Division 21: WA Health, $5 062 550 000 —

Mr T.J. Healy, Chair.

Mr R.H. Cook, Minister for Health.

Dr D. RussellWeisz, Director General.

Dr D.J. Williamson, Assistant Director General.

Mrs R. Brown, Deputy Director General.

Prof. T.S. Weeramanthri, Chief Health Officer and Assistant Director General, Public Health.

Mr A. Frontino, Assistant Chief Finance Officer.

Dr R. Lawrence, Chief Executive, Child and Adolescent Health Service.

Mr J. Moffet, Chief Executive, WA Country Health Service.

Ms A. Kelly, Acting Chief Executive, North Metropolitan Health Service.

Mrs E. MacLeod, Chief Executive, East Metropolitan Health Service.

Mr P. Forden, Chief Executive, South Metropolitan Health Service.

Mr R. Toms, Chief Executive, Health Support Services.

Mr M. Hutchings, Director, Budget Strategy Purchasing and System Performance.

Mr N.J. Fergus, Chief of Staff, Minister for Health.

[Witnesses introduced.]

The CHAIR: This estimates committee will be reported by Hansard. The daily proof *Hansard* will be available the following day. It is the intention of the Chair to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point. The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. Questions must be clearly related to a page number, item, program or amount in the current division. Members should give these details in preface to their question. If a division or service is the responsibility of more than one minister, a minister shall be examined only in relation to their portfolio responsibilities.

The minister may agree to provide supplementary information to the committee rather than asking that the question be put on notice for the next sitting week. I ask the minister to clearly indicate what supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the principal clerk by Friday, 1 June 2018. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice through the online questions system.

I give the call to the member for Churchlands.

Mr S.K. L'ESTRANGE: I refer to page 251 and the heading, "Longer Term Election Commitments—Delivering Quality Health Care for Patients", the first bullet point and then the first sub–bullet point and the statement that the government remains committed to delivering its longer term commitments, including a renal dialysis service at Newman Hospital and the establishment of a Kimberley mobile dialysis unit. Given that no funding has been allocated to either of these commitments, when can the people of Newman and the Kimberley expect these services to be delivered?

Mr R.H. COOK: I thank the member. Obviously we are trying to populate the forward estimates with our election commitments, and some of those are easier to do than others, particularly around costings and things of that nature. With regard to Newman Hospital, the issue we are confronting there is that ultimately we re-scoped the funding under royalties for regions for that redevelopment, so we are currently discussing with the Minister for Regional Development how to go forward with that. We are committed to it and once we have a better idea of the costings associated with it, the member will see that in the forward estimates. Was the other one around the Kimberley mobile dialysis unit, member?

Mr S.K. L'ESTRANGE: Yes, the Kimberley mobile dialysis unit.

[10.30 am]

Mr R.H. COOK: The business case for the Newman health service redevelopment was approved by cabinet in December 2015, with total funding of $59 million. That was a certain amount of funding from royalties for regions,

plus a $10 million contribution from BHP. As I just mentioned, that is subject to final analysis. We are still waiting on costings for the Kimberley dialysis units before they appear in the forward estimates. I will ask Jeff Moffet whether he has any further commentary to make about that.

Mr J. Moffet: As the minister has indicated, we are in the final planning stages with Newman. We are currently working with the Kimberley Aboriginal Medical Services on the Kimberley mobile dialysis unit to ensure we have our program from next year going forward. We are in the final stages of negotiation. It is possible that some services may start in June or July this year, subject to it resolving other funding sources separate to state government.

Mr S.K. L'ESTRANGE: I thank the minister for that. Can the minister also provide an update on the Derby Renal Hostel and the dialysis facility at Fitzroy Crossing that we asked about earlier this year?

Mr R.H. COOK: That is a particularly vexing issue. As the member would be aware, for the delivery mechanisms under the business model, we invited non-government organisations to provide bids to run the facility. That process did not produce any viable bids and as a result we have gone back to market to try to find an appropriate operator. That has obviously delayed the opening of the hospital. My view is that is not good enough and we have to step in and provide at least interim services from within our own workforce or departmental capacity. I have asked the WA Country Health Service to operate that facility until it can find the community-based organisation to provide those services. If I may, Chair, I will invite Mr Moffet to make further comment in relation to those services.

Mr J. Moffet: Yes, we have completed construction of those hostels. We are currently in negotiation with providers from the non-government organisation sector to run it. We are making plans to commence operations as soon as possible, subject to the outcome of those negotiations. It is likely that in some parts of the state, such as Kununurra and Carnarvon, we will operate some of those smaller scale services and facilities ourselves, but in Fitzroy and Derby we expect to have an outcome with an NGO provider.

Mr S.K. L'ESTRANGE: I am not sure whether I heard the minister correctly. Did he say that there are some health department staff working in these facilities while he is negotiating to get a contractor in?

Mr R.H. COOK: That is what I have asked the department to have a look at, yes. If we are going back out to market, my understanding is that we will not have someone in play until the end of the year. That is just the nature of the bidding process. I think we should be utilising those facilities much earlier.

Mr S.K. L'ESTRANGE: Just to clarify, is there a time line for when staff will be put into the Derby and Fitzroy facilities while the negotiation process for somebody to take on the contract is going on?

Mr R.H. COOK: No, I have not been advised of that yet, but I will ask Mr Moffet to provide any information we are able to.

Mr J. Moffet: We are currently assessing what is possible in terms of the staffing and logistics of the operation. We do not have a time frame as yet, but if we can commence services prior to having an independent operator we will do so.

Mr S.K. L'ESTRANGE: How are the patients in the regional area currently being cared for?

Mr J. Moffet: In Fitzroy, for example, we have just commissioned a new four-chair unit. That unit is being well utilised. Current clients have their own accommodation with either separate providers or family. We support them; we provide transport functions. We have a level of uptake of accommodation in the private and, I guess, NGO sector separate to the existing hostel at the moment. Once the hostel is operational, obviously, we will be able to fully utilise the four chairs, so that will be up to 16 people. A similar arrangement exists in Derby, where we have accommodation in various places around town, but clearly once a hostel is in operation it provides a much more stable base for those patients. It enables really only a small number now to return from Perth. We have returned a significant number of patients home to the Kimberley over the last three or four years.

Mr W.R. MARMION: I refer to the royalties for regions expenditure table on page 172 of budget paper No 3.

The CHAIR: We are in division 21.

Mr W.R. MARMION: It has to do with health, yes.

Mr R.H. COOK: Chair, my understanding is that questions can be asked about issues related to budget paper No 3, but they need to be linked to a line item in budget paper No 2.

Mr S.K. L'ESTRANGE: It is on page 264 of budget paper No 2, volume 1, the royalties for regions fund under "Income Statement".

The CHAIR: That is the reference; please ask the question.

Mr W.R. MARMION: The minister will need to look at page 172 of budget paper No 3 to see the figures.

Mr R.H. COOK: That is fair enough.

Mr W.R. MARMION: My question is about funding to the line items "Fitzroy Kids Health", "Ear, Eye and Oral Health" and "Rural Palliative Care Program" about halfway down the page under "Other Health Programs". Funding for Fitzroy kids health stopped in 2016–17 and for the other two stopped in 2017–18. Can the minister explain why and whether they will be replaced by another program or funded from somewhere else?

Mr R.H. COOK: Previously, they were funded under royalties for regions. After discussions between the Department of Treasury and Department of Health, it was decided that those programs were to be absorbed into the main budget of the Department of Health. A range of issues are still being worked through in relation to that. Kimberley ear health is subject to a fresh election commitment, so funding for ear health and Earbus services will be ongoing. We continue to work through how the other programs can be better served out of the mainstream health budget. Palliative care in country health is one of the issues highlighted to me. I will ask Mr Jeff Moffet to make some comments about that issue.

Mr J. Moffet: The rural palliative care funding is provided directly to the department and funds flow to country health. There were some time-limited funds that will cease this year. We do not anticipate any impact on palliative care services. We are planning how we will address that and pick it up through our budget process. Palliative care services will be stabilised. The time-limited nature of all the funding mechanisms the member has talked about—ear, eye and oral health, Fitzroy kids health and palliative care—was part of a fixed-term funding arrangement with royalties for regions. Through the realignment and de-commitment processes there were changes to various health programs right across royalties for regions, and those three programs were particularly impacted. The actual funding for the Fitzroy kids, from memory, flowed to the Telethon Kids Institute; it did not come directly to country health. My understanding is that it was always intended to be a time-limited funding program. Similarly, the ear, eye and oral health program underwent some assessment in the WA Country Health Service. There was a series of funds right across the state to ensure we could adequately pick up ear, eye and oral health programs. The advice we received internally last year was that we could do that ourselves together with the NGO sector. As such, those programs have transitioned into our mainstream programs, both with the NGO sector and with WA Country Health Service.

Mr R.H. COOK: To provide the member with further information, the total funding for the rural palliative care program from the 2018–19 year is $2.235 million per annum. The funding allocated from royalties for regions was $4 million across four years, and there is around about $500 000 in 2017–18. The program is substantially maintained under the current arrangements.

[10.40 am]

Mr W.R. MARMION: I get the gist that basically these programs will be continued and are being looked at, and so they will not stop.

Mr R.H. COOK: Yes. One of the things that I am keen to make sure of, particularly around Aboriginal health programs that were on a short lead, is that we fund them better into the future and that the service providers do not have to continually fill out grant applications on an almost 12-monthly basis. We are very much looking forward to making sure that particularly around rural health we get a lot of these services back on a more sustainable footing to ensure that people can plan for the long term, and also so that we can benefit from the long-term impact of those programs rather than flipping and flopping between different programs on a two to three-year basis.

Mr W.R. MARMION: I have two more questions on that table. Why is there no further funding after 2019–20 for the residential aged and dementia care investment program and also for the regional men's health program? The funding extends a little further than the others I mentioned, but why will it stop? Will those programs be picked up by other funding?

Mr R.H. COOK: I will ask Mr Moffet to make further comment on that.

Mr J. Moffet: I do not have that table in front of me but I assume the member is referring to the stream six funds for grants to the non-government organisation sector in the aged-care and dementia care investment program. That was a time-limited fund that went through EOI processes to market around increasing capacity for aged care in the bush, particularly through the wheatbelt areas and particularly focused on dementia. The grant period will come to an end at that point and the program will be considered to have achieved its objectives. It has been very successful. We have had some great service and capital outcome from that program. I missed the other part of the question.

Mr W.R. MARMION: The other part was regional men's health.

Mr J. Moffet: To my knowledge, regional men's health was provided through an NGO, not through the WA Country Health Service, so I do not have any information on that program. I am very happy to follow up afterwards, but to my knowledge that is not a program that we administered.

Mr W.R. MARMION: It is only a small amount, about $800 000 a year.

Mr R.H. COOK: Perhaps we will provide by supplementary information the funding arrangements for the regional men's health program.

Mr W.R. MARMION: Yes. It has consistently been $800 000 and it seems to drop off in 2019–20.

[*Supplementary Information No A11.*]

Ms M.J. DAVIES: I refer to "Income Statement" on page 264. I have the same question as I asked in the mental health division about royalties for regions. Can the minister provide a list of the projects that are being funded by royalties for regions and define where those projects are being funding only by royalties for regions and where there is a combination of departmental funding and royalties for regions; and list any of the projects or services that were previously partly or wholly funded by consolidated revenue that have been shifted into RforR. I heard the minister say that some had been shifted from royalties for regions into consolidated revenue, so could we have those listed as well?

Mr R.H. COOK: I would be very happy to provide that by supplementary information as this is very detailed. Over what time line—from 2017–18 onwards?

Ms M.J. DAVIES: Yes, for this budget.

Mr R.H. COOK: I will provide for the 2017–18 budget those projects that have been funded exclusively from royalties for regions; those that are funded in part from royalties for regions and in part from consolidated accounts; and any funding that has been transitioned from the consolidated account to royalties for regions from 2017 across the forward estimates.

Ms M.J. DAVIES: And the opposite as well, so any that have been funded by royalties for regions that have gone back into consolidated or been absorbed by the department.

Mr R.H. COOK: It is a four-part question.

[*Supplementary Information No A12.*]

Mr S.K. L'ESTRANGE: I refer to the service summary table on page 252 in budget paper No 2. The community dental health services line shows a funding reduction of 10 per cent in 2017–18 to 2021–22. I note that this service also receives the least amount of funding, making up 1.2 per cent of the total health budget in 2018–19 and only one per cent in 2021–22. Given this includes the school dental service and the government's emphasis on preventive health and the link between oral health and other health issues, such as cardiovascular disease, what is the rationale behind cutting funds to this important area of public health?

Mr R.H. COOK: That is a great question. As the member may or may not be aware—I learnt it over my period as shadow minister—dental services are ultimately regarded as a primary healthcare program; therefore, they fall substantially within the domain of the federal government. Over the course of 2017 we spent much time arguing with the federal government over the new national agreement on dental services. In addition to that, we provide hospital or emergency dental services, for want of a better description, through a couple of large clinics in the community. The actual make-up of dental service funding is a fairly complex beast. It is substantially commonwealth funding, but we provide some funding and are the ultimate deliverers of the service, particularly for school-based dental services. At some point there will need to be a point of reckoning around dental services because, as the member observed, it has an impact on people's overall health and wellbeing; for example, cardiovascular disease. Oral health is an import aspect. We do a pretty good job—not a fantastic job—for schoolchildren. We then lose them for 10 to 15 years, and then in their mid-30s and early 40s they come back into the dental system with what is in many cases a depleted oral health profile. Ultimately we will have to find better ways of doing this. I have diverted from the point of the question, so I will come back to that in a second.

Some work is being done at the moment around the scope of care that can be provided by oral hygienists and whether there can be a better penetration of preventative oral health in the community. That is being wildly opposed by the Australian Dental Association, the national body, in a manner in which one can only imagine we often find when it comes to turf wars in the scope of practice in the healthcare system. The Australian Dental Association WA has a very much more informed position on this matter and is very keen to engage oral hygienists. A debate is still to be had about whether oral hygienists should be able to have an independent practice or whether they should maintain their practice as part of a dental surgery. I am keen to see that work progress because hopefully that will mean people will go to an oral hygienist for a scale and clean and check-up, resulting in better oral health maintenance. I see the member for Kalamunda nodding furiously because he has a couple of oral hygienists operating in his area and they are great champions of the cause.

Returning to the issue the member raised initially about the funding arrangements, it may or not surprise him to hear that I am going to flick pass that and get a more informed answer, firstly, from the director general and, then, his colleagues if they wish to comment.

[10.50 am]

Dr D. Russell-Weisz: I concur with everything that the minister has said. We have also prosecuted an argument with the commonwealth to increase dental funding to the state. Indeed, probably 12 to 18 months ago there was a proposal from the commonwealth to push forward a new dental scheme—a new partnership agreement—to the states. That was not supported by the other states, and did not get up, but it was supported by Western Australia. That means that there is a continuing national partnership agreement for public dental health services for adults. As part of that, across the new NPA, which just basically revisits the old one—unfortunately, it is not the one that was actually proposed—we are eligible to receive up to $21.8 million in revenue, subject to the achievement of more activity. The new NPA reflects a reduction in commonwealth funding per dental weighted activity unit. All states are becoming more efficient in the delivery of health services in general, so the new NPA reflects a reduction from $850 to $600 through what is called the modified Monash model. There is now a loading for patients in rural and remote areas. We will continue to expend the money given to us by the commonwealth through the national partnership agreement, but there is still an argument to seek additional funding from the commonwealth for, as the minister says, a primary health care service.

Mr S.K. L'ESTRANGE: I appreciate the challenges that departments and ministers face with funding arrangements between the states and the commonwealth, but the question is really about the delivery of services to the community, and that is why the budget has a line item for community dental health services. The real concern is that from 2017–18, compared with 2021–22, we are talking about a $10.5 million-plus reduction in the amount of money allocated to this important service. Notwithstanding that the government will be negotiating with the commonwealth over budgets—we get that—which services delivered to the community will have to be cut back as a result of this almost $11 million drop in funding?

Mr R.H. COOK: I do not think there will be any depletion in services. I will provide the member with more analysis of how that funding falls into the forward estimates. As I said, it is a fairly complex funding model. I think it is a great question, and I will certainly get that information to the member. My understanding is that the anticipated volume of work or activity will increase over the forward estimates, so efficiency issues are probably involved. I will undertake to provide supplementary information to the member on the breakdown of funding for community dental health services across the forward estimates, and reasons for any reduction in each of those funding categories.

[*Supplementary Information No A13.*]

Mr W.R. MARMION: I refer to the last dot point on page 251 of budget paper No 2, on the National Disability Insurance Scheme—my favourite subject. Can the minister provide details of what the government is doing to ensure that Western Australian patients do not lose out on services currently being provided to them in the transition to the NDIS? The dot point refers to home and community care clients.

Mr R.H. COOK: As the member would be aware, HACC services are transitioning to the federal government as a result of a decision made in 2016. One assumes that decision was taken in the context of the rollout of the NDIS generally, although at that point we had not signed up to the NDIS. That essentially means that patients under the age of 65 who are currently recipients of HACC services will ultimately transition to the NDIS. In addition, patients over 65 will continue to receive HACC services, but ultimately funded solely by the federal government, rather than on a co-funded basis or a co-delivery model.

I am sure that the director general has a lot of views about the major threats to the Western Australian health budget, but I think the NDIS represents one of the greatest threats. The member will appreciate that that is because, firstly, we still do not know what it looks like, in large part; and, secondly, the NDIS is a model of service that relies on assessment and being able to access private sector service providers. I may be old-fashioned, but I suspect that a young Aboriginal person living in Wiluna will struggle to find a private sector provider of disability services in that town. Therefore, it will fall back to the service provider of last resort, which of course is the WA Country Health Service. The other aspect of the NDIS is that it is based upon an assessment of people's care needs, and they are funded around that. We could imagine someone sitting in a hospital bed waiting to get a care assessment from the NDIS. Before they can transition out to the community, there will be some time lag. We have seen some horrific time delays in care assessment packages in the eastern states, where they have had a bit more experience of that. That means extended length of services and length of stay, which is a key metric in controlling the health budget. Some significant challenges will come with the rollout of the NDIS.

I can provide assurances to the member that no-one will be worse off in receiving the care they need. We will obviously stand by patients and make sure that they are looked after. However, I am very focused on making sure

that genuinely federal government funding obligations are not picked up by the Department of Health simply because of the deficiencies in the NDIS program, therefore resulting in a cost transference to the states from the feds. That is a huge threat to our overall budget. I will ask the director general to provide further comments on that.

Dr D. Russell-Weisz: The minister has summarised it very well. We look at other states, through the Australian Health Ministers' Advisory Council, and other states are finding that patients are going to the providers of last resort, which are their health departments or health service providers. We have to watch for gaps in not only country areas but also metropolitan areas. One issue that is coming up recurrently across the country is delays in assessments. As the minister said, once a patient is delayed in hospital getting an assessment, they are delayed getting out of hospital and into appropriate care. We met this week with the Department of Communities, and we will be monitoring, with our health service providers, examples of the NDIS not meeting the needs of patients quickly enough. As the minister said, there is a very big risk, as there is in aged care, of a cost shift to the state in which we will pick up patient services and patient costs.

Mr W.R. MARMION: I am encouraged on two points. One is that the government will make sure that no-one is worse off—that is a good point—and also that it will be watching the transition. I am encouraged by that. But just to get something back in writing, if it is possible, can the minister list which categories of patients will receive less government funding support for a medical condition, and by how much, under the NDIS than was previously the case?

Mr R.H. COOK: I suspect that I cannot, because we are still trying to work out exactly where the NDIS is going to land. It is a very good question, and I wish I knew the answer—I think we all do—but I do not think we have that level of clarity at this stage.

[11.00 am]

Ms M.J. DAVIES: I refer to the line item for the drawdowns from the royalties for regions fund on page 262 of volume 1 of budget paper No 2. Does this line item contain funding for the upgrade of Laverton Hospital? I understand that $4 million in funding earmarked for Laverton has been quarantined in the royalties for regions budget. Further to that, how does the Department of Health plan to fund the shortfall? I presume that $4 million will not be enough.

Mr R.H. COOK: Obviously, the Minister for Regional Development and I are acutely aware of the need to ensure that Laverton Hospital gets the necessary upgrades. We both went out there late last year and met with the staff at Laverton Hospital and also with the local government authority to talk about how we might progress Laverton Hospital. I have not had an update on Laverton Hospital in the last month or so. I am waiting for the Minister for Regional Development to come back after some of her deliberations; I think she is having some discussions about how we can properly fund that hospital. It is a priority. The buildings at Laverton are substandard, despite the great work that is done there. It had a really good feel. The staff there are really committed and pretty optimistic about their future. But we want to make sure that we get the necessary funding to that hospital as a matter of priority.

Ms M.J. DAVIES: Is work being done on exactly what funding is required? There is $4 million quarantined. What is the total projected budget?

Mr R.H. COOK: I do not have the total projected budget details to hand, but certainly the Minister for Regional Development is looking at how we can better scope that particular project to make sure that we get value for money. With some of these projects, there is a lot of fat in the system, so to speak. The example we use is the upgrade to Bremer Bay hospital. I think the total project cost was $6.3 million. Of that, the Building Management and Works component was $3 million, so half the construction costs of the hospital were going to be taken up with overheads provided by government. We are still trying to get some more information on the needs of Laverton Hospital to make sure that we have an appropriate rebuild. I assure the member that it is a matter of priority. I am just waiting for further advice from the Minister for Regional Development.

Ms M.J. DAVIES: Just so I am clear, because maybe I do not have the process right, would the Department of Health provide the scoping for a hospital, rather than the Department of Primary Industries and Regional Development?

Mr R.H. COOK: Ordinarily, yes, but I am aware that under the royalties for regions program there is more than one stakeholder in the room, and the Minister for Regional Development wants to ensure that we get proper value for money out of that particular project. Also, as the member will be aware, the Minister for Regional Development is the manager of the royalties for regions budget and has a wider body of work within which we can manage these things better.

Ms M.J. DAVIES: Is the intent to pay for the entire hospital upgrade with royalties for regions funding? Has no funding been allocated in the forward estimates within the health budget?

Mr R.H. COOK: I am not aware of funding that would be made available. As the member will be aware, the previous government committed $19.5 million for Laverton Hospital, which was a royalties for regions commitment. When I went there with the Minister for Regional Development in December, we reviewed the drawings and updated cost plans that identified a revised total cost of $16.75 million. That was the recasting around that. We are continuing to work with the Shire of Laverton and the Minister for Regional Development to recast that particular development. I understand that other projects in the area are also being considered as part of the overall package. The Minister for Regional Development is taking, as we would suspect, a regional view of it. I am taking a health view, so I am focused on the hospital. The Minister for Regional Development has a wider scope of consideration.

Ms M.J. DAVIES: Would it be fair to say that if the Minister for Regional Development cannot find the funds within the royalties for regions budget, there will not be an upgrade to Laverton Hospital because there is no intention to put any health funding dollars into that project?

Mr R.H. COOK: I can confirm that there will certainly be upgrades to Laverton Hospital, because we have to bring it up to scratch. At this stage, the funding that we have identified, just as the previous government had identified, is within the royalties for regions package. I am just waiting for further advice on that.

Ms M.J. DAVIES: Is there a time line? I know that the minister has said that he is waiting, but is there a time line for that? Obviously, the staff and the community are very aware of the current state of the hospital.

Mr R.H. COOK: I will get some quick advice on the time lines. I might ask Mr Moffet to make some further comment.

Mr J. Moffet: In terms of trying to manage scope tightly and manage value on the project, we are looking very closely at the previous $19.5 million. It is possible that we can reduce some of the cost, for example, by decoupling some of the age-appropriate accommodation. We are looking at some scope options and some value management of the previous proposal. I do not have an exact time frame, but I imagine that within a couple of months we will have advice for the minister on what we think is possible from a planning perspective. At this stage, we think we can achieve greater value with a very similar outcome with the information I have. I suggest it will probably be a couple of months.

Ms A. SANDERSON: I refer to the spending changes outlined on page 247 of the budget papers and to Perth Children's Hospital. Can the minister quantify the cost of the impact of the historical contract mismanagement by the previous government on the health budget?

[11.10 am]

Mr R.H. COOK: Obviously, the member will be aware that this is an incredibly frustrating project, but we have invested a lot of time and energy in getting Perth Children's Hospital open as early as possible and as safely as possible. I am very pleased that we have now landed on an opening date. The Minister for Transport would say that that is 10 June. I say that we have already achieved the opening date, which was 14 May, but that is as may be. Because of those delays, a range of cost elements are, quite frankly, extremely damaging to our financial position. Obviously, key amongst those is the contract for parking arrangements that operates at the children's hospital. Under the contract with Capella Parking, which is the private equity company that developed the contract—this is not about Capella; I understand it is out there to basically put together a business case that makes sense for it—compensation payments are due to Capella because of the lack of operational beds at the hospital on the Queen Elizabeth II Medical Centre campus. That is ultimately what it is about. There has been some commentary recently to say that now that the government is opening the hospital, surely it does not have to pay compensation to Capella. Until we have patients at the hospital, those compensation payments are still forthcoming. That is an incredibly frustrating situation. Quite frankly, it is gobsmacking that it was not foreseen by the previous government that there may be construction delays and therefore financial risk associated with putting together the contract in that way. I am very anxious to make sure that we get to 10 June so that we can get rid of that particularly invidious part of the contract.

Another compensable aspect is that under the current contract, there was a schedule of fees to be paid by staff and visitors utilising the car park. That schedule of fees was revisited by the previous government, subject to some fairly effective campaigning by some of the health unions at the time. Because we have put a lower trajectory on the way those fees are charged, Capella said, "You, the government, have to pay the difference between what you now want to charge people to utilise the car park and what you previously said you would charge under the contract", so more compensation is associated with that. It is an absurd situation for the government to find itself in. The parking rates for 2018–19 have not been finalised. However, if parking fees for staff increase by 5c to the maximum of $6.05 a day, the agreed rate in the project agreement for 2018–19 is $7.80 a day. Members can understand that across the thousands of staff who will be using that car park, there is a substantial financial risk to the Department of Health. I am not sure about the costs associated with the tariff difference, but we now know that

the cost for operational beds will be over $5 million. This is $5 million of dead money that has to be paid to Capella simply because of the delays at the hospital. The delays at the hospital were for a range of reasons. My thoughts at the time were that an opening date of December 2015 was extraordinarily optimistic. Nevertheless, to peg financial penalties in the contract with Capella to those delays really put us at extreme financial risk. Of course, that financial risk was identified in the Langoulant report, which was quite damning of the car park arrangements. A lot of good taxpayer money has been thrown after dead money. It is a very frustrating situation but, mercifully, we will at least get away from the operational bed penalty once Perth Children's Hospital opens on 10 June.

Ms A. SANDERSON: If the government is supplementing the tariff as well as paying the penalty, and it depends on how many hours an individual uses the car park, is the figure quantifiable? Can we predict what the tariff will be?

Mr R.H. COOK: For 2018–19, the tariff difference has been estimated at around $1.4 million. That is a financial penalty we will pay directly to the private operator.

Ms A. SANDERSON: For one year?

Mr R.H. COOK: For one year, yes.

Ms A. SANDERSON: Because of the contract entered into, is the government subsidising the parking for users of the hospital by $1.4 million just in this financial year?

Mr R.H. COOK: In 2018–19; that is correct. Depending on where the new parking fees are struck compared with what they were anticipated to be under the project agreement, there will always be a penalty until such time, if it happens, that the agreed trajectory of car park fees meets the actual car park fees.

Ms A. SANDERSON: Is Capella a Western Australian company?

Mr R.H. COOK: I do not think it is a Western Australian company. I know of it in the eastern states, put it that way, so I assume it is based in the eastern states. Capella is like a lot of private equity companies; it comes in, does these things and makes a profit on an agreement. For Western Australian taxpayers, this contract is a dud.

Mr S.K. L'ESTRANGE: I refer to page 262 of the *Budget Statements* and the total funding for the asset investment program. I note that the funding for 2017–18 was $653.5 million and for 2018–19 is $411.245 million. The funding drops to $107 million in 2021–22. From 2017–18 to 2021–22, there is a drop of 83.6 per cent in asset investment. Can the minister explain why this investment has been reduced so drastically, especially given the fact that this budget omits important infrastructure needs at Peel Health Campus, King Edward Memorial Hospital for Women, Graylands Hospital, Laverton Hospital and Royal Perth Hospital, plus no doubt others?

Mr R.H. COOK: I thank the member for that important question. The reason there is a drop across the forward estimates is simply that a lot of the costings and scheduling of those projects have not yet been built into the forward estimates. In addition, there is a range of royalties for regions–funded projects, particularly in the wheatbelt and other country areas where there have been major hospital upgrades. To give the previous government its dues, it made the biggest expenditure in southern country hospital upgrades in the history of that government. From that point of view, a substantial amount of capital works are coming to an end, which represents an important contribution. Into the future, as we identify costs and cost trajectories for other capital works, they will be built into the budget. As we bed down the business cases for those capital works, we will get a better line of sight on how those costs will occur across the forward estimates. So the reasons for the drop at this point are, firstly, we are coming from a historical high; and, secondly, we are yet to identify the full costs across those capital works we have identified to date.

Mr Z.R.F. KIRKUP: Obviously, I am not a committee member, Deputy Premier, but Peel Health Campus seems to be the reason for my existence here at the moment. I am keen to understand where in the asset investment program the $4.4 million for the car park at Peel Health Campus sits, given that is what we are looking at here for new works. Can a breakdown be provided of what that $4.4 million will be invested in?

Mr R.H. COOK: The $4.4 million for Peel Health Campus is part of a repurpose of some funding that was discovered from other capital works that came in under scope. It is a good opportunity to direct some funding that way. The South Metropolitan Health Service has identified a range of works that it would like to undertake at that hospital, which go to the question of patient safety and is inclusive of the car park. I want to sit down with the South Metropolitan Health Service to get an understanding of exactly what that funding will be for because I think some elements of that hospital need care, most notably the waiting area for patients in the emergency department, which I think is suboptimal, quite frankly. The emergency department functions pretty well despite its volumes. It is an old-fashioned emergency department in which the staff and patients are all together in the same big room, rather than having partitions. Considering its older design for an emergency department, it functions pretty well and the staff do a good job. However, I am worried about the waiting area and I think we can do better. An upgrade to the car park and some CCTV arrangements around car park security have been identified in the first instance. I am unsure about some other elements at this stage. South metro has said that it needs upgrades to some of the

information technology and communications systems within the hospital. I would like to have a closer look at that to get a better understanding.

Mr Z.R.F. KIRKUP: With regard to further needs at Peel Health Campus into the future, the Deputy Premier identified the emergency department waiting room area, for example. I realise it is not catered for in the forward estimates, but can the Deputy Premier please provide us with an insight into when we might see something like that land more specifically regarding investment into that hospital?

[11.20 am]

Mr R.H. COOK: In part, it is complicated by having a private operator in the field. I am not trying to sound too political about this, but there was an opportunity for some upgrades when extension of the operating contract occurred in 2016. That was a segue in terms of the contract; admittedly it was just exercising a five-year option to 2023. However, I think that the previous government really missed an opportunity to say to Ramsay, "You're operating this hospital. If you want an extra five years on this contract, at least out of an act of goodwill we would like you to contribute, along with the government, to do some work there." But that is a matter of history and as a result at this point in time there are no big asset investment plans across the forward estimates.

Ordinarily, the next opportunity will be in the lead-up to the negotiations that decide that contract in 2023. I do not think that it can wait that long, so I have asked the department to dip in and have another look. If substantial changes were made to the hospital, such as expanding the capacity of the ED, I do not know how that would be done without an expansion of inpatient beds. Ultimately, an emergency department works only when a ward is sitting behind it, and some work needs to be done there. I do not think it is in crisis, as the member would portray it in the community. I talk to staff there on a very regular basis, and they say, "No, things are going very well. We are busy, but we're a hospital; we're always busy."

I will invite Paul Forden, the chief executive officer of south metro, to comment, because in the past he has mentioned that he thinks that we can sweat the asset a bit more and get some efficiencies out of that operation. He is discussing that with Ramsay Health Care at the moment. I, like the member, look at that hospital and think that it is not the most modern in the fleet and that some minor works need to be done to make it a bit more comfortable for the users and the staff who work there. In the second instance, I think we have to plan for it for the longer term, which is the work that would be done around 2023. I have asked the Sustainable Health Review panel to look at that and to give us a good idea about the needs assessment of the Peel region generally.

The member would also be aware that Murray District Hospital is just up the road. It is a beautiful hospital in the finest traditions of a hospital. A jumbo jet could be landed in those corridors and it is built like a double-brick building! I would love to see that utilised better as well, but we are restricted to a certain extent by, one, the population cohort and, two, its fairly old design. What I might do, because estimates is a great opportunity to engage on this stuff, is to get Mr Paul Forden to comment on this matter.

Mr P. Forden: In the short term, the waiting area is tired; it definitely needs some refurbishment.

Mr Z.R.F. KIRKUP: To clarify, chief executive—the ED waiting area?

Mr P. Forden: The ED waiting room, but I would say it is the walk-in waiting room rather than in the main ED. The main department where the ambulances largely drop off, and not those of the inpatients, is the area that is failing not because of its size but because the patients are not getting out of the ED on time. Recently, Ramsay created a short-stay assessment area within the hospital. It has re-provisioned some beds. That has allowed patients for whom there is uncertainty about whether they will be admitted to leave the department and be put into a more respectful environment. As a result, the hospital's WA emergency access target parameters have gone from 64 per cent to 78 per cent. It shows that it is not just about the size of the department, as the minister said; it is about how we pass patients through the service and make sure that they are in the right place at the right time. There were other problems around certainty, where the walk-ins were coming in, and I think there were some areas where the chairs were opposite patients on trolleys. That, again, is not the most respectful place for those people. That has been moved that around and there are some plans to make other changes around that. It will require some spend, but I would not countenance the problem being solely the size of the emergency department. That was not the issue. The rest of the hospital, though, is an area with rising demand in that Mandurah population, so across the whole of south metro we are implementing a demand management model, which is almost complete. That will show us where the population will change over the future years and will allow us to then model the services in Mandurah, not only Peel, but also in Rockingham, Fremantle and Fiona Stanley, and align those service needs to meet the needs of the population. The other part we are doing, though, is actually not in hospital bed–based solutions; we are working with other providers, whether it is in partnership with primary care, with other NGOs et cetera, because a number of patients are still accessing that hospital and other hospitals in south metro, potentially via not the most appropriate route. We have a number of cellulitis patients and chronic obstructive

pulmonary disease patients. With a different model of service we could actually reduce the number of patients getting to crisis stage and therefore needing to be admitted.

Mr W.R. MARMION: I have a question on the asset investment program and I raise the issue of King Edward Memorial Hospital for Women. I understand the Sustainable Health Review stated that there needs to be a commitment to progress plans for a new King Edward hospital. I understand it recommended that it be co-located at the Queen Elizabeth II Hospital. Has the government committed any funding that may not be represented in the budget for further planning of a King Edward Memorial Hospital merger with QEII, or any other replacement structure for King Edward Memorial Hospital?

Mr R.H. COOK: That is a great question. I would love to be the minister to kick off this project. It would be a humdinger! As the member knows, the two big infrastructure elements of the Reid review was for a big tertiary hospital in the southern suburbs. In a great spirit of consensus, that was paid for by a Labor government and built by a Liberal–National government. In relation to the other element—that is, that there should be a new tertiary children's hospital on the QEII campus site—in a great exercise of consensus, that was substantially paid for and built by a Liberal–National government and I took great pleasure in opening it.

Mr W.R. MARMION: I noted that; I got an invite after that. Play on!

Mr R.H. COOK: I insisted that the member got an invite—do not worry about that. The other element is that Reid formed a view about RPH on which there was no consensus, but on which we have since found consensus. The final element, the other aspect of the Reid review, was shifting the women and babies hospital to the QEII campus site. That is, if you like, in terms of the Reid review, the next big tile in the puzzle. As the member knows, neither the government nor the opposition committed in the last election to infrastructure expenditure around King Edward Memorial Hospital. But it was brought to my attention in fairly enthusiastic terms, particularly when I held a staff forum recently at King Edward Memorial Hospital, that people believe there is a very high need to now get on and put a blowtorch to that particular project. The back half of that building is heritage listed and I now understand that the front half has been also heritage listed, because it is apparently good art deco architecture. Now we need to do two things: the first is to keep it functional until a new hospital is commissioned and the second is to work out how to get to the new hospital. The North Metropolitan Health Service is working through an asset audit, which is due by the end of this month, that will identify priority items that will need to be rectified to ensure patient safety and to keep the facility and infrastructure operational. My notes observe that it has been in operation since 1916, so it is well and truly ready for a new way forward. I would like to see in the forward estimates at some point a good chunk of cash for planning to get that show on the road. That is not in the forward estimates, so I must say, no, we have not committed to that in a budget sense; but, politically, I am very committed to ensuring that we start that project. These things always have a long time line. It remains to be seen whether it becomes a Fiona Stanley Hospital or a PCH in terms of who gets to open it.

[11.30 am]

Mr W.R. MARMION: I think the minister almost answered my next question. He is right; it takes a long time to plan. A lot of planning was done for the children's hospital. Staff were involved and workshops were conducted so that the facility met the needs of the people who were going to use it. That sort of stuff should happen now so that we have some options. The scale of the project needs to be considered. Where will it be on the site? Are there problems with that? How high should it be? I have the view that things should be as high as possible because there will be no residents in that area. That sort of planning should be done so that when the button is pressed, at least the government has a project definition plan to work with. Can the minister comment on that?

Mr R.H. COOK: Quite a lot of work was done in 2016 around the operational needs and what it might look like in the future. As part of that, a longer term business plan was undertaken. We have a pretty good idea about where it would sit within QEII. I will ask the director general to make some brief comments about that. Once it sits there, we can understand the economies of scale that will be built into it, with an ICU, operating theatres, catering, laundry and facilities management—all at QEII. The new women and babies hospital will be a very different looking building. I think the member is right; it will be tall because the QEII campus is starting to become fairly constrained in its size. I will ask the director general to make some brief comments.

Dr D. Russell-Weisz: From the early stages of the master plan of the QEII site, there were always plans to place the replacement for King Edward Memorial Hospital for Women there. It is clear that we cannot place a King Edward there unless we look at the economies of scale that we get with the main G Block on the QEII campus, and that would be done with any planning. We would have economies of scale with intensive care and no need for an emergency department at the King Edward Memorial Hospital or whatever replaces it. There has always been a plan to place a new women's and neonatal hospital between the new PCH and G Block so we get those synergies between intensive care in G Block and the emergency department, and also the neonatal

synergies with Perth Children's Hospital. I concur with the minister that this is clearly a priority. It is an ageing hospital. Standalone women's hospitals are not usually built unless they are built on an adult campus.

Mr S.K. L'ESTRANGE: Another hospital that is ageing, as I mentioned in the original question, is Graylands Hospital. The government allocated nothing towards this facility in 2018–19 or the out years. Can the minister update us on what is happening? Is the government decommissioning the facility? Does it have a plan for what will replace it?

Mr R.H. COOK: Yes; absolutely.

Mr S.K. L'ESTRANGE: There is no money in the budget for it.

Mr R.H. COOK: And potentially there may never be. The member would be familiar with the Graylands site. It is a very large site in the western suburbs. It is sitting on some extremely valuable real estate. I know that the director general and the Mental Health Commissioner have been working on developing a business plan around how we would go about decommissioning the bulk of the services at Graylands, but also at Graylands Selby–Lemnos and Special Care Health Service—the older adult site. My understanding is that the draft business case is in its final stage of development and we will be getting that fairly shortly.

The commitment is the same as it was under the previous government. We are looking at a full rollout of this project by 2025. Obviously, the work that needs to be done is fairly extensive. As the member knows, it will involve taking between 30 and 40 per cent of the patients who are at Graylands at the moment and rehousing them in either community-based mental health facilities or other smaller hospital-based facilities. This is consistent with the modern view about how we deal with long-term mental health patients and acute mental health patients. To put it bluntly, I think we would want to chop up Graylands into tiny little bits, make lots of money out of it and fund the project that way. I will ask the director general to make some comments.

Dr D. Russell-Weisz: A lot of work is going on between the commission and ourselves. The business case will look at putting this into bite-sized chunks, so there will be a number of phases. The member would be aware, knowing the site, that to the south and probably to the west are areas with no buildings or very, very old buildings that house services that we believe can be relocated. There are a small amount of dental services and PathWest services. There are stages. We do not want to do this in one approach. As the minister says, patients will need to be housed if patient services are moved, and then we would more than likely concentrate on a forensic health facility at the current Graylands site. That only needs a very small portion of the land. The business case is due. A team between the commission and the department is overseeing that work, and the minister will be briefed within the next month or so.

Mr S.K. L'ESTRANGE: Just to be clear, the minister said that there are patients in great need. If the government is going to develop that site for housing or whatever and use the proceeds of that sale to build the new facility, obviously the transitional facility will need to exist in some form because these people need particular care. At the very least, when will we see the cost of that transitional facility in the budget so that we get an understanding of the government's commitment to looking after these patients?

Mr R.H. COOK: I might ask the director general to answer that.

Dr D. Russell-Weisz: We have to see the business case first. There may be some early wins with the first couple of stages because quite large tracts of land that are occupied could be developed whilst we then deal with the stages that we would need to build or seek funding through ERC for additional capacity at some of our other sites, such as Osborne Park or potentially other areas. We also need to be cognisant that we more than likely need additional forensic services, so additional forensic services would need to be built at the Graylands site around the current forensic service that is situated there because that is the centre of excellence. We now provide outreach services. This is bringing it all together. I cannot give the member a time when it would be in the forward estimates, but I imagine that we will present a completed business case for the 2019–20 budget. Whether it gets into that budget depends on approval from the government at that time. We would certainly want to get one of the first two stages—those early stages—sorted as quickly as we can because we believe there would be minimal disruption to services on that site.

Mr R.H. COOK: Just to round off our response, this is something that we are extremely committed to. This estimates session is going very well; it is cordial and professional. Last time it got a little frazzled and unprofessional when I got a bit shouty at Hon Kim Hames when the Osborne Park mental health bed redevelopment was deferred over a number of years. It ultimately came out of the Osborne redevelopment proposal. I was getting a bit shouty because the building of capacity at Osborne Park was a crucial step in decommissioning Graylands. I do not know whether the member has had an opportunity to see inside Graylands yet, but some of the wards are very confronting.

Mr S.K. L'ESTRANGE: I think the minister is arranging a tour of the facilities for me soon.

Mr R.H. COOK: I highly recommend it. The staff are amazing but some of the facilities are quite Victorian and do not reflect our current values in the way we would like to deliver mental health services. I was really pleased when acting director general Professor Bryant Stokes committed the previous government to 2025. I am absolutely committed to that. I have been harassing the Mental Health Commissioner and the director general about this since March last year.

[11.40 am]

Mr S.K. L'ESTRANGE: Do we have a date for the Graylands business case to be ready?

Mr R.H. COOK: I have not received the draft business case; I just know that it is imminent.

Mrs R. Brown: As the minister has outlined, the Mental Health Commission and the department have been working together. They are in the final stages of the draft and we will be working jointly to analyse that business case and provide advice to the minister probably within the next month or two.

Mr S.K. L'ESTRANGE: I am still on the asset investment program where those facilities are mentioned. Royal Perth Hospital is a key one in that. I notice that there is no funding allocated from 2019. With Royal Perth Hospital not having any investment plan budgeted for, and particularly given that the minister has gone out in public saying it needs a new emergency department, an acute care block and single rooms, what is the government's long-term plan for the hospital?

Mr R.H. COOK: I will not allow the member to verbal me in terms of single rooms and things of that nature! I have ambitions for making sure that Royal Perth Hospital remains our grand old lady of the hospital system—that is, providing great health care, particularly to country patients with whom it has a great tradition—and that it becomes a centre for modern medicine. As it is a smaller city-based hospital, it is ideally located for doing clever, innovative new ideas as it partners with entities such as start-ups and other medical innovators in the CBD. The former Liberal–National government went to the 2008 election saying it would do two things. Firstly, it said it would legislate to protect Royal Perth Hospital as a tertiary hospital and, secondly, that it would redevelop the hospital. An allocation of about $200 million was in the forward estimates after the 2008 election. It is obviously now a matter of record that neither of those things took place. The former Minister for Health introduced the Royal Perth Hospital Protection Bill, but it lapsed on three occasions because of a lack of any progress in the chamber and had to be reinstated onto the notice paper by way of a motion. During the first term of the Liberal–National government, I asked the Minister for Health on several occasions when he was going to start spending this $200 million that was in the forward estimates. I think there was some work done around planning because eventually that $200 million turned into $180 million and then the Minister for Health said, "No, it's a second-term priority."

I move forward to the second term of the Barnett Liberal–National government when there was still no progress with the Royal Perth Hospital Protection Bill. I actually reintroduced it as a private member because there was very little interest from the Barnett government to progress that legislation.

Ms A. SANDERSON: That was despite its election commitment.

Mr R.H. COOK: That was despite its election commitment—and ultimately it was passed under a private member's bill sponsored by yours truly.

In terms of the funding for the redevelopment across the forward estimates, which kept getting bumped out, it finally disappeared from the forward estimates altogether. During the 2017 state election, it disappeared from the Liberal Party's election commitments altogether. At the 2017 election, the Labor Party made commitments about Royal Perth Hospital. Those commitments were not for the wholesale redevelopment of the hospital. I am sure we would all like to be part of a government that basically redevelops that hospital in a way that makes it better equipped for the patients who are using it and a better experience for the staff, despite the fact they continue to provide what is internationally renowned health care, particularly in relation to trauma.

The Labor Party's commitment was around the development of a number of things, but mostly the mental health observation area and the establishment of an urgent care clinic. We made some commentary on the mental health recovery college. I was very pleased to be part of that announcement yesterday with the Premier when we introduced the toxicology urgent care clinic. That is an urgent care clinic inside the emergency department. People coming into the hospital who are alcohol or drug affected can be diverted to a specifically set up clinic that allows them to get the care they need in a more appropriate and safe environment; so we reduce harm. That obviously makes it much more pleasant for other patients sitting in the ED waiting room who are affected by people whose behaviour is perhaps not within the range of normal behaviour we would like to see from patients in an ED waiting area. It also frees up ED staff to ensure they can focus on the patients coming through the door who really need ED care. That is a great development. I am very pleased that we were able to meet that particular election commitment through careful management by the health department. To give the member an idea of how busy that would be, it is a five-bed facility plus a chair. It will receive just under 500 patients a month. They will be patients

who are particularly drug affected or have a range of behavioural issues. They will go into that area and I think it will make a great contribution.

The Labor Party also said it would establish a mental health observation area at Royal Perth Hospital. I am very pleased that that is part of funding in this particular budget. We have also been able to build some dedicated mental health beds into the mental health observation area. The unit will essentially have eight assessment beds. It will receive patients who present with mental health issues—psychoses and so on. Twelve authorised beds will be located near the emergency department. That is important because this stuff really keeps us awake at night. The problem with mental health patients in EDs is being unable to get them into a ward to get care rather than them sitting in an ED waiting for a transfer to a mental health bed elsewhere in the system. This will be a great contribution. It means that we do not have mental health patients sitting there. Sometimes they sit in an ED for days waiting for a bed. That is not good enough. We will be able to get them into at least a short-term inpatient bed inside Royal Perth Hospital before transitioning them, hopefully, to a community-based bed through community mental health services.

They are the redevelopment proposals that we have in mind at the moment. I, like the member, have ambitions for making sure that Royal Perth Hospital continues to provide great care. It is doing some incredibly innovative and interesting work, which is ideal for an inner-city hospital. I hope we will be in a position to fund some more substantial redevelopment of that hospital into the future. There is nothing in the forward estimates at this stage.

Mr S.K. L'ESTRANGE: I thank the minister for outlining the plans that are already in the 2018–19 budget. My question relates specifically to 2019 and out to 2022. The minister has just said that there is nothing in the budget for that. Does the minister have a view about when he might have a project plan for Royal Perth Hospital for those out years?

Mr R.H. COOK: I have an ambition! I would like to have a long-term plan for Royal Perth Hospital in the next 18 months to really map out exactly where we are going in relation to this stuff. I stress there is no funding yet.

There is nothing in the forward estimates but we have hopes that we can provide that long-term vision for the hospital.

[11.50 am]

Mr M. HUGHES: I refer the minister to "Update on Sustainable Health Review" under "Significant Issues Impacting the Agency" on page 248 in budget paper No 2. This question really goes to children's health. We note in the interim report the sustainable health review's key focus area of prevention and health promotion and its recommendation for immediate action on addressing childhood obesity. There are two parts to this question. How is the ambition of tackling obesity being integrated into the work of health service providers, which traditionally focus on treating illness rather than promoting wellness? The second part is: will the minister be looking at further enforcing the Healthy Options WA food and nutrition policy for Western Australian health services and facilities?

Mr R.H. COOK: I thank the member for the question. He is right: the sustainable health review particularly identified childhood obesity as an area that should be an ambition for focus by government. Ultimately, the job of government is to help people lead happy, healthy lives. When they get sick, we have to make sure we have the services in place to assist them on a pathway back to good health. One of the really frustrating elements and one of the social issues underpinning a lot of ill health is the prevalence of chronic disease associated with obesity and other related causes. Our hospitals are places where people go to get better, but they should also be institutions of wellbeing, and everything they do should reflect those values. We cannot on the one hand put out a report that identifies obesity, poor diet and a lack of activity and at the same time not exhibit all those values in the work we do. Something I am particularly concerned about is an issue that was raised at the WA Preventive Health Summit held in March: the availability of unhealthy eating options in hospital environments. It is totally counterintuitive for people entering a hospital to be confronted with sugary drinks, fatty foods and other unhealthy eating options. That was identified at the WA Preventive Health Summit as one of the great low-hanging fruits that the government should address in the first instance. Minister McGinty, when he was Minister for Health, made some headway on this issue. Hon Kim Hames, when he was minister, reversed a lot of the requirements for hospitals to maintain healthy eating options. I think it sends the wrong message and is counterintuitive to the values we have.

The Department of Health's Healthy Options WA food and nutrition policy for WA health services and facilities is a policy response to the question of what food should be made available to the public in our hospitals. The policy was mandated in 2008 and requires all retail food and drink outlets managed by the WA health system to adhere to a traffic light code for healthy foods, displaying at least 50 per cent "green" foods and drinks, 20 per cent or less "red" foods and drinks, including sugary drinks, and the remaining 30 per cent in "amber" food and drinks—those that fall between the other two categories.

I was gobsmacked to see that none of our health service providers are complying with that mandated policy—I am now getting some interjections! I was advised that none of our health service providers were complying with that

mandated policy. I subsequently wrote earlier this month to each of the health service providers to remind them of Healthy Options WA and to make sure that each of our health service providers were complying with Healthy Options WA.

Mr M. HUGHES: I was going to ask whether that was a carrot or stick approach.

Mr R.H. COOK: There are health stakeholders, such as the Australian Medical Association, that believe Healthy Options WA does not go far enough, but in the first instance we should expect our hospitals to have vending machines and food outlets that at least comply with this policy that has been in place since 2008. I have written to the chairs of each of the boards, instructing them that they should meet the mandated requirements of Healthy Options WA, including in vending machines throughout the hospital system. That does not mean that people cannot get a bottle of Coke at a hospital; it just means that the vending machines reflect the Healthy Options WA guidelines.

I have said that they are to meet those standards by October this year, so I have given them six months; it is my understanding that that is how long it takes to reconfigure the vending machines. As a result, I expect hospitals to become paragons of virtue in that regard. I would like to see that extended to all government buildings, to be honest. I think all government buildings should comply with Healthy Options WA so that we, as a government, can walk the talk. We always talk about tackling obesity and healthy eating and lifestyles underpinning what we do, so it should not be too much of an ask for all government buildings to display those values. But in the first instance, I have instructed our government hospitals to make sure that they at least comply with that mandated policy.

Ms A. SANDERSON: Does that apply to private providers?

Mr R.H. COOK: It depends on the contract, but I will certainly check that. I can understand our private providers wanting to be in lock step with our public health system to make sure we are all sending the right message.

Mr M. HUGHES: Can we be reassured that the food provided to our children on the wards is going to be compliant with that?

Mr R.H. COOK: That is guided by dietitians who study the menus carefully and design them.

Ms M.J. DAVIES: I have a very specific question and I am happy to put it on notice, if we need to. It is an issue that has been raised by a constituent, but it goes to the broader provision of services at Northam hospital and making bladder cancer treatment available there. At the moment, patients have to travel very regularly down to Perth using the patient assisted travel scheme. It is pretty trying anyway for people going through that treatment to have to travel; that type of treatment means that they have to be near a bathroom, so if they are driving up and back on Great Eastern Highway, it is a fairly average experience for a patient. It is my understanding that the treatment cannot be provided at the moment because of staffing limitations, not because immunotherapy services cannot be provided at that hospital. My question is: is there an opportunity for us to explore whether there could be additional provision of funding for our regional hospitals? If the minister needs a line item, I am not sure whether it comes under page 255, "Public Hospital Non-Admitted Services", or page 258, "Small Rural Hospital Services". It is obviously a service that is provided through our regional hospitals, and I have a very specific case, but I have spoken to others who say that they could offer it but they are restricted in terms of nursing staff.

Mr R.H. COOK: As the member knows, there is a substantial rebuild going on at Northam hospital; I think it is going to be a fantastic facility once it is completed. What I will do, with the chair's indulgence, is ask either the director general or the chief executive officer of the WA Country Health Service to make a comment.

Dr D. Russell-Weisz: I will pass directly through to the chief executive officer of the WA Country Health Service.

Mr J. Moffet: We have a cancer strategy for country WA that has recently been endorsed by our board, so we are looking at continuing to develop options to keep as many people in the bush as possible with regard to cancer treatment. Cancer treatment obviously has a significant range of modalities; it can be very complex, so the level and range of treatment offered in the bush will always be limited relative to a tertiary or quaternary centre. In Northam specifically we have as part of the redevelopment some chemotherapy chairs being put in place, so we will commence a chemotherapy service there and in other parts of the wheatbelt next financial year. I did see some information on the specific query in the last week or so. I am advised that currently our staff are not trained to support that type of therapy. There are hundreds of different therapies for the very many different types of cancers. Our focus is primarily on cancer support at the moment and then mainstream chemotherapy support for programs that can be supported in a centre such as Northam. We are very happy to look at those issues specifically. I think we committed to do that to try to understand whether there were options, where we could, to support clients who really were suffering by having to access treatment in Perth and then travel back home. The advice I have received at this stage is that our staff are not trained to deliver and support that type of treatment.

[12.00 noon]

Ms M.J. DAVIES: I have advice from treating specialists who are working with the patients in those areas that it is a relatively simple process. There has been a response in relation to this issue that this cannot be pursued at this point in time and the reason given is that it is due to the way that the hospital is set up. The specialist's advice back to me was that that is not the case and these services are being provided in other hospitals. I am just asking for some urgency. There is a particular patient affected, but I am aware of others who are also currently affected. There are up to 16 payments through the patient assisted travel scheme. The treatment is over nine months. For the first six weeks the patient goes weekly, and then it is monthly. For the want of getting a couple of our nurses trained and providing the service, which I am advised can be administered in Northam now without any changes to the set-up, we could be making these patients' lives a lot easier.

Mr R.H. COOK: I am very happy to have a look at that. I thank the member very much for raising the issue.

Ms M.J. DAVIES: I thank the minister; I appreciate that.

Mr S.K. L'ESTRANGE: I refer the minister to page 248 of the *Budget Statements* and the second dot point, which states —

> … the Western Australian health system has also achieved favourable results in the Western Australia Emergency Access Target and Western Australia Elective Services Target.

The document is the "Western Australia Emergency Access Target Performance Monthly Report". We notice that the March report showed that 20 out of 24 hospitals performed below the government target. We also have some information for April that shows Fiona Stanley Hospital achieving only 66 per cent of patients within the four-hour rule, compared with 79 per cent a year ago, and Sir Charles Gairdner Hospital managing 77 per cent within four hours, also down from 79 per cent a year ago. I wonder why page 248 of the *Budget Statements* states that the health system is performing well, but the annual data is showing a reduction in performance in the WEAT monthly performance reports.

Mr R.H. COOK: I thank the member for the question. I remember when the four-hour rule was originally brought in under Hon Dr Kim Hames. I think he set a target of around 90 per cent of patients to be treated, discharged or admitted inside four hours. That has gone through various iterations. I think even he ultimately suggested that 90 per cent was perhaps a little bit too keen. The statewide WEAT performance for the year to date to March 2018 was 76.2 per cent, which is an increase of 1.5 per cent compared with the year to date figure to March 2017 of 74.7 per cent. That was off the back of significant improvements at Royal Perth Hospital of 4.6 per cent; Joondalup of 4.9 per cent; Geraldton, which did some heavy lifting, of 6.1 per cent; Busselton, 4.8 per cent; and Esperance, five per cent. It is true to say that across a lot of the categories we are still below the 80 per cent target. From that point of view, it continues to be an area of focus for the performance of hospital services. I observed that across categories 1 and 5 performance targets were exceeded—one is 100 per cent and the other is 70 per cent. Category 4 has a target of 70 per cent and 67.2 per cent was reached. In category 2, with a target of 80 per cent, 81.9 per cent was achieved. Some of the categories are performing quite well. Patients in category 3 are supposed to be attended to in 30 minutes and the target is 75 per cent, but we are scoring only 53.3 per cent. I am not particularly concerned that we have not hit all the targets across all the categories, but by and large I think we are performing fairly well, and we are certainly performing better than last year. Yet, we are also continuing to see growth in volumes of patients presenting to emergency departments. We understand that in a constrained budget environment we are putting downward pressure on budget growth, but at the same time we are seeing more people. In March 2018, for instance, there were just over 700 000 attendances to emergency departments, which was an increase of 21 728 people or a growth of 3.2 per cent compared with March 2017. In a flat budget environment we are seeing more patients, with a higher number of patients attending emergency departments. By and large we are tracking pretty well in improving ourselves against those targets. But this is health and there is always room for improvement, and we will continue to do that.

The member also raised the issue of elective surgery targets, and we are continuing to track fairly well in terms of seeing patients within the clinically recommended time. We are now only 6.8 per cent over target with reportable procedures. That means we are seeing over 93 per cent of all patients requiring reportable procedures within the clinically recommended time. That is a pretty good outcome. I understand that that does not work for everyone all the time, and we need to make sure that we sit on the median waiting times, but by and large I think that is a pretty good outcome, particularly with increased activity in elective surgery, which I think was up by about 0.9 per cent in March 2018.

Mr S.K. L'ESTRANGE: I think that is the point, particularly with the four-hour rule. With a growing population and increased pressure on our EDs they are going to come under strain, and I think we are seeing that with Fiona Stanley Hospital, which in April achieved only 66.8 per cent of the target. That is considerably less than last

year. Sir Charles Gairdner Hospital was also down at 70 per cent for four hours, down from 79 per cent. We are seeing pressure on these big tertiary hospitals.

Mr R.H. COOK: Yes, the big ones.

Mr S.K. L'ESTRANGE: I am just flagging for the minister that there may need to be some ways of assisting these hospitals. Maybe it could be through dealing with the shortages in general practitioners, for example. We know there is a shortage of GPs in our state and that is putting stress on our EDs. Is the government or the minister looking at a strategy to ensure that EDs are appropriately funded to achieve the four-hour rule, while at the same time growing the GP base to lessen the pressure on EDs?

[12.10 pm]

Mr R.H. COOK: I think the member is spot-on to look at EDs as being a barometer of how the rest of the system is going. Unless we can get people out the back door, it is difficult to get people in through the front door. I will talk about GP capacity in a second, but one of the issues we confront is the lack of residential aged-care capacity. At any point in time we have anything between 150 and 200 patients in hospital beds whom we cannot get out because they are too frail to go home, and we are waiting for them to be assessed to be put into a residential age-care facility. If there is not the capacity in the residential aged-care system, we cannot get them out of the hospital system. If we cannot get them out of those beds, we cannot get new patients into those beds. That is one of the challenges we have and it was one of the issues I raised with Greg Hunt recently in my discussion with the federal government. The average number of aged-care beds per 1 000 head of population across the nation is 8.1. In Western Australia that is just over six, so we are significantly short of our federally funded aged-care bed places and that impacts on our capacity to get people through the hospital system. The member mentioned the shortage of general practitioners. To touch on those statistics, the national average for GPs per 100 000 of population is 95. My notes say it is 77 in Western Australia; I think it has improved slightly to about 78, but we still have a significant shortfall of GPs. We also have the highest concentration of GPs anywhere in Australia, and that is in the western suburbs. They must be very ill there! The member for Nedlands needs to have a talk to his constituents! The member is right to identify the shortage of GPs as being one of the constraints on our ability to deliver health care. I will double-check with Dr Williamson, but I think the study his department did found that between 30 and 40 per cent of patients at EDs would have been able to be treated in a primary-care environment. Is that right?

Dr D.J. Williamson: Those numbers are a bit contentious in terms of what is a preventable GP-type presentation. Emergency department doctors would put the figure lower. However, the minister is right: that is the number from our study.

Mr R.H. COOK: That is the reason one of our election commitments was for urgent-care clinics to encourage patients to receive the care they need in the communities in which they live in an acute primary care environment that might be better suited to their unplanned episode of care. A range of views have been expressed about how effective the urgent-care clinic policy will be. I am happy to admit when I am wrong, but I do not reckon I am. I think we can substantially care for a larger cohort of patients who would otherwise tip into our EDs in an acute primary-care environment where they can receive a range of services such as GP care, some pathology, some X-ray and allied health care. If people can receive that in an acute primary-care environment, it is better for the patient and ultimately takes the pressure off our EDs, which is of course what the urgent-care clinic policy is about.

Mr S.K. L'ESTRANGE: The other aspect to my question, which the minister picked up on in an earlier part of his answer, was to do with the elective services target. I notice that the cases over boundary for category 1 surgery went from 8.7 per cent in May 2017 to 19.5 per cent in April 2018. Again, this could be an indicator of hospitals under pressure when they have to move patients on to other facilities. There has been an increase in movement. It comes back to page 248 where the statement outlines that it is achieving favourable results, but the data is showing that some hospitals are clearly under strain.

Mr R.H. COOK: I will ask the director general or someone else more appropriate to provide some explanation around those specific figures, but it is true to say that we are seeing an uptick in activity around elective surgery as people either do not access their private health insurance or tip out of private health insurance altogether. Anecdotally we are seeing a proportion of patients move from the private sector to the public sector and that anecdotal evidence is borne out in discussions with some of the private hospital providers in the metropolitan area.

Dr D. Russell-Weisz: The minister has covered most of the issues. Obviously, our focus is on over boundaries. If we take it collectively, yes, around 6.8 per cent or seven per cent are over boundary. We would love that to be at zero per cent but we will always get some patients who tip over that over boundary mark, maybe because of their complexity. We now know much better the areas in which we struggle. It might be where we have more patients, such as in urology and plastics. The member is right to notice that there has been an uplift in category 1 over boundary, even though the overall over boundary has not moved and we are doing more cases. The overall number, which we do look at, has jumped from around 19 000 to 22 000 over a few months. The critical thing we look at

irrespective of that is whether we are performing elective surgery within the target. We are trying to keep up with that in a constrained environment. We are also seeing a significant move from private to public health. In obstetrics people may not be dropping but choosing to not use their private health insurance, and we have seen an uplift in obstetric cases. The health service providers will always look at the category 1 cases—I know they are looking at that at the moment—and why they have jumped up that substantially. It will be a focus because category 1 should come before categories 2 and 3. Even with those figures we are measured on the waiting times by urgency categories. For category 1, from July 2017 to March 2018 we are at 18 days and the clinically recommended time is 30 days; for category 2, we are at 58 days and the clinically recommended time is 90 days; and for category 3, we are at 118 days and the recommended time is 365 days. I know they are only statistics, but if cases go to 31 days when they are meant to be performed within 30 days, they are counted as over boundary. The first thing health service providers do is ensure the patients are booked. They have a booked time, even though it might go over. I can assure the member that health service providers are actively looking at those category 1 cases in their health services.

Ms E. HAMILTON: I refer to the "Asset Investment Program" on page 260 of budget paper No 2. Reference is made to an election commitment—stage 2 of the Joondalup Health Campus development. I note that the government's election commitment to open a stroke unit at Joondalup Health Campus is part of the redevelopment and is very much anticipated by the Joondalup community. Where is the commitment at and when will it be available for use?

Mr R.H. COOK: I thank the member for Joondalup for the question. It is a matter on which she is particularly focused and has been for some time, both as a candidate prior to the election and now as the member for Joondalup. I thank her for her aggressive advocacy. As a result of that we have some good news. The opening of the proposed stroke unit is scheduled for the second half of 2018. The timing is dependent on key workforce recruitment, such as a stroke physician and a clinical nurse specialist. The Joondalup Health Campus stroke implementation working party has been established and a collaborative model is being developed in relation to services at Sir Charles Gairdner Hospital. I would like to commend the North Metropolitan Health Service, which has worked with Joondalup Health Campus to bring this to bear. Dr Andrew Wesseldine was recruited in February 2017 to work as the Joondalup Health Campus director of stroke services. He has been working on determining the optimal model of care for Joondalup Health Campus and a review of the best practice models. I am very pleased to say that at the end of 2017 we established the stroke unit working party, which looked at a range of issues, engaged with consumer representatives and strengthened the partnership with Sir Charles Gairdner Hospital. The Stroke Foundation was very animated and active on this issue, as was the member, in particular. I am very pleased that we are now in a position to announce that we are looking at commencing the stroke outpatients clinic from July 2018. That is a fantastic outcome. The target start date for the 12-bed stroke unit is early 2019, depending on staff availability and so forth, and funding for the new stroke unit is part of the WA government's $158 million expansion of Joondalup Health Campus generally. I know that the member was keen to get the stroke unit in before we did the major redevelopment, and I am very pleased to say that the North Metropolitan Health Service has done a fantastic job in now bringing that to fruition. We will soon have our first patients through that unit in July this year, thanks to the member's advocacy—well done.

[12.20 pm]

Ms M.J. DAVIES: I refer to public and community health services on page 257, and the line item for average cost per trip of the patient assisted travel scheme. Can the minister advise how much has been allocated to PATS over the forward estimates? Further to that, will the state government be implementing the recommendations of the PATS inquiry from the last Parliament?

Mr R.H. COOK: We have a choice here, Chair. Either we wait till I find my notes, or I flick past this and get the straight answers and then return to the political issues.

Ms M.J. DAVIES: However the minister would like to do it.

Mr R.H. COOK: I think it comes under the area of the chief executive of the WA Country Health Service.

Mr J. Moffet: I am just trying to check on the forward estimates question.

Ms M.J. DAVIES: I have an average cost per patient, but how much is allocated across the forward estimates?

Mr J. Moffet: I do not appear to have the forward estimates picture. I have the figures only up to 2018–19, so just the next financial year, I am sorry, unless other department representatives have that with them.

Ms M.J. DAVIES: I am happy to take it as supplementary information.

Mr R.H. COOK: I can provide supplementary information to the member for Central Wheatbelt of allocations towards PATS across the forward estimates.

Ms M.J. DAVIES: My second question is also related to PATS, but it was really a question on whether the state government is considering or planning on implementing the recommendations made by the PATS inquiry that was conducted by the last Parliament.

[*Supplementary Information No A14*.]

Mr R.H. COOK: I apologise that we do not have that information to hand today. For the member's information, the PATS 2017–18 budget expenditure profile is $39.9 million, and in 2018–19 this will increase to $45.4 million. Those are the numbers for 2017–18 and 2018–19, and I will obtain the figures across the forward estimates as supplementary information.

I think the parliamentary committee did some great work, and it provides us with an insight into some of the weaknesses of the system, and some of the ways forward. I have not sat down to consider the report in detail. It came out under the previous government and I think the response disappointed both the member for Central Wheatbelt and me. We need to make sure that PATS is properly funded, in terms of not only activity, but also meaningfully meeting people's travel expenses. Some of my initial activity has been focused on trying to develop medihotels, the meet-and-greet service and other services that would benefit patients travelling to Perth. I would also like to see a digitisation of PATS to see whether there is a way to get a better flow of funds to people. I like the nuanced way, for want of a better description, in which PATS is managed by the staff in each of the regional areas. I hear constantly about the good work that they do to try to identify opportunities to get money for people. I am not saying that they bend the rules, but they work with the patient to make sure that the service is provided. I will go back and have another look at the PATS report. I am not familiar with the detail of it, although I recall the substantial commentary it made at the time and, in a broad sense, its recommendations. I will go back and have another look at it and make sure that I am more informed on that subject. I recall sharing the member's disappointment with the response at the time.

Ms M.J. DAVIES: I thank the minister, and welcome a follow-up discussion on how we might work on some of those recommendations, because I think the committee put a significant amount of work into that inquiry.

Mr R.H. COOK: Was the member on the committee?

Ms M.J. DAVIES: No, I was not.

One of the things we have identified from an immediate point of view is that people in the shires of Chittering, Toodyay and Gingin do not have access to hospital care in their immediate location, yet they are not able to access PATS, and so they fall into a black hole right now. That is one of those flexibilities that I am not sure even the PATS staff can be compassionate enough to make work. It is something that could be investigated.

Mr R.H. COOK: Yes, they are just inside the 100-kilometre boundary.

Ms M.J. DAVIES: Chittering, Toodyay and Gingin are the shires, as well as parts of Northam—those peri-urban shires. Although Northam has access to a hospital, those other three shires do not, and that means that residents are required to travel for treatment.

Mr R.H. COOK: As we see the metropolitan area extend northwards, the member is right to identify Gingin, and I suspect some of those coastal areas will also be in that category soon.

Mr W.R. MARMION: I refer to the fifth dot point under "Health System Overview" on page 248 of budget paper No 2, which reads, in part —

> … the Western Australian health system has become more efficient in the delivery of hospital services, with higher than target activity delivered without funding supplementation …

The minister may have to provide this as supplementary information. How many people are currently waiting for elective surgery in Western Australia; and can the minister provide a list of elective surgery wait times by month and hospital for the past 18 months? Can the minister provide a list of the ramping times for hospitals for the past 18 months; and can he provide a list of actual waiting times by triage across all emergency departments for the last 18 months?

Mr R.H. COOK: I can provide that. I can point the member to the Department of Health website, under the link "Our performance" for elective surgery and emergency department performance. The member will find that it will provide all that information. When the member said "waiting for elective surgery", obviously some people are on the elective surgery waitlist, so they have already received an outpatient appointment for assessment, and there is also the waiting for waitlist, which is a list published every six months. That is under "Our performance" on the Department of Health website as well. I am happy to get a member of my staff to forward those reports to the member. I think he will find that they provide all the information he needs, and it would certainly go back 18 months.

Mr W.R. MARMION: Sometimes it takes me an hour to find something on websites.

Mr R.H. COOK: It is not the easiest website to use.

Mr W.R. MARMION: Sometimes I end up in the wrong bit.

Mr R.H. COOK: It is called being in opposition, and trying to navigate that website.

Mr W.R. MARMION: Perhaps someone could press the button, and provide a printout and forward it through as a supplementary printout.

[12.30 pm]

Mr R.H. COOK: Yes. I will get a member of my staff to forward that to the member.

Mr W.R. MARMION: Or give us a complete list of all the different buttons we have to press.

Mr R.H. COOK: No, I will not do that as supplementary information, but I am happy to get copies of those reports to the member. We will send it electronically. It will have the links to those reports so the member can do a single click. You are an engineer, Bill; I thought that would be a snip!

The CHAIR: Just to confirm, that will not be done as supplementary information.

Mr R.H. COOK: No. We will just take that on board.

Mr S.K. L'ESTRANGE: I refer to the total appropriations provided to deliver services in the table of expenses and cash assets on page 247 of the budget papers. I note that that line item in the 2017–18 budget shows that the amounts of the total appropriations provided to deliver services have decreased by $37.2 million in 2018–19, $74 million in 2019–20 and $90.4 million in 2020–21. Given the significant reductions in funding, are any health service providers currently estimated to be in deficit; and, if so, which ones and by how much?

Mr R.H. COOK: I cannot provide the member with a breakdown of the total appropriations. The total appropriation ultimately is a calculation that gets done between the total cost of services and other forms of income, grants, capital allocations from the commonwealth, single allocations from the commonwealth and so on. Certainly, the member has asked whether some of the health service providers are operating in deficit. I can confirm that one is. I will invite the director general to provide further information.

Dr D. Russell-Weisz: To point to the first question, I will look at the overall $8.8 billion for the total cost of services for 2018–19. There is a reduction there. The majority of that reduction is because of the transition of the home and community care program to the commonwealth. That is about $231 million. There is some expensed capital, voluntary severance scheme payments and some other adjustments in the midyear review for the Perth Children's Hospital transitioning. There are a number of reasons why there would be a reduction from 2017–18 to 2018–19, and clearly the majority of that is due to the HACC program. In 2017–18, because I think the member's question related to the 2017–18 health services, yes, four health services—the South Metropolitan Health Service, the WA Country Health Service, the Child and Adolescent Health Service and the East Metropolitan Health Service—are expected to balance their budgets. The North Metropolitan Health Service will come in with a deficit position, but we are not seeking additional funding from Treasury. We will alleviate that position from within the Department of Health funding. There is a deficit position within the North Metropolitan Health Service. The North Metropolitan Health Service has put together, and it is being revamped, a recovery plan for its approach over the next two to three years, which we will rigorously monitor. The incoming acting chief executive has been heavily involved over the last two to three weeks in relooking at that recovery plan to make sure that we meet the strategies within that.

Mr S.K. L'ESTRANGE: Can the minister detail the budget given to each health service provider under this budget and how they compare with last year's budgets?

Mr R.H. COOK: The director general.

Dr D. Russell-Weisz: I cannot today give the member the exact details for 2018–19. We are still going through the process of what we call the service agreements between the budget holders and the Department of Health. But certainly when those budgets are settled, there would be no reason why we could not give him that information per budget holder.

Mr S.K. L'ESTRANGE: To break it down a degree further, can the minister outline which hospitals within each health service provider are estimated to be in deficit and by how much?

Mr R.H. COOK: The director general.

Dr D. Russell-Weisz: When we have given a budget to a health service, we have had a mature model of funding our health services through activity-based funding. It is how we get funded by the commonwealth for the majority of our volume-based services to our hospitals. We have hospital services under activity-based funding and we have non-hospital services. When we give our activity and funding to our health services, we expect them to come in on budget as a health service. Yes, there can be some ups and downs within the hospitals and between one hospital

and another. We could certainly seek that information from the health service providers, but we look at the overall budget and how they are performing as a health service, not as individual hospitals.

Mr R.H. COOK: I will provide some further colour and movement around that. For instance, Osborne Park Hospital has a very different service configuration from Sir Charles Gairdner Hospital's. In addition, it also receives lots of Sir Charles Gairdner Hospital patients as their acuity de-escalates, and therefore they can be treated in a different environment. Although we could probably find a number, it probably would not be very instructive in understanding the overall management of the budget.

Mr S.K. L'ESTRANGE: I understand that getting down to that level of detail is probably not in the context of where the budget is at, but it is in the context of understanding which hospitals may be under pressure. Cross-referencing those statistical pressure points that we have already outlined with some budget pressure points would help give us an understanding of where they may have to spend more to achieve outcomes. That is why I am interested in looking at that.

Mr R.H. COOK: The director general.

Dr D. Russell-Weisz: Certainly, if we had a specific question, I would be happy to take that on notice. To give some more background to this, obviously we had not quite uncontained, but certainly unsustainable, expenditure growth five to six years ago. There was one year when it was growing at 12 per cent. Expenditure growth has been brought down significantly. In the last couple of years, it has been under five per cent, and this year it will be well under that. We have to move more to the national efficient price when we are looking at hospital services. This year we are estimated to be 15.6 per cent above the national efficient average benchmark, whereas we were expected to be 18.9 per cent above it. A huge amount of work has been done by the health service providers to bring down their costs. That is about doing more activity with the same fixed costs, but also doing the right activity. Those pressures will continue in this very constrained financial environment. Also, while we are providing the same, or even better, safety and quality, we have to continue to be more efficient.

Ms M.J. DAVIES: I refer to the line item for the Dongara aged-care facility under the heading "New Works" on page 262 of the budget papers. First, can the minister clarify that this amount is the remainder of the amount for what was previously called the Turquoise Coast Health Initiative?

Mr R.H. COOK: I thank the member for the question. The Dongara aged-care facility was seen as a priority and we re-prioritised other expenditure under the Turquoise Coast Health Initiative. I will ask Jeff Moffet to provide some more detail about that.

Mr J. Moffet: I do not have the table in front of me, but in the budget papers there is a conversion of $1 million from operating to capital for Dongara. I am not sure whether that is the line item that the member is looking at. That is in relation to the development of four to six additional aged-care places inside the existing high-care facility attached to the Dongara health service.

[12.40 pm]

Ms M.J. DAVIES: Is that the only component of the Turquoise Coast Health Initiative that exists in this budget going forward?

Mr R.H. COOK: I will refer to Jeff Moffet.

Mr J. Moffet: Yes, it is based on the previous Turquoise Coast Health Initiative.

Ms M.J. DAVIES: Will the Minister for Health provide an analysis, if one has been done, of existing health service gaps in the turquoise coast region?

Mr R.H. COOK: I do not know whether a service gap analysis has been done. I assume one would have been done in the context of drawing up the Turquoise Coast Health Initiative in the first place. I therefore assume a document somewhere in the system could be requested under the freedom of information process, depending on whether it was subject to cabinet deliberations. Ultimately, the Turquoise Coast Health Initiative was to address perceived gaps in services so I assume an analysis was done at some point ahead of the 2016–17 budget. The member might have a better idea than I about the status of that document.

Ms M.J. DAVIES: No, I do not, that is why I am asking! Funds have been significantly re-prioritised and my assumption is that the service gaps still exist and are probably becoming more acute. What work is being done by the department to ensure appropriate infrastructure and service planning for the turquoise coast?

Mr R.H. COOK: We continue to support health services on the turquoise coast. They include two nursing posts in Lancelin and the expanded and refurbished Jurien Bay Health Centre, which delivers a range of primary health, aged-care and emergency response services. Dongara Medical Centre provides 24-hour, seven-days-a-week nurse-led emergency responses and stabilisation services. It has two acute beds, one respite bed, one palliative care bed and six aged-care beds. Three health centres are run by Silver Chain in Mingenew, Eneabba and Leeman, and baseline nursing roster care support is provided for the emergency telehealth service. Although I am sure there is

disappointment that the Turquoise Coast Health Initiative has been scaled back, some would say significantly in the context of the previous allocation, we continue to support health services in the region.

Ms M.J. DAVIES: Minister, the previous allocation was $20 million and there is now $1 million in the forward estimates for the Dongara aged-care facility. Presuming a document somewhere identifies the needs of that region, what work is being done to make sure service gaps do not widen over the forward estimates? What future projections of population, particularly the ageing population, have been done by the department to manage that? It is a fast-growing area that does not have historical hospitals, unlike the wheatbelt or the great southern.

Mr R.H. COOK: I thank the member and acknowledge her concern for the area. As I said, a network of nursing posts throughout the region provide good primary health care; in Dongara there is 24/7 nurse-led emergency care. I understand that as it becomes an area with, for want of a better description, a less transient and growing population we will have to keep a close focus on it. I imagine Jurien Bay could become a growing hub for health services given it is strategically placed on the turquoise coast, but we will continue to make sure that the people in that area receive good health services. Regarding the management of those services, it might help if I call on Jeff Moffet again to make some commentary about health services in the area.

Mr J. Moffet: The organisation is rolling out a range of strategies more generally around aged-care support, use of telehealth, stroke care and enhancing transport services, so although it is not a specific initiative to the turquoise coast those services in those locations are benefiting from some service expansions that we are currently undertaking. In fact, irrespective of the funding for the turquoise coast, we have increased the hours of operation of the Jurien Bay facility. It is currently operating 23 hours a day, to my knowledge, and we plan to go to a 24-hour service there fairly soon. We want to make sure we can manage patients overnight, short term before —

Ms M.J. DAVIES: Is that the only hospital that is likely to be 24/7 between Geraldton and Joondalup?

Mr R.H. COOK: Currently, Dongara is a 24/7 nurse-led facility, but I will ask Mr Moffet to comment.

Mr J. Moffet: That is right. We are not characterising Jurien Bay as a hospital per se, but we are certainly characterising it as a health centre that needs to have a greater capability for short-term acute care. We are doing some enhancements in Jurien Bay in particular to ensure we can respond to acute needs. We are rolling out telehealth and emergency telehealth services from Lancelin right up and down that turquoise coast strip as well.

Ms M.J. DAVIES: Does the department have any projections of population, particularly the ageing population, for that health service area?

Mr R.H. COOK: I am sure that the department has a range of population studies for that area. I will ask the director general to make comment.

Dr D. Russell-Weisz: I would probably have to take that question on notice regarding aged care in that specific area. I do not know whether Jeff Moffet has anything to say on it, but we will take it on notice and provide it to the member if we have.

Ms M.J. DAVIES: Does the minister want me to put it on notice rather than ask for supplementary information?

Mr R.H. COOK: Yes; it sounds like it might be a bigger piece of work.

Ms A. SANDERSON: I refer to pages 254 and 255 and the headings "Public Hospital Admitted Services" and "Public Hospital Non-Admitted Services." Regarding St John of God Midland, I want to know whether the hospital now has a defined referral pathway for those services that Catholic health operators have deemed restricted services within the hospital.

Mr R.H. COOK: In the first instance, I will refer the question to the chief executive of East Metropolitan Health Service.

Mrs E. MacLeod: Thank you, minister. I understand that it does have a defined pathway for those services. I am not sure of the detail of it, so we would need to provide further advice on that if that is what the member is after.

Ms A. SANDERSON: Does that pathway involve those services being referred directly from the hospital to Marie Stopes Midland, which is providing the services?

Mrs E. MacLeod: That is the detail I will have to check—whether it specifies Marie Stopes as a clinic to be referred to. I am not sure whether the hospital provides the referral to the facility.

Mr R.H. COOK: If I could provide further information for members, as a result of the privatisation contract of Midland Public Hospital, the health department now goes out and purchases the services that would otherwise be provided by a hospital in the local community. It is a perversion of our public health system whereby we discriminate between different patients simply on the basis of the convictions or otherwise of the hospital provider. It is an entirely regrettable situation. We do our best to compensate for that and I hope the member and the local community is comforted by the fact that we have the public purchase of these sort of services. We have to continue

to monitor it because although the services are provided by those organisations—in this case, Marie Stopes—and that is important, we know that because they are out in the community, members of the public who access those services, and do so in a legal way, are subject to a certain amount of harassment. That is a pretty unhappy situation. We will continue to monitor that situation. It is entirely regrettable and of course it could have been entirely avoidable had the previous government contracted those services differently.

[12.50 pm]

Ms A. SANDERSON: Under the arrangement entered into by the previous government, about $1.2 million went towards the redevelopment of the Marie Stopes clinic to provide some of those services. Do we now know the ongoing cost of those services and where that would be in the budget? Would it appear under public hospital non-admitted services?

Mr R.H. COOK: I might refer that question to the director general.

Dr D. Russell-Weisz: I would have to check that. I imagine that is where it would be. It would be a very small component of our greater non-hospital services, but it would be under contract. I might see, through the minister, whether the chief executive of east metro can provide any other information or whether we will have to take it on notice.

Mrs E. MacLeod: Sorry, but Marie Stopes sits under the North Metropolitan Health Service because of the King Edward association.

Mr R.H. COOK: I might then refer that particular question to Angela Kelly, the acting chief executive of the North Metro Health Service.

Ms A. Kelly: Yes, the North Metropolitan Health Service holds the contract with Marie Stopes. There are two parts to that, and one was to do with the extension following the Midland Health Campus coming online. It is a contracted service so it would be non-admitted through our hospital service. I am happy to provide the detail of the amounts of that contract as a supplementary answer or on notice. I do not have the detail with me.

Ms A. SANDERSON: I will leave that to the minister to decide.

Mr R.H. COOK: Would a supplementary be appropriate—to 1 June?

The CHAIR: Would you like it to be supplementary information or leave it to the minister?

Ms A. SANDERSON: That is fine.

The CHAIR: You will follow it up later.

Mr W.R. MARMION: I refer to page 247 of volume 1 of budget paper No 2, and specifically to the total appropriations to deliver services to the Department of Health, which show the total appropriations provided by the state government for recurrent purposes. I note that in the 2017–18 state budget, the government forecast total appropriations provided to deliver services of $4.98 billion in 2018–19; $5.05 billion in 2019–20 and $5.15 billion in 2020–21. In this 2018–19 state budget, those appropriations have been reduced to $4.94 billion in 2018–19, $4.98 billion in 2019–20 and $5.06 billion in 2020–21. I have been informed that is a reduction of $201 million over three years. I have also been advised that when the spending changes in the table are added, it comes to only $102 million. The question is, what are the other spending changes that account for that gap between $102 million and $201 million over three years?

Mr R.H. COOK: I did not follow all that commentary, member, and the way I was following it probably differs from that of the member. Perhaps I will provide some general commentary that may answer some of the member's question.

Firstly, in relation to total appropriations, they are net of other forms of income, be they from the private sector, contracts or grants from the commonwealth government—the national health agreement and so on. From that point of view, the total appropriations are not a really good indication of the bought activity, for want of a better description. What is a better reflection of overall budgets is the total cost of services. The member will see that the estimated actual for 2017–18 for that was a smidge over $9 billion. In 2018–19 it is $8.8 billion and in 2019–20 it goes up to $8.9 billion. That is of some interest because, as the director general said, we have the transference of home and community care funding directly to the commonwealth, whereas previously that money would have come through our books. That is the reason for that reduction. In that particular instance, that is $231 million. Other issues impacting on that are expense capital associated with the Perth Children's Hospital of $35.2 million; the impact of the voluntary targeted separation scheme; the social and community sector supplementary payments; other adjustments approved in the midyear review and so on. Of course in the 2017–18 midyear review there was a top-up for Capella Parking of $5.2 million, and expense capital adjustment, other than PCH, of $13.5 million, and there is significant wash through from things that have impacted around that.

However, I will draw the member's attention to WA Health expenditure on hospital services. The full forecast for 2017–18 was $6.3 billion, and in 2018–19 it was $6.5 billion. That is a growth of around about $2.9 billion. In 2019–20 it is at $6.7 billion, with a growth of $3.3 billion. In addition, there is the purchase of non-hospital services. For non-hospital services in 2018–19 there is a substantial reduction of 16 per cent, and that will continue to wash through in home and community care funding in a reduction of three per cent, one per cent and a slight uptick in 2021 of 5.4 per cent.

For the purposes of public consumption and what can be deduced from these numbers, it could be said that hospital services are continuing to grow at a modest rate, at an average of 3.3 per cent over the forward estimates. That is crucial because we also have a growth in hospital activity of about 2.3 per cent. The impact of that is downward pressure on the average costs of the weighted average unit of activity. It is the first time since the new regime of activity-based funding was introduced in 2012–13, I think, or in 2009–10, that we have seen a reduction in the weighted average unit cost of activity, particularly in its relativity to the national average price. Traditionally, there would have been continued growth in the projected state price and a reduction in the national average price. We are now for the first time contracting that gap. That is an incredibly good outcome for the WA health system and is a credit to the leadership that sits next to me and behind me. That has not happened in the health system before and it is really why this budget is a game changer in overall budget management. The reason the Treasurer has a big grin on his face nowadays from getting the finances back under control is due to the hard work done by the people in this chamber, and it is a real credit to them.

Mr W.R. MARMION: I was actually asking a simple financial accounting question. It was not a criticism about the figures. I might be wrong—someone might have added this up wrong—but I thought the table on page 247 is supposed to compare the changes from last year's budget with this year's budget. It is purely financial accounting. I know the minister has done a financial accounting MBA.

Mr R.H. COOK: Take us through the figures again. Perhaps I misunderstood.

Mr W.R. MARMION: If we compare the figures from last year with the figures this year there is a reduction of $201 million. Someone has added up the figures in the spending changes table, which is supposed to clarify the difference between last year and this year, and they have come up with $102 million, but the figure in the budget paper is $201 million. There is an imbalance. There might be a simple accounting explanation.

Mr R.H. COOK: Can the member give me the numbers again to make sure we are looking at like for like?

Mr W.R. MARMION: I have already. If we take $102 million off $201 million we get something like $99 million.

Mr R.H. COOK: Is the member talking about the net appropriated to deliver services?

Mr W.R. MARMION: I am saying that in this table on page 247 there is a difference between last year's appropriation figures and this year's appropriation figures.

The CHAIR: Minister, you have about 10 seconds.

Mr R.H. COOK: I see.

Mr W.R. MARMION: Perhaps the minister can get back to me.

Mr R.H. COOK: We will provide that by way —

Mr W.R. MARMION: That would be great.

The appropriation was recommended.

Meeting suspended from 1.00 to 2.00 pm