Division 8: WA Health, $5 239 372 000 —

Mr S.J. Price, Chair.

Mr R.H. Cook, Minister for Health.

Dr D. Russell-Weisz, Director General.

Mr E.A Locke, Chief of Staff.

Mrs R. Brown, Deputy Director General.

Prof. T.S. Weeramanthri, Assistant Director General, Public Health.

Mr P. May, Chief Finance Officer.

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

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

Mr W.R. Salvage, Chief Executive, North Metropolitan Health Service.

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

Ms G. Carlton, Acting Chief Executive, South Metropolitan Health Service.

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

Ms A. Kelly, Assistant Director General, Purchasing and System Performance.

[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 discussions 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. 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, 29 September 2017. 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 Nedlands.

Mr W.R. MARMION: My question relates to the total appropriations to deliver services on page 113 of budget paper No 2. Minister, I note that the state government appropriations provided to deliver services are reduced by 1.7 per cent in 2017–18 from $5.139 billion to $5.053 billion and by 1.3 per cent in 2018–19, which is from $5.053 billion to $4.984 billion, or increasing slightly to effectively have 1.9 per cent growth over the four years to 2020–21. I therefore ask: how achievable are the forward estimates growth figures for the Department of Health given that the 2016–17 budget highlighted total activity–based funded possible expense growth would average 4.3 per cent across the forward estimates?

Mr R.H. COOK: Thank you very much for the question. I think it is an important one. As we know, the legacy of health in this state has always been one of high expense growth and, obviously, a growing proportion of the overall budget. In some respects, the credit for where we are now at lies with members opposite and also with us in that over the years, we have been able to do a range of things. First of all, it is about identifying costs and understanding where they land. The outcome-based model is a particularly important component of that, because it is about understanding the activity and the cost inputs for that activity. We are getting better at understanding the estimates for activity going forward and at understanding the costs going into that. That has enabled the director general, particularly under the new governance arrangements, to focus on and get efficiencies into the system whereby we have an extraordinary outcome; namely, that growth over the forward estimates is estimated to be somewhat modest. Whereas, historically, health has grown significantly into the future. As the member noted,

there is modest growth in the forward estimates, particularly in 2018–19. I will ask the director general to make some subsequent comments.

Dr D. Russell-Weisz: As the minister has said, there have been significant increases in funding for health over the last few years. Over the last two years, we have been able to curb some of that expenditure growth. At one point—six or seven years ago—expenditure growth was nearly 11 per cent. Over the last two years that expenditure growth has been brought down to in the vicinity of 4.5 to five per cent.

We understand our costs a lot better. The activity-based funding model, which was brought in over the last two to three years, has allowed us to understand our costs much better in hospital services and non-hospital services. We can compare our expenditure, our activity and our overall performance to those of other states. The 2017–18 budget provides for expenditure of $8.9 billion for WA health, an increase of 1.4 per cent, which, as the member stated, is an expense growth of one per cent over the forward estimates.

For hospital services, it is still $6.4 billion, representing a growth of 2.5 per cent, relative to the actual expenditure in 2016–17, and annual average expense growth for hospital services over the forward estimates is 3.3 per cent. Over the last 18 months to two years we have put in this outcome–based management framework. It sounds a bit dry, but it shows what we actually spend in hospital-based services and in non-hospital services. We can now measure those exact areas and we recognise that we were counting costs in non–hospital based services that should have been in hospital-based services. We will therefore have a much better way of measuring what we do over the next few years.

The growth in the state price over the forward estimates has been revised downwards to one per cent per annum and we are beginning to see efficiencies. Over the last two years, we have seen efficiencies with a reduction in expenditure growth over that time. In the 2017–18 budget for activity—it is all about activity for patients—there is an annual average growth of 2.3 per cent over the forward estimates. We have found that we have managed to do more activity within our budget settings. We did not go back to Treasury last year for more funding; we stayed within our budget settings. If I may, through the minister, I will ask Angela Kelly to provide any further commentary if I have missed anything out.

[2.10 pm]

Mr C.J. BARNETT: I refer to the same table on page 113. Given that over the forward estimates absolute funding is reducing, and also given population growth and inflation, could the minister provide, perhaps by way of supplementary information, a figure showing the real per capita reduction in health spending from the expected outcome from 2016–17 through to each of the four years in the forward estimates?

Mr R.H. COOK: Obviously those details are there, but I can certainly give the member the weighted average unit costs —

Mr C.J. BARNETT: No; I want the real per capita appropriation.

Mr R.H. COOK: The weighted average unit costs associated with the activity.

Mr C.J. BARNETT: It is a different concept.

Mr R.H. COOK: That would obviously demonstrate that, going forward, we are expecting growth in activity. In addition to that, we are delivering that at a more efficient price. In terms of the actual cost, the member can see that there are a range of services against "Total Cost of Services". The Bureau of Statistics will quite happily provide him with population growth figures. It is simple maths from there.

Mr C.J. BARNETT: No; that is not the question I asked. I asked a simple question. I respect the fact it will probably need to be provided via supplementary information, though it is not difficult to calculate. I want to know the real per capita change—so, allowing for inflation and population growth—in total appropriations from the expected outcome from 2016–17 through to each of the four forward out years. It is a pretty straightforward question. I realise the minister probably will not have the numbers in front of him.

Mr R.H. COOK: Chair, I can certainly confirm that we do not have the numbers in front of us. I am quite happy to provide that information to the member. I will ask the director general to further comment in relation to non-hospital expenses, which explains the reason there is a drop in those costs.

Dr D. Russell-Weisz: Just to extrapolate further: although there has been an increase in activity and an increase in funding for hospital services, there has been a significant reduction in non-hospital services. There are two reasons for that. Prior to the budget realignment through the outcome-based management framework, non-hospital services made up 26 per cent of total health expenditure; they now make up 24 per cent. The decrease, as I explained a couple of minutes ago, was because we are counting better. We know there are more in-hospital services than non-hospital services. The other major contributing factor to the decline in non-hospital services is an annual reduction of $273.4 million from 2018–19 to 2020–21 for the home and community care program. This

program and associated funding have been transferred from WA Health to the Disability Services Commission under the National Disability Insurance Scheme and will come into effect in 2018–19. That means that non-hospital service expenditure of $2.17 billion in 2017–18 represents a reduction of 3.9 per cent, or $88.8 million, and an annual average expense growth of nearly six per cent for non-hospital services over the forward estimates.

The CHAIR: Minister, can you please clarify what information you will provide?

Mr R.H. COOK: I am quite happy for the member to direct me on this, but I think what the member is looking for is a calculation of total cost of services across the forward estimates.

Mr C.J. BARNETT: No; total appropriations.

Mr R.H. COOK: Total appropriations across the forward estimates on a per capita basis.

Mr C.J. BARNETT: On a real per capita basis.

Mr R.H. COOK: What does the member mean by "real"?

Mr C.J. BARNETT: Real is allowing for inflation; per capita is allowing for population growth. Treasury can help the minister out.

[*Supplementary Information No B7.*]

Mr W.R. MARMION: Given the minister will manage some budgetary cuts, including $199 million of agency expenditure review, can he guarantee that no frontline services will be impacted?

Mr R.H. COOK: I can certainly guarantee to the member that frontline services will not be impacted. I can do that by drawing the member's attention to the activity across the budget. The member will notice that in 2017–18, the budget provides for activity settings of 907 938 weighted activity units, an increase of 16 871, or a 1.9 per cent increase —

Mr W.R. MARMION: What page is the minister referring to?

Mr R.H. COOK: I am referring to the budget, Chair. I think the member will find that on pages 116, 117 and 118. In fact, it is wholly on page 117.

Mr W.R. MARMION: The second last dot point?

Mr R.H. COOK: Yes. Over 2016–17, the estimated actual average weighted growth was 2.3 per cent over the forward estimates. As I said, activity-based funding allows us to see that transparency. We can see what the actual numbers mean in terms of activity. The activity is growing, but the growth in costs is being constrained both through OBM and other related activities.

Mr S.A. MILLMAN: I refer to "Works in Progress" on page 129, which is under "Asset Investment Program". I refer in particular to the line item "Perth Children's Hospital (PCH) — Development". How many forecast deadlines were missed by the builder at PCH, and what was the cost of those delays; what was the attitude of the builder to remediating lead in potable water at PCH, and was the builder willing to apply polyphosphate; and was this a key consideration in the government granting practical completion of the project?

Mr R.H. COOK: Thank you very much for the question. This is a particularly important issue. I understand the member has some young children, so he would be particularly interested in the answer. Perth Children's Hospital has been an issue about which I have been almost solely focused since coming to office. It is a very complex project and it is one that we are determined to resolve. Upon coming to office, I was informed of the government's frustrations around the delivery of the project via the managing contractor. There were a couple of issues. One was the estimations around practical completion. The contractor had missed 16 different deadlines. Of greater concern, I suppose, was the lack of information and transparency from the managing contractor around the chlorination processes that took place when the pipes were installed and water was basically pushed through those pipes. Understanding the nature of that chlorination event is absolutely crucial to understanding the lead issues that are now in front of us. I will ask the director general and others to comment shortly. Not having that information made it very difficult to understand the source and the remediation requirements in relation to the lead around the pipes. In addition to that, we were not interested in the blame game; we were actually interested in getting into the problem-solving game of how to resolve the issues around the dezincification. The advice we received at the time was that the polyphosphate treatment process was incredibly important around that.

At that time, the managing contractor was still basically trying to prosecute an argument that somehow the lead contamination was coming from elsewhere. I understand the commercial realities around that. This is a big, expensive and complex project and from time to time that requires people to take differing points of view. The fact of the matter is that inhibited us from getting on with the job and resolving the lead issues. The taking of practical completion actually got us on-site and enabled us to take active, and indeed proactive, steps to get better

line of sight about what the problems were and then to go about the remediation. Without taking practical completion when we did, we would never have been able to start the polyphosphate treatment process. As we now know, that treatment process is having some impact but, from the perspective of the Chief Health Officer, that will not get us there. We have had to take a closer look at other aspects and we have come down to the thermostatic mixing valves and the assembly boxes that they sit in as being another source of lead. There has been commentary that somehow the problems with water in the hospital are some sort of apocryphal event and we should be able to put sick kids in that hospital—the most vulnerable cohort of patients that we have in our system. We are determined to make sure that when they do get into that hospital, it is absolutely safe to do so. To contemplate moving kids into that hospital prior to being 100 per cent sure about the issues there is, quite frankly, a reckless notion.

I will ask the director general and others to make comment about where we are at with the lead remediation issues.

[2.20 pm]

Dr D. Russell-Weisz: In a moment I will ask Dr Lawrence to comment about where we are at. I would like to concur with everything the minister has said. Commissioning these sorts of large hospitals is extraordinarily complex. There are a number of workstreams. A recent independent review showed that we are on track with all the clinical commissioning workstreams, yet we were continually frustrated by the construction workstream. We were promised 16 forecast practical completion dates, we have had 253 days of PC slippage and there have been other issues that have been well publicised, such as asbestos in the roof panels, remediation of other construction activities such as sterilisation, and the ongoing potable water issue, which we need to make sure is solved for day one, but also for day 30, day 90, one year, three years and well into the future. That has been our focus.

In taking PC, enough was enough and we had got to the stage at which we did not have control of the site. Every time I, the Chief Health Officer or the Child and Adolescent Health Service staff wanted to enter the site, we had to get permission from the managing contractor. PC was deliberated at length. The advantages and disadvantages were discussed at length, and it was clearly felt that it was the right thing to do. We did take the State Solicitor's advice at the time. But it was definitely the right thing to do. We undertook polyphosphate treatment, which the builder had refused to do. We allowed the Chief Health Officer to undertake testing on two occasions, and we provided the Chief Health Officer with unlimited access to complete his report. That report identified noncompliant elbow joints within the assembly boxes, which was something that had not been found to date and required a health official to find. We intervened to remediate defects that the builder continually refused to do—it was doing some work, but not others. Basically, it allowed us to undertake commissioning activities, so there is a heap of work going on in parallel. It gave us better clarity. We are not out of the woods yet; a huge amount of work is being done on the potable water. I would say that that is probably the most significant issue by a long way that we need to concentrate on.

If the minister allows, I would like Dr Lawrence to comment on where we are up to to date.

Dr R. Lawrence: The remediation of the TMV assembly boxes, which was suggested by the Chief Health Officer, has been under intensive review since the time of that report. We have a group that meets daily on that. It has become clear as we have progressively looked at a variety of options that there are very, very limited options. The assembly boxes are accessible; they have a panel in front that can be removed to get to the bits and pieces in it, but they are not truly designed for individual pieces of those assemblies to be removed.

Initially we focused on the cold water loop, which was the recommendation. As it turns out, in searching for components for the cold water loop and now the noncompliant elbow joints—I do not know whether members want to use the pictures; we have some pictures that might make it easier to understand which bits we are talking about —

Mr S.A. MILLMAN: A point of clarification: are those elbows components in the thermostatic mixing valves?

Dr R. Lawrence: They are in the assembly box. At the bottom of the picture, members can see some elbows in the red boxes. Those elbows and the little yellow bits in front of them—the Binder test points—are the noncompliant components, and the Building Commissioner has now sent a rectification order to the builder to remove and replace them. As it turns out, these components were custom made for these specific assembly boxes—not necessarily specific for PCH, but for the assembly box components—and there are no replacements that are watermarked and compliant in Australia. Luckily for us, somebody has been working on the stainless steel replacement of the entire componentry. Just this morning, we tested putting that into the box, which we have been successful in doing. It has proved to be the easiest option that we have tested so far, and at this stage it would appear to be the only option that deals with both the noncompliant parts and the parts recommended to be replaced by the Chief Health Officer. It means, therefore, that everything within the box in the picture will be stainless steel apart from one connector at the top, which we call a Rehau connector, that will have to remain as brass.

Mr C.J. BARNETT: With the Perth Children's Hospital, given that we all understand the contractual complexities, the very exacting standards and perhaps also some of the measurement issues, if the water supply to

the children's hospital, as it is today, is not used for drinking by either patients or staff—it is simply used for cleaning or any other use—is there an identifiable medical risk to patients?

Mr R.H. COOK: The member makes an interesting point. For instance, the member would be aware that one half of the building—that is, east block and west block—will not be used for clinical services. One will be used for the Telethon Kids Institute and the other will be an administration area. Understandably, our focus is not on that part of the hospital for the early remediation works. We could anticipate a time when we can say, "Okay; we've resolved the issues with clinically exposed areas; therefore, we should move forward with the commissioning process. We'll get those other areas at a later date, and people in those areas can take the precautions in that they need not drink directly out of the taps." Generally, people getting water will go to a water fountain or a dispensing machine that has filtered water anyway. I would have thought that the risk to people in that particular part of the hospital is fairly minimal.

We confront the large part of the lead contamination issues in the hospital's central and south blocks, where there is the predominance of taps associated with bedside areas, operating theatres and so forth. I will ask the Chief Health Officer to make some comments on that, because I think it is a very good point. For instance, it has been drawn to my attention lately that, as one would anticipate, sinks for scrubs—for washing—are next to operating theatres. I would not have thought that resolving the water issues with those particular taps would be important, because they are obviously not going to be used for drinking. I understand, and the member for Nedlands as an engineer will understand, that they are designated as sinks, not troughs. By virtue of being a sink, the Building Commissioner takes a very different view than if they were designated as troughs. Water needs to be potable for a sink; if it is a trough, it does not. The water needs to be potable because the certification process refers to them as sinks.

As I have said on many occasions, the one opinion that matters on this is that of the Chief Health Officer, because he has to provide oversight of the works and ultimately certification of the building. I ask the Chief Health Officer to make some comments.

[2.30 pm]

Prof. T.S. Weeramanthri: The current situation is that although the taps can be turned on, I have determined that there is no water supply as such, in that no-one is drinking the water on the Perth Children's Hospital site. More than that, there are management processes in place that actually educate all the people coming onto the site. There is a well-understood prohibition against drinking water; there are signs in place et cetera. So prior to practical completion—I also confirmed after practical completion—the same restrictions on the drinking of the water on that site were in place and remain in place to this day. My considerations as to the suitability and safety of the water supply only come into focus when the water is being drunk. Any risk is only if the water is being drunk, and the credibility of any solution which would, for example, say "In this area the water is suitable for drinking" and "In this area the water is not suitable for drinking" would rely on the proponents being able to come up with a reasonable, rational plan about how they would implement that solution, how they would communicate that to patients and staff, and then we would look and see whether that was a reasonable overall management of the risk. So it is not just about the safety of the water in terms of testing, but it is also about the water quality management plan and any other risk management that needs to be put in place. But I would have to be convinced that it was reasonable, it was communicable and that people would understand it and that therefore the public, including both patients and staff, would not be at risk.

Mr C.J. BARNETT: Correct me if I am wrong, but I take it from that that you are saying so long as the water is not drunk—that might be easier said than done—then in terms of the water supply, the hospital is safe? I know you have to measure standards and all the rest of it—I am not dismissing that—but in terms of the health risk is my question.

Mr R.H. COOK: Chief Health Officer.

Prof. T.S. Weeramanthri: There is a slight distinction to be made between water that is drinkable and water that is meant to be drunk. The Australian Drinking Water Guidelines have a broader definition of what constitutes the drinking water supply than simply the taps that are there for specific drinking, if you like. We include a range of other outlets, such as showers and things like that, which could be drunk from under certain circumstances. We have an understood frame of all the outlets which we think constitute the drinking water supply. At the moment—barring level 6 and 7—there are approximately 1 500 outlets, but we have determined that around 1 200 of those outlets we consider as potential drinking water outlets. In terms of the Chief Health Officer–approved testing, we randomly sample those 1 200 because that is the total frame of what we consider to be drinking water outlets.

Mr W.R. MARMION: I have a supplementary question.

The CHAIR: A further question?

Mr W.R. MARMION: Yes, a supplementary on this same topic. I have a number of supplementaries, so I will just do one question at a time. In replying to the questions, the minister talked about chlorination and implied—I think it is in the Chief Health Officer's report—that there is not enough data on chlorination. My understanding is that chlorination is an inhibitor of dezincification. My understanding is that chlorination is unlikely to be the source of the dezincification. I would like the minister's comment on that.

Mr R.H. COOK: Yes, certainly. Obviously the member will not be surprised if I throw it across to the director general very shortly. But certainly one of problems we have is the lack of understanding about the nature of the early chlorination. I do not mean in 2016; I think this goes back to about May 2015. There is little or no documentation—or none that has been shown to us—around the nature of those chlorination events, how long, how much and in particular the other healthy suspicion that is that after the chlorination event it was not properly flushed, and therefore was left within the pipes. I think that is one of the reasons people are particularly focused around those issues. I might ask the director general to make further comment.

The CHAIR: Just before you do, just to assist with the AV technicians can you just say your name and introduce yourself when you go to speak, please.

Dr D. Russell-Weisz: Okay. Sorry. Dr David Russell-Weisz, director general of Department of Health. I thank the minister. The minister has covered it well. This has been an issue of significant frustration because it is not just related to chlorination, it actually goes further than this. This goes to the priming—although I am no engineer, I do know more about plumbing now than I did in the past—of the water system, then the flushing and then the chlorination. Most systems get chlorinated. My understanding is that if there is chlorination and the system is not then properly flushed, dezincification is increased. If there is chlorination and the system is flushed and continually flushed well, that risk is mitigated. But these large systems have to be chlorinated, flushed and flushed well. From my own experience at Fiona Stanley Hospital, when we were in pre-commissioning there were taps running a lot of the time. The commissioning staff were constantly told to stop switching them off because the builder wanted them left on because they were conducting a very robust flushing regime. It is my understanding, and looking at the experts—we have had a number of experts look at this—ultimately the Chief Health Officer has given an opinion as to why we have high lead in the water. We started off with 16 hypotheses, then it went down to about four, and then down to one. We have not been able to ascertain from John Holland, after 11 times of asking through Strategic Projects, what the chlorination regime was: what happened, what it did, was it super-chlorinated, was it chlorinated too much and how much it flushed. We have not been able to ascertain that, except we know there is a problem and we believe it has caused the dezincification of the brass fittings.

I make one other comment in relation to the points made by the Chief Health Officer in relation to the potable water. I think what is driving us is the remediation activities that will need to be done. That is why there has been so much work since the Chief Health Officer's report into what has to be done to the assembly boxes. Clearly, we want to do this on a schedule basis. Clearly, if we can do the south and the central blocks before the other blocks, we can open and cause as least disruption as possible. But the worst thing we could do, and it would probably be indefensible, would be to open a hospital and then have to do significant remedial works where we have patients in rooms. Even if we actually said there, "Look, the water is not safe to drink, so drink out of bottled water", we would still be doing remediation activities that are not conducive to an operating hospital site. Dr Lawrence and her team have been doing a significant amount of work on scheduling and looking at how the replacement boxes might be scheduled, and how then we might test a floor or two and then how we potentially might do some works after opening the hospital.

Mr W.R. MARMION: I have a supplementary question. The minister also mentioned the TMVs.

Mr R.H. COOK: Yes.

Mr W.R. MARMION: We all want the hospital open, but the minister mentioned that he was not sure what the cause was. I do not know whether that is an issue for us—we want to open the hospital—but the minster talked about the cause. One possible cause that I think people have ruled out—it is a bit hard to measure now because it is a long time ago—is that the water went into the hospital in January, and then the dead leg was not removed until September. The question is: can the minister rule out the possibility that contaminants from the dead leg were sucked into Perth Children's Hospital when it was first opened up, the contaminants found their way to the smallest diameter of pipes, which happened to be the TMVs, and that there may be lead or even a very high quantity of iron in the dead leg? I think it was 530 times the normal limit for iron, and it could have been sitting there in the TMVs for many months. That might have started the dezincification of the elbows in particular. Can the minister rule out that as a possible cause of the dezincification?

Mr R.H. COOK: I believe I can. I will ask either the director general or Chief Health Officer to make further comment in relation to that. As the member for Nedlands appreciates, I am acting on advice on those technical points.

[2.40 pm]

Dr D. Russell-Weisz: I thank the minister. In relation to the dead leg, I think the answer to that is no; it was not a cause. A briefing was given on 1 May by the executive director of Strategic Projects that went into this in some detail. Clearly, when we originally looked at the problem and when the problem first came up we were looking at outside the hospital and inside the hospital. The Water Corporation gave its water a clear bill of health. We did look at the QEII ring main and also at the other North Metropolitan Health Service sites. We looked at testing around those sites. There had been the odd exceedence, but basically all were well below the Australian Drinking Water Guidelines and of no concern, so much so that the Chief Health Officer issued a statement at the end of January 2017 about the drinking water on the QEII campus. As I said, I am no plumber nor an expert in this, but the dead leg was found to have a number of other nasty heavy metals involved—some very specific nasty heavy metals. Those heavy metals were not found anywhere in Perth Children's Hospital at the levels at which the lead was found. To assume on basic science that the dead leg was causing the lead to come in but the other heavy metals were not would seem not to support that the lead was coming from the dead leg. The dead leg was cut off in September 2016 and I believe it has not been a problem, nor was it a problem before that. It was also found—again, I am going back to the Strategic Projects presentation—that the dead leg was very much undisturbed, so there were very much undisturbed areas within that dead leg.

The Chief Health Officer stated in his report the likely cause of the lead contamination in Perth Children's Hospital, which is what I have said—namely, dezincification of the brass fittings. To summarise, our advice is that the dead leg is not an issue and never has been an issue and we have had that backed up by reports that have followed that. I will ask Professor Weeramanthri to comment.

Prof. T.S. Weeramanthri: The only additional piece of information I would add to that is that apart from a discrepancy between lead levels and the other heavy metals that Dr Russell-Weisz has just pointed out, the tanks that supply the PCH water have been consistently clear. Three tanks are fed by the incoming water supply, and after that it obviously goes into the four buildings of PCH. Those tanks have been consistently clear, even at the time prior to September 2016 when the problem was first identified. I remember looking at the results at that time when we were first notified, and the lead levels that were of concern were actually at a higher level than they are now, but even at that time when the overall levels were higher, the tanks were clear. If there had been a problem with the dead leg, you would have seen that manifest in some problem proximal to or in the tanks. The fact that the tanks were clear, and, in fact, levels increased after that, suggests that the problem was not proximal to the tanks.

Mr W.R. MARMION: You talked about the lead levels, and that opens up the whole issue of how you test, how you take a sample. There is an infinite number of ways of sampling. I know that all the samples that were taken were not all taken in exactly the same way. The most scientific sampling technique is done by the Chief Health Officer. All the others were tested but we do not know how. The Australian guideline specifies what the limit is. It does not tell you how to test, but it does imply a daily intake. It could even be more than that—a yearly intake—but let us just take it back to an easy thing like a daily intake. In other words, if you opened a tap at the source, filled up the sink, got that massive volume of water and then took the lead amount in that, surely that would be a better representation of what the lead percentage of that is, rather than taking a very small sample and also under different conditions; that is, everything is stopped for 24 hours and flushed, and you wait for 30 minutes. There is an infinite number of ways of sampling. Are you confident that the sampling technique that you are adopting now gives a non-biased representation of the probability of someone drinking water out of the hospital that exceeds the guideline?

Mr R.H. COOK: I will invite Professor Weeramanthri to make some comments about the testing process and sampling.

Prof. T.S. Weeramanthri: We looked at this in a great deal of detail. The Australian Drinking Water Guidelines, as you would be aware, comprise over 1 000 pages. They are an important set of authoritative guidelines—a consolidated experience of experts in Australia and internationally over many years that are continually revised and updated. However, the problem we are faced with at the children's hospital is unique and we have to come up with a testing regimen appropriate to the problem in front of us. The problem was identified by the managing contractor and reported to us in September. After that, as the member says, there were a large number of tests, going into the thousands, that we were not confident of. There were many testing agencies as well, and many consultants. As a result of that we were provided with spreadsheets full of data, and we could not with a degree of surety be absolutely clear why any one sample had been taken and for what reason or for what purpose, the exact method used and who had tested it et cetera. There were some discrepancies. In around December 2016 we came up with a proposal that rather than looking backwards through thousands and thousands of results, to try to facilitate the safe opening of the hospital we would look forward and set up a prospective testing methodology which was robust and which the proponent—in this case the state government—could undertake as a kind of

threshold to pass. Rather than us having to look at thousands of documents and getting a few people to do a few PhDs to try to analyse it, let us set up something prospective which was rigorous and which we could be confident in, and that is the CHO methodology.

To do the sampling strategy we consulted with our experts in the health directorate, who obviously linked in with international experts and looked at the guidelines, but also looked at recent reviews, such as from Hong Kong around what they did when faced with a particular issue in Hong Kong, and have published ahead of time, prior to the first testing that we were asked to do, the rationale for our methodology—why we chose the particular way of taking the samples that we did, the analytic level of the sampling and the level of accuracy guaranteed by specific laboratories and, in addition to that, the epidemiological or analytic methodology that we would apply so that when the results came back, we knew exactly how we would analyse them, and then run them through our spreadsheet and hand them back to the proponent.

Everything was set up prior to the first testing in June. We went through a few iterations of that because it is complex and technical and took a bit of feedback, but we would stand by the transparency of the methods, the fact that we think it is fit for purpose, and the fact that we think it is fair and gives us a basis to actually allow the proponent to meet that and move on.

Mr S.A. MILLMAN: This relates to my initial question regarding the benefits to the state government of the granting of practical completion. Has there been a change in the testing regime that has been applied since the granting of practical completion or since the original tests were first undertaken?

Mr R.H. COOK: Yes, very much so. Practical completion basically gives the government ownership of the site. Rather than seeking permission to go onto the site or having agents, through the managing contractor, going onto the site, it means that we have the site to ourselves and we can say where we go, what we do and where the sampling is taken from. I will ask the Chief Health Officer to comment further, particularly about the period when he had control of the site himself via the Department of Health for that testing regime that was put in place recently.

[2.50 pm]

Prof. T.S. Weeramanthri: By about mid-2017, we had settled on what we thought was a reasonable sampling strategy and analytic methodology. That has not changed. Obviously, the proponent has to trigger that, because it is the proponent who supplies the water and has to be happy that it is supplying a safe water supply. Once the state government was in that position, it invited, through Dr Russell-Weisz, the Chief Health Officer to come in and run our methodology, which we did. Part of that was to give the state government a baseline. From memory, there was a 74 per cent pass rate on that first round. During the time in which I stepped back and did my review, I looked for a way forward and came up with the recommendations that culminated in the report. We were also interested in the continued effect of the phosphate. We wanted to know whether, if we had left the phosphate there for longer, it would have had the desired effect, so that we could be sure that it was not just a matter of not enough time having elapsed.

Out of the 1 200 sites, we randomly sampled 300 or so. Instead of doing a second random sampling, we sampled the same 304 sites again. That is not the same test we would have run had the state come back to us and said that it had replaced some boxes, was now happy that it had compliant water, and wanted us to come in again and test. In that case, we would have randomly sampled again, which should have meant that a different 300 outlets would have been sampled. For the Chief Health Officer's report, we sampled the same 300 outlets, but that was for a specific scientific approach to see how well the phosphate had worked. The essential analysis and sampling strategy has not changed.

Mr W.R. MARMION: We have opened up the issue of the sampling technique. Page 37 of the Chief Health Officer's report states that water is collected "preferably in wide-mouth sample bottles, at a medium to high flow rate". Can the minister advise me how the two 125-millilitre samples were collected and what the flow rate of the water was when they were collected?

Mr R.H. COOK: I might also refer that to the Chief Health Officer.

Prof. T.S. Weeramanthri: We have a published a three-day protocol. The day of sampling is day zero, which has usually been a Sunday. We undertake steps on each day: day minus two, day minus one—that is, Friday and Saturday in the lead-up. The steps include closing down the site, training the people who will take the samples, generating a random sample and allowing the proponent to make its arrangements. This culminates on the Sunday, when a whole team of people descends upon Perth Children's Hospital and takes all the samples from 300 sites, on a strict protocol where they have to flush, leave the tap for 30 minutes, and then come back and take samples. It is important to get the consistency. We do not have a definition of medium to high flow rate—that is something for the organiser who is in charge of the whole thing to say—but I think there is a commonsense definition of what that is. It does not mean trickle it out, and it does not mean put it on as fast as they can. It is somewhere in the

middle. We standardise it as far as we can, we give as much training as we can to make it as consistent as possible, and then we analyse the results. You can see on pages 36 and 37 that we have specified the protocol in as much detail as is practical.

Mr W.R. MARMION: I understand all that. The simple question is that medium to high would be turning a tap on so that the water is coming out at a reasonable velocity. I want to know what the velocity was, because if the samplers turned the tap on just to fill a little test tube, it would not be coming out at what I would call a medium velocity.

Prof. T.S. Weeramanthri: The key factor is that the taps are turned off for 24 hours, and then flushed for five minutes, which allows a lot of water to be released. If a tap is flushed for five minutes, quite a lot of water is being taken out. It is then sitting for only 30 minutes, so anything that is coming out has come out in the 30 minutes between ending the flush and taking the sample. Then two 125-millilitre samples were taken and averaged. That gave me confidence that what I was seeing in the two averaged 125-millilitre samples was reflective of a reasonable assumption about how people might drink the water.

Mr W.R. MARMION: I will let the adviser off the hook. I will ask just one more supplementary question but I could ask more. This is through the minister because I do not think he will be answering it.

Mr R.H. COOK: Do not be like that!

Mr W.R. MARMION: Have a go if you like.

Mr R.H. COOK: That is harsh.

Mr W.R. MARMION: If four, six or eight samples had been taken instead of just the two, under the same rigorous technique of leaving it for 30 minutes and then taking the first 250 millilitres, can the minister advise what the lead content might have been if they had taken 500-millilitre, 750-millilitres or one-litre samples?

Mr R.H. COOK: I am sure that I can answer that question, but I will let Tarun do it just on this one occasion.

Prof. T.S. Weeramanthri: Thank you, minister.

The distinction the member has made is important. People do water testing around Australia all the time and no-one worries much about the flow rate—there is a sampling technique and the sample is taken. That is why we have outlined that test here in much more detail than would normally otherwise be outlined so that we get a sense of confidence about the quality of the drinking water. That is outlined in the appendix. What the member is discussing is a more scientific approach, which we used in our CHO review. We took 125-millilitre aliquots out of the outlets attached to the six assembly boxes, and we took them at a low flow rate because we did not want to get turbulence through the pipes or mix the first 125 millilitres with the next 125 millilitres. We thought that the flow rate was critical to get a scientific understanding of exactly where the water was coming from. There might still be a bit of a grey area, but the results about the peak lead levels came from those tests, in which we deliberately reduced the flow rate so we could be confident that the first 125 millilitres came from the tap and the next one came from further back. When we looked at the diameter and length of the pipes, we calculated the distance from each assembly box outlet to the assembly box based on the different calibres of the piping. We found that the peak lead levels usually did not occur in the first 125 millilitres, but at a distance that was consistent with where the assembly box was. That data is in the report. I think there is a difference between when particular emphasis is put on the flow rate for a scientific test versus just asking people to go around and take samples and you say, "Turn the tap on and fill up these tubes."

[3.00 pm]

Mr W.R. MARMION: On that, there is the suggestion that if a greater sample had been taken—if a litre had been taken—the result of that specific testing would show that the greater the volume and the greater the flow rate meant less lead was in a sample.

Prof. T.S. Weeramanthri: The only comment I would make is that I have to be confident that the water is safe. I have to set up a methodology I am comfortable with. We could not have gone into more detail about our rationale and what is before us, frankly, to an unprecedented level, but there are some people who, rather than accepting it is my job to see whether it is safe and it is someone else's job to make the water safe, want to continue to argue with the methodology as though that, in itself, will make the water safe. I am sorry but the water will be safe when something is done to address the cause and when I sign off on it. I am very happy with my methodology. I am a fairly experienced regulator. Some people want to regulate the regulator; they want to tell me how to do my job all the time. Feedback is fine. I am very happy to take feedback—to do open-minded science—but there comes a point when as a regulator arguing about all the niceties of this, I wonder whether people should be doing other things than continuing to ask about the very, very minor refinements of my technique.

Mr C.J. BARNETT: The standards are fine and the margins are fine; we understand that. We are talking about a minute measurement and therefore any standard error can transcend the boundary. I understand the problem; I am not criticising.

Mr R.H. COOK: In addition to that, one of the reasons that we are now able to have this conversation around the detail and get such insight into the issues—this is a rare opportunity for members of Parliament, so I think it is a very valuable opportunity to have this conversation—is, in relation to the member's earlier question, that we took practical completion. I think that was a very important step in the life of this project because, by getting in there and getting this level of understanding, we are now in a position to move forward around remediation and ultimately, commissioning.

Ms M.J. DAVIES: I am very happy to revisit what we just spoke about, but I would like to ask a question about the Turquoise Coast Health Initiative. I refer to page 129 of budget paper No 2, under asset investment program, and the section "Works in Progress". It specifically refers to the Southern Inland Health Initiative and I note that only $1 million has been allocated towards the Turquoise Coast Health Initiative. Previously, $22.5 million was allocated to the initiative. What is the $1 million for and, in undertaking the project's reassessment—because, clearly, a significant figure has been allocated somewhere else—who did the government speak to about the value of that project for the region? How does the government intend to improve the healthcare needs of residents living in this catchment? It is a high-growth area and reports have been done by the Department of Health to understand the gaps in service delivery. I am very interested to know where that money went and what the $1 million is for.

Mr R.H. COOK: The $1 million is for the development of an additional four to six aged-care residential beds in the Dongara Eneabba Mingenew Health Service. The full service delivery model of this initiative was valued at $22.461 million for the whole Turquoise Coast and we have uncommitted from this program. We came across a range of projects under the country health initiatives that were, quite frankly, uncosted and had no business cases. They were thrown into the mix at the last minute. I think the Turquoise Coast Health Initiative was one of the very last to be thrown into the mix before the government went into caretaker mode. I am conscious of the fact that we need to understand the health needs of people in those small communities that run up the coast. We will certainly be taking the opportunity to have a look at them in the coming budget rounds to make sure we have things in place. As the member knows, there was a constrained environment for the overall budget. We had to find some savings around the place. We went to projects that were less prepared in their business cases and this was one of them.

[Ms S.E. Winton took the chair.]

Ms M.J. DAVIES: Is the minister then unaware of the work that has been done by the Department of Health to identify the service and delivery gaps in the Turquoise Coast that underpinned the business case for that $22.5 million?

Mr R.H. COOK: I am certainly aware that the department is doing some ongoing work around those service gaps and what needs to be done. I do not think we can do it at $22.5 million. The fact is that we have a constrained environment and that was one of the projects in the very early stages of development. As I said, it was thrown into the mix just before the previous government went into caretaker mode. As a result, we have had to set it aside to take a closer look at it. Some initial work has been done on the aged-care beds in Dongara and it is important for that to continue. Some ongoing work has identified where there may be some service gaps, if they exist, and we will address them when we get a better understanding of whether they exist.

Ms M.J. DAVIES: To clarify, the $1 million will provide four to six aged-care beds in Dongara; the remainder of the funding is gone; and the minister is not aware of the work that the Department of Health has done to identify the service gaps for emergency, acute, palliative, short-stay, community-based care, antenatal and postnatal services.

Mr R.H. COOK: Yes; I can confirm the member's earlier remarks, which were that the money will go to the Dongara health service to provide four to six aged-care beds. I can confirm that ongoing work is happening to identify the needs of people in those communities and, Chair, I will ask the chief executive of the WA Country Health Service to make some further comments.

Mr J. Moffet: We have been asked by government to do some further work on a number of initiatives, including the Turquoise Coast. As the minister said, it is accurate to say that the four to six beds in Dongara are the item that appears in the budget, so we will proceed with planning in Dongara. Another amount for Dongara will be combined to make an integrated initiative that will come from our smaller primary care reform program, so Dongara will in fact be a $6 million to $7 million project. That is proceeding. In terms of the impacts on the broader Turquoise Coast, including Lancelin and Jurien Bay, we are currently reworking planning as requested in order to get back to government on that.

Ms M.J. DAVIES: The chief executive just made a comment around the primary healthcare centre in Dongara. Centres in Dongara and Mullewa were to be funded. Are they confirmed as continuing and where would we find that in the budget?

Mr J. Moffet: Through the minister, yes.

The CHAIR: Thank you. Member for Nedlands, would you like to defer?

Mr W.R. MARMION: It is all right; it is only a quick question, given that the member had three or four questions.

I refer to page 113 of budget paper No 2. I note a dramatic drop in the allocation of capital in the forward estimates in which the government has said that it is "committed to the expansion and upgrade of a number of metropolitan hospitals" and, in fact, they have been listed. Why has there been no allocation of estimated costs for these facilities in the forward estimates?

[3.10 pm]

Mr R.H. COOK: Is that for any particular project?

Mr W.R. MARMION: The hospitals.

Mr R.H. COOK: Just hospitals generally.

As the member knows, we have just come out of a period of unprecedented growth in capital development, particularly in metropolitan hospitals, but also in hospitals in the wheatbelt. From that perspective, the member would understand that there is probably less to do in capital works across major hospitals. As he would have gathered from the previous discussion, we are pretty keen to bed down Perth Children's Hospital, and he would know that the commissioning process is complex. At Fiona Stanley Hospital, we are only just now beginning to get into a comfortable space in the commissioning process. From that point of view, there is probably not a great deal of work around major hospital redevelopment in the metropolitan area.

The next cab off the rank, as the member knows, according to the Reid review, is the relocation of the women's and babies' hospital. I would love to be in a position to advise on work on that going forward, and I have ambitions to see some early work done so that we can have a better idea of the cost, development and service implications. As the member knows, having just come from the Treasury benches, there is not a lot of money, and we are going to have to make do, make what we have go further and make sure that we use that money more wisely. I will ask the director general to make some further comments on the capital works.

Dr D. Russell-Weisz: We are working on some election commitments at the moment. One of those is the Joondalup Health Campus redevelopment and expansion. That work is ongoing and a team established between the Department of Health and the North Metropolitan Health Service is working on that. It may not appear in the budget papers, but it is an election commitment that the department has already commenced work on.

Mr W.R. MARMION: I will just pick up on Joondalup Health Campus, but the election commitment is also around Royal Perth Hospital, Osborne Park Hospital, Fiona Stanley Hospital, Geraldton Hospital, Bunbury Hospital and Collie Hospital. I understand the figure for the Joondalup project has been quoted in a press release at around about $76 million. It might even be more than that.

Mr R.H. COOK: Actually, off the top of my head, it is $167 million.

Mr W.R. MARMION: Yes, I must have got it around the wrong way; I was being dyslexic. How come the government has not put that in the estimates?

Mr R.H. COOK: It is quite simple. We do not know the actual numbers yet but when we do and we have worked the proposal up properly, we will take account of those figures in future budgets. I will make the observation that we have in the past seen numbers dropped into the forward estimates with little or no science and even less commitment. The member will remember that $200 million was sitting in the forward estimates for the redevelopment of Royal Perth Hospital. That was a commitment made both in 2008 in 2013, and we never saw any of that money.

Mr C.J. BARNETT: There were some improvements.

Mr R.H. COOK: It is not a question about what is put in the forward estimates; it is about getting a proper line of sight of what the cost implications are and the model of funding associated with it.

Mr W.R. MARMION: So in the next budget, should we see in the forward estimates capital works for Joondalup Health Campus, Fiona Stanley Hospital and some of the country hospitals?

Mr R.H. COOK: Yes.

Mrs L.M. O'MALLEY: I refer to the line item, "Total Cost of Service", under the heading "Public Hospital Admitted Services" on page 123 of budget paper No 2. What is the government doing to reduce the demand on hospital services in the future?

Mr R.H. COOK: We often talk about how clever we are at putting hospitals together and pushing as many patients as we can through them, but one of the important things we have to do is make sure that we manage the demand on our hospitals as well. There are not only supply-side policies for the output of hospitals and our capacity to meet the demand, but also the capacity to address the demand issues. Western Australia has a very high reliance upon emergency departments. We know that patients who go into emergency departments have a 30 per cent chance of being admitted into a hospital.

One of the important measures we are considering is around urgent care clinics. Urgent care clinics are an important initiative, because they make sure that we craft our services to meet the needs of patients. We know that roughly 30 per cent of patients do not need to go to an emergency department, even though they need urgent care. One of the things we are trying to do is craft an urgent care pathway, which is an enhanced primary health pathway rather than necessarily an emergency department or hospital-driven pathway. We will then be in a better position to take the pressure off our emergency departments and ensure that they are freed up to meet the needs of patients who actually do need emergency department services.

We have held an initial workshop on urgent care policies with both primary and hospital care stakeholders. It was a really good day-long workshop to look at what a business model would look like. We have some really good understanding and some good commitment from people around the urgent care centres in the community. We are still working on those in some of the hospital environments, although I note that Royal Perth Hospital is making some good progress towards developing its urgent care centre. We are hoping that by identifying these patients as primary care patients, they will go to a primary care centre, which means that they will get appropriate care. Also, as primary care patients they will be catered for by the commonwealth department under its funding arrangements, and that is obviously an upside for us as well. I will ask the director general to make further comments.

Dr D. Russell-Weisz: We have done a lot of work on the urgent care clinic concept and the pathway concept. As the minister said, we held a workshop with three different experts on urgent care. There is no one-size-fits-all solution, so when we talk about urgent care, we are not being prescriptive. We are not saying that what could work at Joondalup will work, say, in the country. One of the most innovative solutions was from New Zealand, where there is a college of urgent care physicians. I might not have got the term quite right, but these are physicians who work in between primary health care and the emergency departments. They have a truly community-based urgent care clinic that did not sit next to an emergency department. Some models are being trialled in the eastern states in which urgent care clinics sit right next door to emergency departments. They can also be enhanced general practitioner primary care clinics.

We have done quite a bit of work and they are at different stages of advancement. We are looking at potentially piloting different models, including one at Joondalup. We have a model that is more advanced than others at Royal Perth Hospital looking at specific clients and specific patients. Obviously, in the country, we should be able to look at telehealth facilities. There has been huge investment in that over the past few years. We have a vibrant telehealth facility now based at Royal Perth that services the country. A strategy paper has just been put to the minister outlining the different urgent care pathways we could look at, and we have a number of priorities. If the minister allows, I might ask the chief executive of the East Metropolitan Health Service to comment on the progress and the type of model being looked at in Royal Perth, which is innovative and goes to the clients that it services.

[3.20 pm]

Mrs E. MacLeod: The model we are looking at for Royal Perth Hospital is reflective of the location and the frequent patient cohort, particularly the emergency department at Royal Perth Hospital, which is often what we refer to as behaviourally affected due to either drugs or alcohol. The urgent care clinic that we are looking at there, incorporating in proximity to our emergency department, is around the behavioural assessment and management of this cohort of patients, which will provide a better method of management of these patients. It will also provide the care in a different setting. Currently, they are within the emergency department, so it will allow the emergency department to focus on the other patients coming through the ED. We are working up that model at the moment in conjunction with some of the other patient flows, particularly around the mental health observation area at Royal Perth Hospital as well. We are looking to make sure that we have clearly defined pathways and we will look to implement that over the next 18 months.

Mr R.H. COOK: The other aspect of health that we do not talk about enough in this state—I talked about demand-side management—is the need for patients to go to hospitals in the first place. One of the key factors influencing that falls into the space of preventive health. It is something we do not do enough of in this state. In

particular, we need—I alluded to this in the previous division—to get serious about the issues of alcohol and alcohol abuse in our society. In 2014, one person was hospitalised for an alcohol-attributable condition every 27 minutes, and 113 500 hospital bed days were used. There were 545 alcohol-related deaths in 2013. We simply have to get serious about the alcohol debate in our community. It is the elephant in the room and, quite frankly, it is the one that as a society we are continuing to ignore. Recently, Aldi announced that it will look to sell bottles of wine for as low as $2.78 each. That represents a significant threat to the public health of our community—people accessing large amounts of alcohol very cheaply. One of the things I have asked the Mental Health Commission and the Department of Health to do some work on is to provide a minimum floor price for alcohol. That program has been looked at in the United Kingdom, in Scotland in particular, and in Canada, whereby companies have to sell a unit of alcohol at a particular price. If implemented, that would mean that the high-volume, low-cost users of alcohol would be deterred and consumption rates would go down. We would see hospital attendances avoided and alcohol-related crime reduced and a much greater benefit to our community. It is not saying that we want a bigger tax take; we are saying that we want a lower alcohol intake. Quite frankly, until we get serious with off-premise or bottle shop alcohol sales, we will not be able to put downward pressure on health costs and the costs of policing, of providing community safety and of domestic violence generally. It is time that society got serious about this debate. As I said, this is something we have asked the Department of Health and the Mental Health Commission to look at.

In addition, we will host a preventive health summit early next year. The idea of the preventive health summit is to bring together 150 or so experts within the state to put the focus on preventive health issues in our community to make sure that we can put downward pressure on our hospital queues so that we can put downward pressure on our hospital costs. This is an important aspect of what we do. We are constantly asking ourselves: how do we better serve the patients who come to our hospitals? We often do not ask: how do we lower the number of people who need to go to hospital in the first place? The biggest threat to public safety is alcohol abuse. Until we get serious about that, we will simply not get to the nub of the problem that is afflicting our hospital system. We have to look at a minimum floor price for alcohol because we have to stop the discount sellers of alcohol and make sure that we can therefore address the social impact of alcohol abuse in our society. As I said, we will have a preventive health summit at the beginning of the year. The idea of that is to bring experts to the room to give voice to these sorts of issues and make sure that we are advancing the debate. I am not saying that we will introduce a minimum floor price, but I am saying that we will have a really good look at it to see whether it is a viable option to make sure that we have better control of the amount of cut-price alcohol that is flooding our communities. This is the very issue we are confronting in the Pilbara at the moment. It is a live issue. We can see people in the west Pilbara struggling with this issue which, of itself, produces complex negative social conditions and it is time we took this issue seriously.

Mr W.R. MARMION: It was nice to learn about alcohol and drugs but the question was about urgent-care clinics. I am trying to get my head around how urgent-care clinics will work, because customers already have a choice of going to GPs who operate after hours, GPs who operate during hours and emergency departments. I am trying to work out in which space the UCCs will fit. There is a wonderful app that we should promote more that tells us the emergency departments and waiting times. I used it three times on the weekend. Already, some consumers know where to go for an emergency department or they can go to their own GP. How will they work out whether they should go to an urgent-care clinic? The minister's first hurdle is to explain what an urgent-care clinic is; then there must be a sufficient number of them. The minister has to sell the idea—I do not know what they will do—that a UCC is where to go. However, a patient might say, "The closest one is here, but there are three emergency departments closer, so I won't go there." Can the minister explain how they will work?

Mr R.H. COOK: Certainly. As I said in my earlier remarks, this is about creating urgent-care pathways, an enhanced primary care pathway that people see as a viable option to going to a fully-fledged emergency department. We are not talking about some of the smaller GP clinics. I think we are talking about larger GP clinics with diagnostic, some pharmaceutical and radiology capacity. From that point of view, I agree; it is important that we understand what is on offer. The member for Nedlands is right; it is in part about behaviour change. In the workshops we had a presentation from a clinician in New Zealand where they provide, via an app, a live feed about how long a person would wait if they went to their local ED and how long the wait is at their local care centre. It is about educating the public so they understand what their health options are. I will ask the director to make further comment.

Dr D. Russell-Weisz: In developing and implementing this strategy, we need to be smart for the local area so we need to look at the local areas and see what they need. Liz MacLeod talked about the Royal Perth initiative and that is definitely tailored to the clients. It is not a standalone building. We are not talking about standalone buildings. It might be that we build an urgent-care clinic when we do a new hospital redevelopment. It might be that we put one out in the community. There are a number of options, so we will naturally look at, say for Joondalup

Health Campus, how we could potentially partner with St John Ambulance WA because it has a type of urgent-care clinic. We would partner also with other GP practices. We have to give options to patients. The options are not always to come to emergency departments. Obviously, the success of the four-hour rule means that as a whole patients are treated within four hours, but a lot of them do not need to be there. Some of it is better education. We know that a lot of GP practices have appointments that patients can utilise, so it is also getting that information out there. It is not just one pathway fits all. I think the solutions in the country will be very different. They will be different from Joondalup hospital, Royal Perth Hospital and Osborne Park Hospital, and potentially to the other urgent-care centres or pathways that the government announced.

[3.30 pm]

Mr W.R. MARMION: I understand there are lots of options, but I will stick to an easy one. This might work in the regions better, but using Royal Perth Hospital as an example: it is almost as though the department is already triaging. Let us say there is one next door or in the same building—it is close by—and a person rocks up. If they have not been educated about it, they go to the emergency department but they did not have to go. Another complication is they may have diagnosed themselves to work out which one to go to. If they rock up at the emergency department at Royal Perth Hospital, they are told, "Go next door to the UCC." That is another thing they have to do. That also has to be funded. Does the government split the emergency department into another one, a minor emergency—the UCC? I am still grappling with how it might work.

Mr R.H. COOK: In some respects the triage process will be important. One observation made to me by St John Ambulance is it would also like a bigger role in triaging. It has a commercial interest in getting patients to urgent care clinics. As the member knows, it bought out the Apollo Group. It is keen to have that as an extension to its current services. It is about offering a diversified service to what is a very diverse patient cohort.

Ms M.J. DAVIES: I would like to talk about the Carnarvon residential aged-care project. It is on page 129 of budget paper No 2 under "Works in Progress", specifically under "North West Health Initiative (NWHI)". I note that only $10.577 million has been allocated to this project, which is significantly less than what was previously allocated. How has the scope of works changed to deliver this reduction in funding; how many beds will be provided to service Carnarvon's ageing population; why has the project been pushed out by a year; and is the minister exploring any alternative sites in Carnarvon for the project?

Mr R.H. COOK: It is a good question. I am looking forward to engaging very strongly on this project. As the member has observed, it now receives funding of $2.6 million, down from $25 million. It will require some planning and rescoping. In communicating some of these decisions, I contacted the Shire of Carnarvon to chat about this particular project. Without trying to quote the shire, it basically expressed concern about the project and said that it has a different vision of how it would like to see aged care developed in Carnarvon. Very shortly, I will ask the chief executive of Country Health to make some comments. I was quite taken aback with how aggressively the shire was trying to pursue its own vision around the provision of aged-care services in Carnarvon. I see that as a great opportunity to perhaps redirect our efforts in Carnarvon to add value to whatever it has planned —

Ms M.J. DAVIES: Albeit with less money.

Mr R.H. COOK: — for this aspect of it, which is 38 new aged-care beds on the Carnarvon hospital site. It has ambitions for a different site and would rather its aged-care patients are cared for in a non-hospital environment. I am very sympathetic to that view. I am very keen to catch up and engage with it on that. It is a great opportunity when a local government authority has such a clear vision about how it would like to see it developed. Going forward, that will be some of our early work. Does the director general have some commentary to make?

Dr D. Russell-Weisz: I would pass to Jeff Moffet.

Mr J. Moffet: We have 16 beds in the existing facility in Carnarvon. The project was to deliver about 38 beds. With the budget change, we are anticipating that we would still be able to deliver probably at least 24 beds. Having said that, if there is involvement with the private sector or a local government, we may be able to achieve a greater scope than that. We are currently relooking at what scoping options will occur; a bit of replanning and rescoping will occur. In terms of demand, we have around 10 or 11 clients who need care and are awaiting placement. They have been identified in the community as needing aged care in a residential setting into the future. We anticipate 24 to 26 beds will satisfy the short to medium-term demand. I think that is good news for us. Obviously, 38 beds would be a longer term demand picture.

Ms M.J. DAVIES: My understanding is that the site has already been cleared at the hospital for this project. Substantial planning and preparatory works have already been done. Can the minister confirm that that will not be the future site? Are other sites being investigated? Is that money now sunk and lost?

Mr R.H. COOK: No. As the member has observed, forward works have been done for that. Obviously, we will now need Building Management and Works to go ahead and do some work on rescoping that project. I guess what I am saying, member, is that if the Shire of Carnarvon is of the view it would rather, in the first place, this development took place elsewhere, we need to listen to those concerns and start doing some fresh thinking in conjunction with the Shire of Carnarvon. Does Mr Moffet have any further comments to make?

Mr J. Moffet: No; except obviously the reserve contingency is that there is capability on that site to accommodate the project. Our strong preference in all country regions is to partner with the private sector. In Carnarvon that has proved difficult over time. If local government is interested in having a discussion, in fact providing care possibly, we would welcome that. We do that in a lot of settings in the wheatbelt, as the member knows. We will explore options as requested by government, knowing that the reserve option is still on-site alongside the current facility.

Mr R.H. COOK: I can confirm I have spoken to both the CEO and the shire president about this stuff in the context of the budget. They are keen to engage on it.

Ms M.J. DAVIES: I look forward to the minister doing the same in the shires on the Turquoise Coast that no longer have funding.

Mr R.H. COOK: Indeed. I have spoken to the CEOs or presidents of a range of shires that we had to deliver that difficult message to. Can I just say, member, that their message was, "Yes, we hear you; we understand the difficulties of your current budget —

Ms M.J. DAVIES: I am not sure anyone in the member for Moore's electorate paraphrased their comments like that. If that is what the minister heard, that is fine.

Mr R.H. COOK: What the member sees out there is an understanding of the difficulties we face with the current budget. That is a budget that fundamentally the member was responsible for, and we have to fix it.

Ms M.J. DAVIES: They are very aware that that funding is going to Collie.

Mr W.R. MARMION: My question relates to the last dot point on page 118 of budget paper No 2. It relates to ValleyView Residence, an aged-care facility in Collie. I do not know whether I have visited it. I am interested to know who owns it and whether there are other aged-care facilities there. I have visited one aged-care facility in Collie. Are there other aged-care facilities in the town? Does the minister have a rough handle on what it might cost to upgrade the facility? When will it likely be scheduled? Of all the aged-care facilities in regional WA, why did the state government prioritise this particular Collie facility over others for upgraded funds?

Mr R.H. COOK: I thank the member for the question. I will make some preliminary comments before handing over to the director general. It was an election commitment. I am sure that the member would be horrified to think that we would not keep an election commitment. Director general, would you like to make some further comments?

Dr D. Russell-Weisz: I think this goes to the government committing to making aged-care beds more available. I do not know the residence in Collie myself. It is a 64-bed aged-care facility based in Collie that provides residential aged care, secure dementia care and respite care. It is pretty outdated. The election commitment of $500 000 to upgrade the facilities at ValleyView Residence aligns with the election commitment that the department is obviously pursuing. I would ask Jeff Moffet whether he has anything to add on that.

[3.40 pm]

Mr J. Moffet: I have nothing further except to say that we have just started engaging with ValleyView around planning the upgrade priorities and options. We have just commenced discussions with it.

Ms M.J. DAVIES: So there is no business case?

Mr R.H. COOK: My understanding is that a business case is being developed as part of this funding for the 2018–19 budget round. The money is specifically being used to develop that business case.

Mr W.R. MARMION: I will qualify this by saying that I have a conflict of interest; my wife is related to about one-third of Collie.

Mr R.H. COOK: Does that mean that between your wife and the member for Collie, that pretty much cleans up the entire population?

Mr W.R. MARMION: I want to know who owns the facility. Is it a private facility or a local-government-run facility?

Mr R.H. COOK: I was about to say that the member should not quote me on this but, of course, he will absolutely be able to quote me on this. I understand that the facility is run by a community board. It was run by a private entity, but the community came in and took over when that entity decided to withdraw its services from the facility.

I met with the board members recently, and they are all community folk. It is a classic country-run aged-care facility.

Ms M.J. DAVIES: When we were in government I know that we had discussions about providing aged-care services, particularly when it was a community board. This is no disrespect to those who are passionate and committed and operating those services, but, as the minister would understand, this is a complex area to operate in, so any funding provided by government to upgrade and provide a greater level of service probably needs to go with the proviso that it has to be a service provider that understands that very complex regulatory system. Is that something that the government is contemplating?

Mr R.H. COOK: Yes; it will obviously be part of the business cases.

Mr B. URBAN: I refer to page 136 of budget paper No 2, volume 1. The heading is "Net Appropriation Determination", the subheading is "Grants and Subsidies" and the line item is "Commonwealth Grants". There are five parts to this question. What are the relative cost differentials for providing health services in remote Western Australia? Does the commonwealth fund Western Australia differentially for hospital services in remote and regional areas? How does that compare with how it funds other jurisdictions? What is the budgetary impact of any difference? Was any action taken by the previous government to rectify this situation?

Mr R.H. COOK: I thank the member. This is important. When I was in opposition, I always railed at the government around the national efficient price, which is part and parcel of the national government agreements for hospital funding. The feds contribution is, in large, based on issues in that national agreement and is subject to the deliberations of the Independent Hospital Pricing Authority. I always assumed that the national efficient price was what was considered to be an efficient price for providing an episode of care in a particular hospital, given its particular circumstances. It is not. The national efficient price is an average price that does not take into account the particular differentials associated with delivering an episode of care in Western Australia or, in particular, a remote community. For instance, the Independent Hospital Pricing Authority provides the commonwealth contribution based on a remoteness loading. It considers that Launceston has a remoteness loading of 2.7 per cent; it considers that Port Hedland hospital has a remoteness loading of 1.9 per cent.

Ms M.J. DAVIES: Launceston's capital city is Melbourne.

Mr R.H. COOK: Precisely. I think I said in a perhaps intemperate moment, member, that Launceston was an outer suburb of Melbourne by comparison.

Certainly, in terms of what it costs to get staff to operate and provide services—around logistics, transport and petrol alone—there is no way that we can compare delivering an episode of care in either Ballarat hospital or Launceston General Hospital with delivering hospital care in the Pilbara or the Kimberley. I note that five Tasmanias fit into the Kimberley alone. From that point of view, it is not an appropriate comparison or a fair mechanism for hospital funding. My understanding is that if we tweaked that remoteness alone, we would resolve our budgetary issues around the WA Country Health Service. It would represent a $15 million per annum increase to country health services in the Pilbara and the Kimberley simply by recognising that we are potentially a little more remote than Launceston. The story does not end there. Whether it is Medicare benefit schedules, the pharmaceutical benefits scheme or the number of aged-care facilities, regardless of which way one cuts it, Western Australia continues to be undercut on commonwealth funding for healthcare services.

With the Chair's indulgence, I will pass around this infographic, which I have spoken about before in Parliament. The infographic really goes to the issue of how much it costs to deliver health care in Western Australia. In particular, it refers to the way in which we have to significantly change our tactics in our relationship with the commonwealth. For instance, in Western Australia, we have about 77 general practitioners per 100 000 head of population. The national average is 95 per 100 000 head a population. To further rub salt into the wound, Perth's western suburbs—represented by the members for Nedlands and Cottesloe, who happen to be in the chamber—have the highest concentration of GPs anywhere in Australia. That gives members an idea of how few GPs are out in the bush. This does two things. It means that we do the heavy lifting when it comes to primary health care. Whether it is in the eastern wheatbelt or beyond the twenty-sixth parallel, we are it for the provision of primary care. That is not the way it is supposed to be. In addition, if communities do not have a number of GPs, they struggle to have GPs doing their rosters in the local hospital, and that impacts the local hospital's capacity to provide emergency department services.

We have to do this differently. Members can see the statistics. We could launch a public campaign around kicking Canberra on this. In some senses that would be easy politics, but bad policy. I can confirm that I have already raised this issue with the Council of Australian Governments and I have had discussions with the commonwealth minister about a potential bilateral agreement between us and the commonwealth that has the commonwealth doing a greater share of heavy lifting in the provision of primary healthcare services in the bush to make sure we bring

a bit more honesty to that relationship. The previous government had the same problem, but its solution was to throw money at the problem. Good programs such as the Southern Inland Health Initiative are about state governments doing the extra heavy lifting around the provision of primary care services and making sure our hospitals have the number of GPs that can rotate through them. But we should not be doing the heavy lifting. This is primary care. It is the job of the commonwealth to be there. I can confirm that the commonwealth minister acknowledged the problem and said that he is keen to engage with us on this issue. But we have to stop simply throwing money at the problem because we can.

[3.50 pm]

Mr C.J. BARNETT: Do not forget Curtin Medical School, precisely for that reason.

Mr R.H. COOK: Indeed, member for Cottesloe. Curtin Medical School makes a great contribution to that —

Mr C.J. BARNETT: That is right. So we did do something.

Mr R.H. COOK: — and some great work is being done in Western Australia. I remember that legendary Australian Medical Association function at which the member for Cottesloe was ambushed by the AMA on the issue of Curtin Medical School. I think the member for Cottesloe confronted the members of the AMA on that occasion with the very statistics that we are now talking about. I think the proposal that the member for Cottesloe made at the time was that if we do not need more GPs through another medical school in Western Australia, why are we importing so many doctors into Western Australia. Look, I acknowledge the limitations we have around training for doctors. That is going to be a challenge for us going forward. But we have to increase our GP workforce because one of the ways we can resolve this issue is by priming the marketplace so that more GPs can see an opportunity to practise their craft out in the bush. Rural clinical schools are an important contribution to that. They are doing a good job in getting training in the bush for some doctors, and we know that if doctors get that experience early in their training and medical degree, they often take that back to do that work. At the end of the day, we need the commonwealth to do much a greater share of the lifting around this. We cannot simply go on throwing money at the problem. It is time the commonwealth stepped up and played its role.

The CHAIR: Member for Nedlands.

Mr W.R. MARMION: My question relates to medihotels, which are referred to on page 119 of Budget paper No 2. I have a number of questions on the proposed medihotel to be located at the Royal Perth Hospital site. Will it be a separate building? How many beds will it have? What is the estimated capital cost? Will the capital be provided by the government or the private sector? If the capital is to be provided by the private sector, what will be the likely terms of any user agreement? Will it be a long-term lease? Will a bed utilisation component be in the contract?

Mr R.H. COOK: I thank the member for Nedlands very much for the question. Obviously, we have had a lot of debate around the medihotel that we announced today, which is the Fiona Stanley one, as part of the health and knowledge hub located on that campus. Obviously, the RPH medihotel is a different kettle of fish. I have made the observation before that medihotels will ultimately not be the same. The needs of country patients going to Fiona Stanley are much different from the needs of country patients going to RPH. There is not a hotel within eight kilometres of Fiona Stanley Hospital. Obviously, that is a challenge for patients going in and out of that hospital when they are travelling from the country. But RPH has a different set of circumstances. We have a lot of spare building assets at RPH, so I am hopeful that we will be able provide a relatively more affordable development. That means that we will be able to benefit from the services without having to create a fresh build. At the moment a detailed prospective audit is being conducted to ascertain the patient cohorts that would best be served by a medihotel located around RPH. We are also exploring utilisation of existing accommodation to reduce the unnecessary risk of high fixed costs related to capital builds. As we know, in Perth at the moment there is a fairly high vacancy rate in hotels, so there is, of course, the potential to utilise some of the existing facilities. With your indulgence, Chair, I will ask the chief executive of East Metropolitan Health Service to talk about some of the early works it has done in that area.

Mrs E. MacLeod: As the minister noted, we have done a prospective audit around the existing patients within Royal Perth as to who would be suitable for a medihotel. We were keen to undertake this exploratory work so that we could ensure that any model of care that we implemented actually reflected the needs of the patient cohorts at the hospital to assist in efficiencies. The audit was completed about two weeks ago. The early analysis of it is that approximately 10 patients might be suitable for a medihotel-type facility. We are taking that work and then looking at what would be an efficient way of delivering that facility. As the minister stated, there are obviously facilities within the CBD with which we could formalise some arrangement, or we have existing capacity at the hospital. Again, we could work with that existing capacity to utilise that as a medihotel. It is making sure that we deliver the model that will meet the patient cohort here.

Mr W.R. MARMION: I have a supplementary question. When up and running—let us use a live example—say 10 people can be moved into the medihotel. Will the 10 acute beds that they have moved out of be backfilled, or will they be taken out of the equation? It looks to me like it will end up costing more because even though it will be cheaper for those 10 patients in the medihotel, there will still be 10 acute beds, and if they are backfilled straightaway in the new efficient way, more funds will have to be provided to service those more expensive clients backfilling the acute beds.

Mr R.H. COOK: Yes, that right. The member for Nedlands has raised this point in Parliament, and he is absolutely correct. If all we are doing is simply moving patients from one bed and creating opportunities for patients in another bed to fill that space, we will not make any savings. The idea of medihotels, apart from our mantra of putting patients first—that is, improving the services we provide to patients—was about creating a more efficient health system. If we put lower downward pressure on the weighted average unit costs and then we create a more efficient health system, that in turn allows us to provide care for more patients. Obviously, who is put into that next bed depends on the contract from the Department of Health to the East Metropolitan Health Service. The member knows that the health service providers are contracted for a particular activity level. It is not simply a matter of scouting around, finding someone and plonking them in there; it is part of the overall management of the patient flow according to the contracted services under the activity-based funding model. The point we were making in our narrative around medihotels is that if we can reduce the number of days that a patient stays in a hospital bed by putting them in a subacute care bed, we are actually making savings to the system because we are reducing the average cost of delivering services to those patients. I take the member's point. Unless we go back and pull those beds out of the system, we will not make a saving as such. The savings are in a more efficient health system.

Mr W.R. MARMION: If they went home, there would be even better savings, rather than a medihotel.

Mr R.H. COOK: Indeed, and that is obviously the preferred option. I have not seen the statistics lately, but the statistics that we were working on while crafting that policy were that the average length of stay for a WA country health patient was nine days; the average length of stay for a New South Wales country health patient was seven days. We basically said that if we could reduce that length of stay by two days by having that patient sitting in a lower cost bed, that would be a win for the patient because they are being cared for in a better, more family-friendly environment, and it would be a win for the health system because that patient is not sitting in a costly hospital bed.

Mr S.A. MILLMAN: My question relates to the spending changes on page 114 of budget paper No 2. The subheading is "Other", and the line item is "Perth Children's Hospital—Capella Parking". I refer to the estimated $500 000 paid per month to a private provider of a car park at Perth Children's Hospital that, unfortunately, does not currently hold any cars. Can the minister outline the total cost that has been paid to date to the private provider for this car park? Can he outline specifically what clauses in the contract locked in the government to paying Capella even when the car park was not in use? What could have been added to the contract so that this situation did not occur and the state was protected against unnecessary costs?

[4.00 pm]

Mr R.H. COOK: This is obviously one of the great frustrating aspects of Perth Children's Hospital. When the Capella contract was put together, it was envisaged that Perth Children's Hospital would be completed in December 2015 and then there would be an increase in the number of visitors and staff working at the QEII campus and obviously an increase in revenue to the contractor in addition to the 300 new car bays for the contractor to put people in. That has not happened, obviously, because we still do not have a hospital. Under the privatisation contract with that consortia, the consortia anticipated getting revenue from the new hospital, so the consortia is basically bound to make a call on that and call on the government to make good that commitment in relation to it. That means that we do not have the benefit of the children's hospital or of the hospital parking bays, but we still pay for them. My understanding is that is at a cost of half a million dollars a month, which is a lot of money. I will ask the director general and his colleagues to make further comment on the global costs associated with that.

Dr D. Russell-Weisz: The minister has covered it well. When the car park was built, it was envisaged that Perth Children's Hospital would be open from 1 July 2016, but it was not. For many of us who remember or who worked on that site, there were significant issues with car parking on the QEII site, as there always have been. The car park has certainly alleviated a lot of the car parking issues on that site for both visitors and staff. The multistorey car park was built to accommodate Perth Children's Hospital, but also, as the minister said, with the additional 300 bays underneath. There were bays underneath and capacity in the multistorey. I will hand over to Mr Salvage, the chief executive of the North Metropolitan Health Service, to comment further.

Mr W.R. Salvage: The background is pretty much as explained by Minister Cook and the director general. I will correct one element of the question: I think there has been a lot of speculation that the compensation payment to Capella relates to the non-use of the 300 bays underneath Perth Children's Hospital. In fact, it relates to a clause in the contract that stipulates that by 1 July 2016 it was expected that there would be 888 operational beds on the site. Sir Charles Gairdner Hospital has approximately 670 beds. To reach the operational bed target, obviously we need to have Perth Children's Hospital opened. The clause in the contract relates to financing arrangements that Capella had to enter into to secure funds to build the car park. Under the agreement, the responsibility for volume risk resides primarily with the car park operator, except in the circumstance in which there is a delay in the opening of the hospital. Under the contract, once we got to 1 July 2016, it was necessary to accommodate compensation payments to Capella and that will continue until we reach an operational bed target of 888 beds on the QEII campus, which obviously requires Perth Children's Hospital to open.

I can provide the payments to date for 2016–17. In the last financial year, total payments under this clause of the contract to Capella were $8.2 million, somewhat higher than the $500 000 a month that the minister quoted—closer in fact to $700 000 a month. We anticipate that will continue until the hospital is commissioned.

Mr S.A. MILLMAN: As a supplementary question, perhaps the chief executive of the North Metropolitan Health Service might be able to assist with the comments that he has already provided on the clauses in the contract. The third part of my question is: what could have been added to the contract so that this situation did not occur? We are stuck with the hand that we have been dealt this time around. However, as a former lawyer I have an interest in making sure that the draft contracts contain the necessary terms and conditions so that the state is protected from these sorts of costs. What could have been done and what could we do in the future to avoid this sort of thing from occurring?

Mr W.R. Salvage: I will provide a bit more context around the structuring of the agreement. Capella had to go to the market to borrow the money—I think it was about $120 million—to finance the multistorey car park at QEII. Essentially, a couple of parameters needed to be locked into the agreement to meet the financing obligations, one of which is an estimate of demand. In the main, demand risk is carried by the car park operator. The other parameter is price: the agreement has a locked-in schedule for price. Both of those parameters gave an estimate of the revenue that would be generated through the car park facility. Clearly, as the demand proxy is the 888 operational beds on the campus, the timing of the commissioning of Perth Children's Hospital was a critical factor. As the minister said, it affects demand on car parking facilities on the site; therefore, it was something that was negotiated into the agreement. If the member is seeking advice about what could have been done differently, in the context of a contractual negotiation, sure, we might have put forward a proposition that no such clause existed. Obviously that would have resulted in significant commercial exposure to Capella in the context of that negotiation.

Mr S.A. MILLMAN: Surely Capella should carry the risk if it has the problem of having to go to the market for the capital. Forgive me if I am wrong, but has it not just shifted that risk onto the state in the way it has negotiated the terms of the contract?

Mr W.R. Salvage: I cannot speak for the motivation for particular clauses in the contract at the time; all I can do is explain the rationale as I see them for their existence at this point in time.

Mr W.R. MARMION: I have two supplementary questions. Firstly, which government department advised the previous government to sign the contract? Secondly, why can the car park not be utilised for commuters going to Perth to catch a bus? I drive past it two or three times a day and people ask me that question.

Mr R.H. COOK: I might go to Mr Salvage or the director general on this question.

Mr W.R. Salvage: I will take the second question and I might have to rely on my friend the director general for the first. We have been endeavouring to make greater use of the car park. There was an access issue for a while, but the car park is now being used by staff coming from Princess Margaret Hospital who are involved in commissioning activities at the site, so there is some, although not full, utilisation occurring.

Dr D. Russell-Weisz: I can give a bit of history on this. I think it is important to know the history. This goes back to probably 2004–05 when we were trying to do redevelopments on the QEII site, with the new PathWest building, the new research building and the new cancer centre, which is not that new anymore but it was then. It has been totally redeveloped. The Western Australian Planning Commission would not give us or the government of the day permission—I probably would say it frustrated the government of the day—to build anything until we had sorted out the car parking problem. A master plan was drawn up for the site and a multistorey car park was planned for an area that was at grade. A decision was then made to go ahead with a public–private partnership for a car park. As Mr Salvage says, it was to cost around $120 million. It probably would have cost the state more to build a car park that potentially went to another hospital redevelopment. The actual contract was run then by the

Department of Treasury, but it was done with the close knowledge of the Department of Health and the North Metropolitan Health Service, of which I was the chief executive at the time.

[4.10 pm]

Mr W.R. MARMION: So it is your fault!

Dr D. Russell-Weisz: I was being open and honest.

Mr R.H. COOK: They wanted to build a hospital and they said, "You've got to build a car park first."

Dr D. Russell-Weisz: That was it.

Ms M.J. DAVIES: I will go back to some slightly smaller facilities and hospitals. On page 121 there is the line item for small rural hospital services under "Service Summary". There seems to be a reduction across the forward estimates. I would like an explanation of how those numbers were arrived at and why there are reductions. I have a question about the services that are provided and the contracts that are struck with doctors in those small hospital services. I will do it as a follow-up, if that is all right. Firstly, can I get an explanation of why those numbers are decreasing across the forward estimates?

Mr R.H. COOK: I will ask Ms Kelly to respond to the first of those questions.

Ms A. Kelly: Thank you, minister. I will take the first part and I think Jeff might give us some more information.

As we advised earlier, the 2017–18 budget is based on the new outcome-based management framework, which has given us 10 different service lines, one of which is small rural hospitals. Through this process, we have seen movement from non-hospital services into hospital services, which we are still trying to understand as we work through this process. We have mapped 40 000 cost centres based on the actual 2015–16 outcome to help us understand where our costs are. In this area we have picked up on these service lines. Mr Moffet can give the member some details around these fundings, if the member is happy with that.

Mr R.H. COOK: Mr Moffet.

Mr J. Moffet: Thank you. As Angela said, the small hospitals service descriptor does not include just small hospitals; it includes a range of other programs. The changes that the member has referred to have an explanatory item between the 2016–17 actual and the 2017–18 budget. In summary, our small hospital budget is being worked through with the department but there is no material reduction in our small hospital programs at this stage. We are currently unpacking the OBM framework. To give the member some examples of the impacts, there is a $6 million decrease in the residential aged-care program. Some of the royalties for regions funded projects are dropping off in terms of time frames and have impacted on this budget line. Small hospitals are normally allocated around $180 million or $190 million just for small hospitals. That is essentially preserved going forward. We just received our budget two days ago and our revenue plan yesterday, so we are still working through our analysis of that. To answer the member's primary question, there is no direct impact on small hospitals.

Ms M.J. DAVIES: I cannot find it in the budget estimates because I suspect it is too detailed, but I am after a breakdown in the contracts or the nature of services supplied by general practitioners into these small hospitals such as the close on-call contracts. My experience has been that the services vary although the department has tried to standardise them. For each of those country health services, can we be advised of the nature and terms and any other relevant details pertaining to the contract the department has through a medical service agreement or close on-call arrangements it has with GPs? I am happy to take that as a supplementary because the minister will not be able to do that today.

Mr R.H. COOK: It is a humdinger! Mr Moffet, do you want to make some comments first?

Mr J. Moffet: I will make some general comments. Later this year we are coming up to renegotiation of our medical services agreements at a whole-of-state level, not just in country WA. I anticipate that the fee-for-service arrangements that we have in place for small hospitals will largely remain unchanged. As the member will be aware, through stream 1 of the Southern Inland Health Initiative, we have a medical workforce incentive program that flows to district and small hospitals. That is in the budget papers. We are currently working through any policy changes about that based on the evaluation of the medical workforce stream investment. It is likely there will be some small changes to contracts as a result of that evaluation, but nothing material at this stage.

Ms M.J. DAVIES: Can I have, by way of supplementary information, for each of those country health services, contracts the terms, the nature and any relevant details pertaining to close on-call and medical service arrangements for each of the hospitals? I am trying to see how standard they are across those different hospitals.

Mr R.H. COOK: We may have to take that on notice, member, due to the timelines and detail of the information.

Ms M.J. DAVIES: Okay. That is fine.

The CHAIR: Minister, could you clarify exactly the information you will provide?

Mr R.H. COOK: I am happy to sit down with the member afterwards and draft that question on notice.

The CHAIR: Is the member happy with that?

Ms M.J. DAVIES: Yes, as long as I have an undertaking that we will get the information that we are after.

Mr R.H. COOK: Yes. I am happy to make that undertaking.

The CHAIR: We are in agreeance.

Mr R.H. COOK: We will not trouble you any further on that one, Chair. The request is that we put that on notice rather than provide it as supplementary information so that we can get the detail that the member needs.

Ms M.J. DAVIES: I am saying that I trust the Minister for Health.

The CHAIR: As long as you are happy, we are all happy.

Ms M.J. DAVIES: He has a trustworthy face.

Mr R.H. COOK: I just wonder if members could note that.

Ms M.J. DAVIES: It is noted in *Hansard* in perpetuity. I am sure that it will come back to haunt me.

The CHAIR: It is up to you to do that, though.

Ms M.J. DAVIES: Yes, that is fine.

Mr W.R. MARMION: My question relates to page 129, "Asset Investment Program", and the amount of money that has been allocated in the budget for Perth Children's Hospital for 2017–18. Does that amount allow for any outstanding variation orders that the minister thinks might come to fruition? If so, how much? Does it allow for the replacement of any components during that period such as, for example, brass fittings?

Mr R.H. COOK: That is a very good question. I will resist the opportunity to try to have a stab at that and will ask the director general to comment further.

Dr D. Russell-Weisz: The budget paper is as it is read. Since the hospital was transferred from John Holland to the Department of Health we have been working through the capital budget to see how much contingency is left for defects, design change requests or remediation activity. We have had to step in—I am not talking legally—and one of the advantages of taking practical completion was that if the builder refused to do certain things such as put in the polyphosphate, replace the brass fittings or do remediating work in the sterilisation area, we are able to do that through Strategic Projects, which would get somebody else to come in and do that work. We have started that work and are keeping a log of our bills and what we are paying. We will seek to take that off John Holland but we are not delaying the project. I said yesterday that with what we know at the moment we have spent about $1.5 million that John Holland will owe us in the future. Obviously, we keep a record of that. That does not include the resolution of the potable water issue but, clearly, we need to get on and fix it. We will seek to recover that from the managing contractor. As of today, we do not think that we will exceed the contingency, but that may change in time. If so, we will have to have a discussion with our colleagues at Treasury.

Mr W.R. MARMION: Is the minister saying that the $1.5 million to date includes the cost of replacing brass fittings?

Mr R.H. COOK: Director general.

[4.20 pm]

Dr D. Russell-Weisz: No, it does not. The $1.5 million is for a number of areas that we have had to do some work in. We have had to do some work in the sterilisation department, which we believe is the builder's responsibility; the builder should do this but it has shown it does not want to. We have now done it because we do not want it to delay us any further. We are keeping a log of these issues. The potable water remediation is not included. I might, if I can through the minister, ask Dr Lawrence to comment, but at this stage we do not know the final cost of the replacement of the thermostatic mixing valve assembly boxes nor all the final components. Clearly, we know what the water testing cost and we have kept a log of claims for that. Ultimately, we will have to put together a sum of moneys to seek from the builder for the potable water remediation because we are doing it and the builder is not.

Dr R. Lawrence: I think it is fair to say that we cannot yet quantify the cost of the potable water issue. We are in the early stages of determining which product and once we know what product it will be, then we will be able to seek a cost as we go through the procurement phase and there will be the cost of labour. At this stage, it would

appear that John Holland will not fulfil the rectification and the state will have to step in, but that has not yet been fully dealt with contractually.

Mr W.R. MARMION: On the brass fittings, I have a fairly technical further question. The dezincification of brass fittings is a complicated process but it can partly be caused by electrolysis, which is affected by the make-up of the water. There can be lots of components in water—iron is one—and different types of salts. If electrolysis is set up in the TMVs, can the minister, through his staff, advise whether the brass fittings, which I understand are linked to the stainless steel via poly pipe, are not earthed and has the department ascertained whether the brass fittings or components can be earthed, which may reduce the amount of dezincification that is occurring?

Mr R.H. COOK: I will ask the director general of plumbing to make a comment about that!

Dr D. Russell-Weisz: I will take a stab at that. We have not yet landed on what we want to replace the brass fittings with, so we are looking at whether it will be a replacement of the brass fittings, nickel-plated brass, dezincification-resistant brass or even stainless steel, and the focus has been on stainless steel and also plastic. We are looking at a whole suite of things. Obviously, we would like to keep away from brass and it will also depend on what the Building Commission says and what the tests are likely to be, because we need to be compliant. Once we have landed on the component with which we will replace the fittings, we could potentially answer the member's question. Regarding the electrolysis, I cannot make any comment on that. The minister might want to pass to Professor Weeramanthri or Dr Lawrence to see whether they have any knowledge of that issue.

Mr R.H. COOK: Professor Weeramanthri.

Prof. T.S. Weeramanthri: I might take this opportunity to answer one of the questions that the member raised previously about chlorination because I think they are related. Without being a chemist, clearly the chemical milieu of the water is critical for the dezincification. Lots of different chemicals can be involved but the member asked previously whether chlorination protected against dezincification. Actually, in reading the Jacobs report, which is a proper consultant report—I think the final version was handed down in April—it clearly points to the chemical milieu and hyperchlorination as a potential cause of dezincification. Once dezincification has occurred, the lead can leach out, off the alloy, as the member knows. I think it is important to say that we also looked to the Australian standards in this area. Appendix 25 of the Chief Health Officer's report goes through all the various Australian standards that apply to the plumbing and to other related issues. It is a very, very complex area. It is actually a bit beyond me but a couple of my staff looked at it in great detail. A relevant part of that set of Australian standards goes to chlorination in particular, and it states how long chlorination should be left in for, which is not more than six hours. That is part of the Australian standard. The assumption that we have all been working on, which I think still holds, is that if we put in components of the Australian standards in the right way, we have the proper chemical milieu and we control that, and we have proper flushing to avoid stagnation, one would not expect there to be any problem with dezincification of brass fittings, which might have a very small amount of lead in them, but which is acceptable. It is not the lead in the brass fittings per se; it is the total combination of brass fittings, plus chemical milieu, plus potential stagnation that could lead to a problem.

Mr W.R. MARMION: This will get a little bit further technical. I have had advice from someone who commissioned a large building overseas and the issue gets back to electrolysis. The problem when the water flows into a new building is that it goes through PVC before it hits the brass fittings, which sets up a static charge. Very high current levels were measured when the water flowed through the PVC pipes and then hit a set of metallic objects such as brass. The high ampage meant that there was a lot of extra electrolysis compared with what there would be normally. The water in this case had a higher iron content, and the higher iron content meant more electrolysis. Another theory is that there is higher electrolysis because a PVC pipe is being used. In this facility overseas, the problem was solved by having a larger diameter of PVC pipe and that stopped the static. I will just throw that in as another possibility. That was why I suggested that if the metallic TMVs were earthed, the electrolysis and therefore the lead might be reduced. I will throw that in.

Mr R.H. COOK: Professor Weeramanthri—electrolysis as part of the dezincification process?

Prof. T.S. Weeramanthri: Thank you. We have received a lot of expert advice. I think the important thing is to have a process to consider that. We consider the total body of evidence and the new data that comes in—new expert advice—and we ask other experts as well. We have the Australian standards, which is one process. We have the Australian drinking water guidelines, which is another process. We also have a particular situation in front of us, which has also been the subject of consultants' reports. The important thing is that there are lots of different expertise—engineering, plumbing, metallurgy, and public health—and none of us are experts in each other's areas. We have to try to bring this all together. One of the reasons that the report I produced did not make definitive statements about Australian standards et cetera but merely gave a set of observations to the Building Commissioner was that I felt someone else should have a look at this, whose day job it was as a building and plumbing regulator,

to look at these issues. I am sure that those kinds of suggestions will be incorporated into the considerations of other people, but perhaps not me.

Mr R.H. COOK: In addition to that, obviously, like the member for Nedlands, we are inundated by people with different ideas about the issues that impact on the Perth Children's Hospital. We take it all seriously, we take all ideas on board, and we appreciate everyone's concern.

Mrs L.M. O'MALLEY: I refer to the line item "FSH: Facilities Management Services Contract Asset Solution" on page 130 of budget paper No 2. I have two questions. Firstly, could the minister please outline the impact on the budget of the Serco contract at Fiona Stanley Hospital? Secondly, has the contract led to savings and efficiencies, and has it been serviced as promised?

[4.30 pm]

Mr R.H. COOK: The Serco contract has attracted a lot of attention, in particular the attention of the Auditor General. As members will be aware, the Auditor General began a process of review in May 2016 to look at the contract for facilities management, and the extent to which it is delivering value for money. As the member knows, I am on the record, along with other members of the government, as being very critical of the Serco contract. The issues go not only to the contract numbers, but also to the aspect of the contract that led to a new cohort of workers—patient care assistants—being engaged at the hospital, because of the mistakes that were made in putting that contract together. The porters, who were envisaged to undertake the work of patient care assistants, ultimately could not do so because under the contract they were not allowed to touch the patients.

The Auditor General has done a great piece of work. He found that the cost of the contract is $24.6 million higher than the original contract estimate over two years. This contract is due to run over a long time. We can understand that if, after two years, we are $24.6 million in the wrong direction, that would be of particular concern. He also talks about the contract disputes and differences in interpretation, valued at between $6 million and $7 million, and approximately $10 million of financial claims are unresolved, as a result of conflicts between the contractor and the government over whether or not money is owing. This is a big piece of work that needs to be undertaken on an ongoing basis. The Office of the Auditor General also made the observation that if the contractor were to fulfil the full range of activities involved in the contract, it would have to produce a 14 000-page report every month on its key performance indicators. That is obviously impossible to undertake, and it is quite frankly an inefficient way of delivering services. Our preference would obviously be that these services are delivered in-house, as they relate to important clinical aspects of the work that the hospital does. I admit that not all of them are related to clinical aspects. Cleaning the windows and mowing the lawns do not have a clinical aspect, but a lot of the other functions do. From that point of view, I think it is very important that we take a good, hard look at that contract to make sure that, in the first instance, it gives value for money to the WA taxpayer, and in the second instance, it contributes to the care provided to people in the hospital. I might ask the director general, or someone from the South Metropolitan Health Service, if appropriate, to make further comments.

Dr D. Russell-Weisz: The minister has covered nearly everything that was in the Auditor General's report. Going back to the original contract, as I recall, at the time the public sector comparator stated that this contract would save $515 million over 20 years. The Auditor General noted some other things in his report. At the time of the signing of the contract, a number of subcontracts were not resolved. This is going back to 2011, as far as I can recall. Also, since then, looking at my own experience of Fiona Stanley and that of my colleagues behind me, three service lines were taken away from the facility manager. The first was health records management and clinical coding, the second was scheduling and billing, and the third major one was sterilisation. One of the recommendations was for reviewing and revising the original contract estimate to monitor the current contract cost. That does need to be done, to look at what the original public sector comparator was. Obviously, certain services have been taken out. This is a very broad contract. I would totally agree with the minister that this contract is broader than facilities management. This is a support services contract, and has some clinical-facing services. The report noted that the South Metropolitan Health Service had done a very good job at contract management, with what was a very good contract, and we did specifically invest in good contract management for the state. Once that contract had been signed, we wanted good contract management, based at South Metro Health Service. However, there is more work to do, and the South Metro Health Service has committed to do that work, on the recommendations that have come out of the Auditor General's report.

Ms M.J. DAVIES: I am having a stab in the dark about where this would come in the budget, but it is under the small rural hospital services.

Mr R.H. COOK: That is all right, just put it under "Total Cost of Services"—that is what I used to do!

Ms M.J. DAVIES: It is about maternity services at Northam and Katanning. I am sure it will fall under the heading "Small Rural Hospital Services" on page 128 of budget paper No 2. I note that the previous government did

a significant amount of work trying to improve the midwifery service model in both Northam and Katanning. I note that a service is being rolled out at the moment, and I am very supportive of that. I would like some clarification and guarantee that this does not mean that the WA Country Health Service and the government are walking away from trying to recruit doctors and support personnel to provide obstetrics at Northam, Katanning and other regional hospitals, particularly in the wheatbelt. There is nowhere to have a baby in my electorate, between Kalgoorlie and Midland. Northam hospital, as the minister knows, is having a couple of upgrades, and there is significant concern for those women who live between Kalgoorlie and Northam, who would have to go a long way if they are caught short in needing to have a child.

Mr R.H. COOK: This is a really important issue that we have all actively engaged with over the past few years. I remember going to Katanning recently to talk about the issues there. On this issue, one of my predecessors, Hon Kim Hames, famously said, "You can't run a maternity service unless it is on the coast." I do not accept that idea. I understand that there are challenges associated with it. I will ask Mr Moffet to make some comments about the work that WACHS is doing.

Mr J. Moffet: We are certainly not walking away from any commitments, to start on that point. As the member is aware, we are looking at establishing a midwifery-led model of service delivery in Northam, supported by arrangements with Midland hospital. We continue to do that work, and hopefully will start services early in 2018 on that front, in terms of the actual delivery of babies. We will continue to try to recruit general practitioner obstetricians to strengthen that service. We want to offer a range of choices wherever we do obstetric service delivery across the state. Katanning has the same set of circumstances, with GP obstetrician supply being challenging as well as GP anaesthetists to support that service, so it is a little more challenged. We have a community midwifery service combining ante and postnatal care in Katanning. We will continue to look at strengthening that service. That is more challenging over time, because we need to find both GP anaesthetists and GP obstetricians in that community. One of the advantages of Northam's proximity to Midland is that the times for transport, should we have complications during delivery, provide a level of comfort around a midwifery-led service. That level of comfort is not the same with Katanning, because of its distance from Albany, so that is a bit of a challenge for us. We absolutely remain committed to the service. The funding for the Southern Inland Health Initiative stream 1, going forward, maintains capability around those alternate midwifery and birthing pathways.

[4.40 pm]

Ms M.J. DAVIES: What funding has been allocated in the budget to attract those doctor–obstetric services? I am not talking about the stream 1 doctors' incentives. I know that the issue has come about in Northam and Katanning because patients who were being admitted by private practice doctors are now at a stage where they do not want to do that any longer, and that is not likely to change. My concern is that unless a salaried doctor is available with an anaesthetist, this is pie in the sky. We can have an ongoing budget line, but I would like to know how much money is set aside in the budget to attract and maintain a doctor with relevant experience in the Northam Health Service and Katanning Hospital with the staff to go with them.

Mr R.H. COOK: Obviously, the work under Southern Inland Health Initiative workforce issues is an important part of that work to make sure we do maintain that critical mass of GP and GP specialists in the country areas. I will ask Mr Moffet to make further comment.

Mr J. Moffet: We have a specific provision for the midwifery-led services and midwifery nurse practitioners, so we could provide that to the member in relation to the SIHI budget. The budget for medical officers in Northam hospital is part of the aggregate hospital budget so we can certainly provide an estimate of what it would cost to attract a GP that has both ED and obstetric procedural skills. It is embedded within the Northam hospital budget; there is not a separate specific initiative around that. As the member knows, we have a degree of salaried staff on-site there already. The challenge is to find more than one GP obstetrician, whether they are community based or working inside the walls of the hospital, because we need at least three to restart the service in a sustainable way.

Ms M.J. DAVIES: I would like confirmation that there is an allocation within that global budget for Northam and Katanning hospitals and that we are actively pursuing and recruiting doctors with obstetrics and the appropriate nursing or support staff. Has that changed over time? The minister knows what I am trying to get to. Is there an amount; is it an appropriate amount; and will it stay within the forward estimates until we have successfully achieved said outcome?

Mr R.H. COOK: Are there dollars there for a maternity workforce and are we pursuing that workforce?

Ms M.J. DAVIES: Yes, to achieve what the minister said he was very passionate about.

Mr J. Moffet: Obviously, we have an activity-based funding budget for Northam hospital. I cannot tell the member exactly what it is; I do not have it with me. The mix of GPs, whether we have GPs based in the community

versus based in the hospital, is a balancing act and issue. Our preference is to, obviously, have community-based GPs coming in who also have an obstetric interest. That works better for the balance of services and for making sure that we have three GP obstetricians who can share the workload. If we looked at trying to salary the whole service in-house, that is certainly possible. However, that also competes with the general practice services, if you like, because of the available time they have for other services beyond ED. We want to keep a balanced GP workforce. We have looked at options around trying to recruit directly and have a salaried GP–obstetrician. That has not been successful to this point. We will continue to look at blended models. The cost of providing a service is not the key barrier to us in Northam; it is about attracting the skills, despite the fairly attractive packages we have for both GPs in the community and salaried doctors. Katanning is different, however. A larger number of practitioners is required to restart the service because it applies to both anaesthetics and obstetrics, so I think Katanning is a more challenging circumstance. But, again, it is not constrained by dollars; there are dollars in the available budget. It is simply about attracting the right workforce. We had this challenge right around the state. Lower-volume sites are suffering more due to a lack of GP–obstetricians and, I guess, continuing interest from younger doctors to move into that type of practice.

Mr W.R. MARMION: That answered my supplementary question.

Mr S.A. MILLMAN: The next question I have refers to Royal Perth Hospital, which is a terrific state institution and one the people of my community of Mt Lawley greatly appreciate. My question relates to budget paper No 2, page 118, under the significant issues impacting the agency. I refer to the line item "Making Care More Accessible" and the fourth dot point from the bottom of page 119, which states in part —

> Upgrades to the RPH over the coming years, including the creation of a Western Australian Innovation Centre, a Mental Health Observation Area …

Mrs MacLeod, the executive director of East Metropolitan, and the director general mentioned previously, in answer to a question on urgent care clinics, a mental health observation centre at Royal Perth Hospital. Can the minister outline the work being done about the mental health observation area at Royal Perth Hospital—perhaps also with the DG and Mrs MacLeod—and what will be the benefits of the observation area to assist staff to treat patients with mental health issues more appropriately?

Mr R.H. COOK: It is an important question. We did not invent mental health observation areas; the previous government started that program and put them in at Sir Charles Gairdner Hospital ED, and provided the funding—I do not think construction is completed yet—for Joondalup Health Campus. It is an important point around the issues driving patients to our emergency departments. One of the challenges is that although our emergency departments are incredibly sophisticated parts of our hospital, they need to be fairly nimble to adapt to the changing cohort of patients going there for services. Obviously, patients with mental health issues and drug-related psychosis and suffer from overdoses are increasingly becoming part of the everyday business of an emergency department. It is therefore about adapting the way we deliver those services to meet the needs of those patients. The mental health observation areas are obviously an important part of that in making sure we have appropriate areas for patients to be cared for and better treated away from the loud and bright nature of emergency departments. I will ask Mrs MacLeod to make further comment.

Mrs E. MacLeod: As the minister said, the MHOA in particular assists with patient flow through the hospital. It also helps provide care in the most appropriate setting for this group of patients, importantly, for the MHOA and, similarly, with the urgent care centre we are establishing for Royal Perth. The other aspect is the facilitation of patient flow out to the most appropriate setting and making sure we have those linkages in place. We are currently undertaking some work through our clinical teams at Royal Perth Hospital, which involves the mental health staff and emergency department staff to look at some of what we call models of care. They include how the care will be provided and what the patient pathways will look like. That is being developed at the moment. We are making sure that is done with full cognisance of the full mental health service at Royal Perth Hospital. We currently have 20 open beds, the ones that are unauthorised, so we need to take into account the impact of those beds and whether we need to change. It is likely we will need to change those services as well. We are doing a lot of work around the MHOA, but making sure that what we are doing about the MHOA fits with the rest of the flow through the hospital so that we have a comprehensive service that links into the remainder of the mental health services in the community and the other inpatient services at Bentley Hospital.

Mr C.J. BARNETT: I refer to Graylands Hospital, which the previous government and this government, I understand, is heading down the path of closing, which I agree with. Mental health beds in hospitals and community living is all a good thing, but I will ask a question that is based on anecdotal information. Graylands is in my electorate and a lot of people talk to me about it.

Mr R.H. COOK: I thought it would be in the electorate of Nedlands.

Mr C.J. BARNETT: No; it is on the border in my electorate.

The community strongly supports Graylands Hospital. A number of family members of patients have made the point to me over the years—it may be a small proportion—that a number of patients simply will not cope in a community setting or perhaps even a hospital setting and probably will never cope in the community. I question whether there will be a specialist mental health hospital. I am not talking about forensic patients necessarily. Many of them have no family, friends or support in the community. That is the sad reality. I wonder whether the government is grappling with that problem. It may be less than half the current Graylands population or maybe a quarter; I do not know.

[4.50 pm]

Mr R.H. COOK: I think it is a great question, Chair. Some early work has been done by the director general and the Mental Health Commissioner. I will ask the director general to speak about that fairly shortly.

I think the member is absolutely right. This is my second term with the mental health portfolio. Some lasting memories from my time in opposition include family members coming to me to say, "We understand the importance of community health services, but our relative is sick and has been at that hospital for a very long time; they consider it their home." I will answer by way of anecdote, because that way we get to talk about another issue. The Quadriplegic Centre is another example of a facility that is providing outdated services in an even more outdated facility. That is in the member for Nedlands' electorate. We are obviously keen to see those patients accommodated in a much more modern environment. For many of those people, that is their home. We have to be sensitive to the fact that people have lived there for a long time. They have a great attachment to that area and to that facility. We need to be sensitive to ensure we accommodate them in anything new we do. A cohort of patients will be accommodated in the new facilities at the quad centre site, albeit the majority of patients will be accommodated in a community setting. That is much more consistent with modern standards for the care of patients with long-term and high-level physical disabilities in that sense. In answer to the member's question, we are very conscious of that. I ask the director general to provide some further explanation on the work that has been done.

Dr D. Russell-Weisz: I agree with everything that has been said here. We have taken a very measured approach with the Mental Health Commission regarding Graylands. I will ask Wayne, through the minister, to provide some more detailed information. It would not be a blanket closure; that is, that we would close at one date in time and just hope the patients could be placed. Graylands has a number of areas that could be sold off in a staged way and it would not affect the patients on site. A lot of land to the south is not particularly well used, or patients could be housed elsewhere. The planning with the commission has been a four-stage approach. It is very early in its planning. The member mentioned forensics. We see forensics as staying on site in the longish term until there is an established forensic facility at one of the prisons, but I think that is quite a way away. There were always plans to build other mental health inpatient facilities at other sites, such as Osborne Park. This is not just going to the community. There are plans to determine which patients could be better housed in the community and then be treated at other facilities. If patients are to be moved from Graylands, they will need modern, contemporary inpatient facilities at other sites. I can assure the member that a four or five-stage planning process is underway. The easy stage is potentially moving away from some of the land that will not impact on direct patient services and then planning the cohort of patients, much like we did with the quad centre. Patient numbers went down at the quad centre, but we found about 25 to 30 patients needed to stay in that environment for a period. I can assure the member we would not move patients into the community who could not be either housed or treated well in the community. I will pass to Mr Salvage.

Mr W.R. Salvage: I support the comments that have been made by the minister and the director general. A planning process is underway for the eventual decommissioning of the Graylands campus. That is focused on opportunities to parcel particular pieces of land that might be available for disposal in order to free up some funds. Critically important as part of that planning process will be an individual patient-based assessment of their readiness to transition either to the community or to require ongoing care and support in a more supported environment. I certainly agree with the comments that there is a strong parallel between the process that we are following for Graylands and the one we followed for the Quadriplegic Centre in identifying the absolute cohort who will need to be retained in a very strongly supported environment for the remainder of their lives.

Mr R.H. COOK: To follow up: if the member wishes, I am very happy to keep him informed on the progress of that project as it develops.

Mr W.R. MARMION: This will be my last question, and it is non-technical. It relates to a fairly significant reduction in expenditure. I refer to page 114 of budget paper No 2 and the expenditure reductions for non-hospital services, which are quite substantial in the forward estimates. There are a lot of service providers in my electorate including Coeliac Western Australia, Parkinson's Western Australia and Solaris Cancer Care. Could the minister

provide a list of external service providers that will be affected by these rather large cuts? Will I be getting letters from all these organisations in my electorate asking me to lobby the minister not to cut their funds?

Mr R.H. COOK: I can assure the member that we are not taking the axe to a whole range of hospital contracts. The member said it was not a technical question, but it probably is because it relates to some of the realignment associated with outcome-based management and the home and community care program. I will invite a response from the director general, who will no doubt perform a graceful flick pass to Ms Kelly for final analysis!

Dr D. Russell-Weisz: I think it does relate to those two areas. It is purely that we count better now. We have a realignment of services from non-hospital to hospital. The overall quantum is the same except there is a significant reduction in non-hospital services because of the home and community care program. That is $273.4 million from 2018–19 through to 2020–21. That has been realigned to the Disability Services Commission. I cannot think of a current provider that the member mentioned that is being defunded through this program. This is as a result of better and more appropriate counting, and the HACC program. I will pass on to Ms Kelly.

Ms A. Kelly: It is exactly as the minister and the director general have indicated: it is largely the realignment of non-hospital services into hospital services, which are provided to hospital services via the state price.

Mr R.H. COOK: Essentially, we now better understand the cost input of a hospital episode. The funding is coming out of what were previously considered non-hospital services and allocated to that particular activity.

Mr W.R. MARMION: How many non-government providers are being funded by the non–hospital service expenditure? The department is saying it is just a realignment. The HACC reduction is a separate line item; it is just the realignment.

Ms A. Kelly: The hospital services in the past were using non-hospital services, so they actually had an appropriation line to fund hospital services. We now can say, "This is the element of hospital services and this is the element of non-hospital services." The total amount does not change; it is the mix between the two.

The appropriation was recommended.

[5.00 pm]