your nurse EBA that causes the cost, Minister. Can I move on anyway though. Can I just go back —

Members interjecting.

Mr D. O'BRIEN — No, I want hospitals to be adequately compensated for any decisions made by government, Mr Dimopoulos.

Can I go back to the Ballarat question? I am not sure I understand. You are beginning service planning imminently, but when will the theatres at Ballarat be operational?

Mr FISKE — I cannot give you the exact answer but I can provide guidance around how long these projects actually take in terms of time. We would typically expect that the planning, development and the design phase of a hospital redevelopment of this size would be approximately two years.

Mr D. O'BRIEN — From today?

Mr FISKE — From the allocation of budget funding, which has just occurred with BP4, and after that stage we would then look to the procurement and the construction and early works. For a hospital of this size you would expect that the construction phase would be anywhere between three to five years.

Mr D. O'BRIEN — Three to five years. Sorry, that is for the full project?

Mr FISKE — That is for the full project.

Mr D. O'BRIEN — Okay, no. I am asking specifically about the Drummond Street building and the theatres there.

Mr FISKE — We would expect that the Drummond Street theatres and the actual fit-out of the hot floor of the inpatient buildings is about an 18-month construction.

Mr D. O'BRIEN — Thank you. Can I just quickly go to VPTAS? Minister, budget paper 3, page 72, has some funding again for the VPTAS scheme — it is the Victorian Patient Transport Assistance Scheme. Again it has only been funded for one year. Why are you only drip-feeding VPTAS?

Ms HENNESSY — We are not drip-feeding VPTAS at all. In fact —

Mr D. O'BRIEN — There is nothing in the out years. It was funded for one year last year, it is funded for one year again this year. Why has it not got ongoing funding in the out years?

Ms HENNESSY — We have put more money into VPTAS than VPTAS has ever had. The issue is, because it is based upon the applications and eligible claims are then paid and budget allocations are based on historical trends, it is something that needs to be reassessed each and every single year. As you would be aware, there are reviews of VPTAS done for two years.

Mr D. O'BRIEN — Minister, that is the case for the Victorian health system —

The CHAIR — Order! Ms Shing until 12.20 p.m.

Ms SHING — Thank you very much, Minister and staff. I would like to go back to the amount of capital investment that has been provided and in particular to look at the provision of capital allocations throughout regional Victoria. In this regard it is the budget information paper on rural and regional, at page 18, and also budget paper 4, page 62. I would like to have a better understanding of the health capital items in the budget

going beyond Ballarat Base and looking at the other major and also less enormous amounts of funding that have gone toward health infrastructure, including the Regional Health Infrastructure Fund.

Within this context if you could refer to managing population growth and the challenges of our growing communities as people move to the regions and also to go back to your point around those hospitals that have missed out on advocating for new builds, for upgrades and for greater envelopes than perhaps they have received. How do we place that into context around the work that is being done and what the pipeline is proposed to be into the future around meeting those needs?

Ms HENNESSY — Thank you, Ms Shing. I am really delighted with our very significant investment in rural and regional health. It is the largest the state has seen in a significant period of time. Initially of course we have boosted our Regional Health Infrastructure Fund to $250 million. Again, by way of contrast, I think it was $57 million under the previous government. That has been really important for organisations that have not small but medium-sized capital asks in essence where it is really difficult to find a funding stream. I would make the point that all regional public health services, local and small rural health services, public residential aged care, registered community health services, bush nursing hospitals — which I know are a matter of interest to Mr O'Brien — women's health services and Aboriginal community-controlled health organisations are all eligible for that funding.

I can confirm, just to give you an example, some of the projects that have received that funding: Bendigo Community Health received around $384 000 for three new GP consulting rooms and new women's sexual health services. Cowbaw Community Health Services — a really big rebuild there that has been warmly welcomed, $9.7 million for a new community health access hub. They do amazing work at Cowbaw and they are very much grounded in the local community. Nexus Primary Health, 616 000. They have got a growing number of children that they support at Wallan in that kind of peri-urban area but they required support. Expanding the maternal and child health, and home and community care services at East Grampians, $4.12 million. East Wimmera community health service, 1.3, renovation of the Birchip campus and aged care. Dhauwurd Wurrung Elderly and Community Health Service, refurb. Latrobe Community Health Service received 304 —

Ms SHING — Well, we will get onto Latrobe. Yes, absolutely.

Ms HENNESSY — for a new dental prosthetic clinic expansion. Moyne of course is having a redevelopment at $2.1 million. Heywood Rural Health, 680 to integrate their primary care services and their medical clinics. So those are just some very small examples of some of the important investments that have been made there.

Of course we have talked about the Ballarat hospital redevelopment that has been so warmly welcomed in the Ballarat community and the surrounding Grampians region. Of course $115 million for Wonthaggi hospital as there is incredible growth in the emergency department demand there. I think it is around 9 per cent. Similarly at Ballarat it is about 10 per cent growth in the demand that is occurring. That is not to say others, and I know one that you are very interested in, Warragul hospital, is not a worthy project. I know that they were very hopeful of support for a redevelopment. We have supported Warragul hospital with about $9.1 million to rebuild operating theatres and expand short-stay units. We have put significantly more money into their opex, but I accept that everyone who does not get their full capital funding up on one budget day can sometimes feel disappointed. I understand that. It is not to say that they are not worthy projects, but over $600 million in rural and regional health is in this budget. I would also add that we have continued to put significant investments into the operational funding for all of our regional and rural hospitals as well to enhance and expand their capability to provide services. On top of that, I think it is utilising things like the Regional Health Infrastructure Fund to assist. And that can be like for the Elmhurst bush nursing hospital. It was about a car. They wanted a car so they could actually do outreach to some of their clients.

Ms SHING — Gelantipy, the most remote bush nursing service in the state, again it is getting access to assistance and better facilities. Including telehealth mechanisms to provide that interface with technology is important. With the time that we have available to us, I would like to get a better sense of growth areas capital as well in the context of that health capital that we have already discussed within the region. So BP4, pages 62 to 66, again refers to the budget investments in health capital. We have got the Victorian Heart Hospital, we have got other areas in the south-east and then a future Footscray Hospital. How are we investing then in that

interface and that peri-urban and suburban area to manage population growth and that demand that will come into the future?

Ms HENNESSY — There is really significant demand, particularly in all of the local government areas that are well-known to us all, from your Caseys, which is why we are doing the rebuild and expansion, to your Wyndhams, which is why we have expanded the Werribee Mercy — it is a fantastic project underway — why we are building a new women's and children's hospital at Sunshine and why we are doing an expansion at Northern Health. Specifically in this budget another important investment is the $29 million investment for the Sunshine Hospital emergency department. An important part of that project of course is actually designing up some proper paediatric spaces in the design of our emergency department. There are fantastic clinicians in both the paediatric and the general obstetric space at Sunshine. This cannot come soon enough. The demand is extraordinary. It grows year on year. Putting in place the proper infrastructure is absolutely important to meet the needs of patients but also to give staff decent working conditions.

Ms SHING — On that point about giving staff decent working conditions, one of the challenges back to regional Victoria that we have is finding clinicians and staff for those regional areas and for hospitals and health services. How are we building on investments to provide a better quality of working experience and the support that young workers and workers often starting in the sector and in the profession need in an often geographically-isolated environment?

Ms HENNESSY — We have got a number of big programs that effectively support both our rural and regional doctors as well as trying to expand training and educational opportunities. Many things in the doctors-in-training enterprise bargaining agreement went to that end. Trying to ensure that they are getting the right kind of supervision and oversight has been important, as has funding scholarships for people to be able to get dual recognition. So you might not just be a generalist when it comes to obstetrics; you might be a generalist when it comes to orthopaedics or another area of specialisation, which then also grows your capability and your scope of practice in rural and regional locations. We do not have a supply problem; we have got a distribution problem.

Ms SHING — Absolutely.

Ms HENNESSY — So we have got to keep working hard to attract and retain people into rural and regional locations.

Ms SHING — In relation to, finally, preventative health and population growth, I would just like to get a sense of how we are tracking in relation to vaccinations and also preventative health measures across the out years in the forward estimates.

Ms HENNESSY — We have hit herd immunity for the first time in Victoria at 95 per cent, which is fantastic for everyone. I am trying to be very quick. There are lots of important prevention initiatives in the budget. Two of the really important ones from a rural and regional perspective are both the prevention lab — and these came out and regional partnerships — and Healthy Heart. We know that in those areas people are overrepresented in cardiovascular illness and disease.

Ms SHING — Particularly the Latrobe Valley.

Ms HENNESSY — Particularly in places like the Latrobe Valley as well. So those are fantastic projects that community-based groups have been wanting for such a long period of time, but, again, no kind of funding envelope.

Ms SHING — Some information on notice would be appreciated.

Ms HENNESSY — We have funded them in this, and we will provide that on notice.

Mr MORRIS — I will just get this one out of the way while I think of it. Secretary, could we have a list of lapsing programs that will conclude in 18–19 and are not funded in the forward estimates?

Ms PEAKE — Certainly; I am happy to take that on notice. I think some of that information is in the questionnaire, but not the 18–19 ones.

Mr MORRIS — Yes, just so we have got a cross reference. Thank you. Can I just go back to Ballarat quickly. I am just trying to reconcile the figures. In 18–19 there is $800 000 in the budget. In 19–20 it is 5.8 million. In 20–21 there is $27.5 million. So it would seem that the earliest time the new theatres could be completed would be 2021, given the funding in BP3. Is that an accurate assessment of the situation?

Mr FISKE — If I go back to the previous answer around the design phases, I guess the point at which we are in the project —

Mr MORRIS — I just want to know when they are going to be operational. There is not sufficient funding to make them operational before 2021, as far as I can see.

Mr FISKE — Not operational, but to commence the construction and the fit-out works, yes.

Mr MORRIS — I want to know when they can be used, when they are built, really.

Mr FISKE — Again, we are at a point where we have to actually redo the master plan and the feasibility studies. Some of that detailed work that you are seeking around when these projects will actually be finished from a programming point of view —

Mr MORRIS — When will the Drummond Street building be operational?

Mr FISKE — We are certainly targeting that 2021–2022 period, but again it will depend on when we will actually complete the program.

Mr MORRIS — Thank you for that. Minister, can I ask you about — and there was some discussion earlier — the proton beam therapy centre?

Ms HENNESSY — Sure.

Mr MORRIS — There is a relatively modest amount in the budget, some $5 million, with $45 million in remaining expenditure — a TEI of $50 million. Is the remaining 45 million still in contingency or has it not yet been allocated or has it been allocated elsewhere?

Ms HENNESSY — I will have to seek some advice. We are committed to 50 million. Where and how that is identified —

Mr MORRIS — I know, we heard about the north-east link, that there is a commitment there too, but there is no money in the budget, so I am just trying to nail it down a bit.

Ms HENNESSY — I will just have to seek some advice. Actually I might invite Mr Stenton to tell you what he just told me, lest I stuff it up on the way through.

Mr MORRIS — I have got the clock ticking down here.

Mr STENTON — I will be very quick, Mr Morris.

Mr MORRIS — Okay, let us go for it.

Mr STENTON — It is partly a technical issue. In the appropriation bill those funds are allocated for this project. If the timing of the project does not allow that to be spent in the period, effectively we do not have to go back and seek further authority. So there is a thing called the State Administration Unit, which is like a bank account. It resides in that bank account for us to access when we need to spend the money on the project.

Mr MORRIS — What you are saying is effectively the total sum is available in the forward estimates. Is that correct?

Mr STENTON — Correct. Yes, so we do not need to re-seek authority to spend it.

Mr MORRIS — Has the business case been completed and what is the cost according to the business case if it has been?

Ms HENNESSY — The business case has been completed, but we are not going to reveal the cost because of commercial sensitivities.

Mr MORRIS — Can we get a copy of the business case with those costs redacted?

Ms HENNESSY — The business case is the subject of cabinet-in-confidence at the moment. I am happy to provide you with some further information that does not either offend or potentially diminish the commercially sensitive information contained in it, but if your question is will I give you the business case, the answer is no.

Mr MORRIS — Yes, of course.

Ms HENNESSY — I say that as respectfully as I can, Mr Morris.

Mr MORRIS — We had a range for the heart hospital; can we get a range for this project?

Ms HENNESSY — Sure, I think that is a fair question.

Mr MORRIS — Regarding the site, your original 2015 media release said it was to be located at the VCCC; now it is at the RCH. Why the change of mind?

Ms HENNESSY — Just simply work that was done during the development of the business case.

Mr MORRIS — What caused the change of mind?

Ms HENNESSY — That it was more likely to be of benefit to paediatric patients, and therefore being closer to the RCH was a better site location.

Mr MORRIS — That obviously then begs the question: is this facility going to be available to adults?

Ms HENNESSY — Yes, it is our intention that that would be the case.

Mr MORRIS — Then why did the Premier in his letter to the Prime Minister say that the centre would meet the needs of patients from paediatric through to adolescence and young adulthood, clearly excluding adult use?

Ms HENNESSY — I know that is not his intention. I know that is your reading of his words. I am not in a position to attest to his state of mind when he drafted that letter. The predominant focus —

Mr MORRIS — Paragraph 4 says:

> The Victorian centre would meet the needs of the nation's cancer patients for paediatric through to adolescence and young adulthood.

Ms HENNESSY — The facts of the matter are that proton beam is largely of beneficial use to paediatric patients and those in a very small adult cancer group that have tumours located in places that are more difficult to treat with conventional radiation treatment. That is not exclusionary, and I would submit to you that that language is not exclusionary of adult access.

Mr MORRIS — In the couple of minutes available, Secretary, I would like to ask you a few questions about the impact of the Metro Tunnel, but in the context of that conversation we have just concluded, did the Metro Tunnel have any impact on the decision to move from VCCC to RCH?

Ms PEAKE — No. As the minister has outlined, the assessment that was made was really based on further research, further discussions, particularly with facilities overseas, around the best targeting of the use of proton beam therapy and that predominantly the client group — not exclusively, but predominantly — that benefits the most are the paediatric group. That was the basis of that decision.

Mr MORRIS — More broadly with regard to the Metro Tunnel, can you detail each of the risks to hospitals and research facilities that are being actively worked on and managed as part of the Metro Tunnel project? We know a few things about electromagnetic interference, but I am interested to know a bit more.

Ms PEAKE — Certainly. I am going to ask Mr Fiske to unpack this in a bit more detail for you, so really my comment would just be that we have been doing a lot of work both with the health services themselves and

with the Metro Rail Authority around understanding both the nature of the risks and the ways of mitigating those, including planning and scheduling as to the ways of mitigating those risks. But I will just ask Mr Fiske to step you through that.

Mr FISKE — We have been working very, very closely with the Metro Rail Authority on the impacts. At this stage they are still working through the actual construction methodology that they are going to apply to the construction of the station and the railway.

Mr MORRIS — Okay. Is there a time frame for when we expect the solution might be known?

Mr FISKE — So it will occur over the course of this year. We are expecting a firmer view of their construction program before the end of July, but at this stage what we do know is that their construction methods provide a great deal of flexibility around how they will actually construct it.

Mr MORRIS — So is it going to involve shutdowns of equipment, do you think? Is that where it is heading?

Mr FISKE — Not necessarily.

Mr MORRIS — Not necessarily. So is it intended to make the solution known publicly when it is available?

Mr FISKE — We will be working with all the stakeholders in the Parkville precinct, and there will be no issues around whether or not it can be made public.

Mr MORRIS — Okay. Thank you.

Mr T. SMITH — If I could just briefly ask about the master plan for Albury Wodonga Health, are both Albury and Wodonga campuses complete?

Ms HENNESSY — Sorry, I did not hear your question. So I heard 'Albury Wodonga', and then I did not hear anything after that.

Mr T. SMITH — Yes, Albury Wodonga Health. For both the Albury and Wodonga campuses is the master plan complete?

Ms HENNESSY — I do not believe it is. One of the challenges from the perspective of Victoria is that —

Mr T. SMITH — Minister, we have only got, like, 40 seconds left.

Ms HENNESSY — it is proposing that some services would be moved from Victoria to the New South Wales campus, and so getting the model of care right in a way that does not mean that Victorians miss out on services —

Mr MORRIS — Can we get the rest of the answer on notice? The hammer is going to come down on us.

Mr T. SMITH — Can we get it on notice?

Ms HENNESSY — Yes, absolutely. The issue is around losing services from Victoria, without being too provincial about it.

The CHAIR — Order! I would like to thank the witnesses for their attendance: the Minister for Health, the Honourable Jill Hennessy, MP; Ms Peake; Mr Symonds; Dr Grigg; Mr Stenton; Ms Skilbeck; Ms Congleton; Professor Wallace; Mr Foa; and Mr Fiske. The committee will follow up on any questions taken on notice in writing. A written response should be provided within 10 business days of that request.

Witnesses withdrew.