Division 35: WA Health, $4 088 561 000 —

Mrs D.J. Guise, Chairman.

Mr J.A. McGinty, Minister for Health.

Dr P. Flett, Director General.

Ms S.J. Brooks, Acting Executive Director, Workforce.

Mr D. Cloghan, Chief of Staff, Office of the Minister for Health.

Mr E. Dillon, Acting Executive Director, Drug and Alcohol Office.

Mr J. Dodds, Director, Environmental Health.

Mr P.V. Jarman, Director, Dental Health Services.

Mr R. Keesing, Consultant, Health Reform Implementation Task Force.

Dr R.A. Lawrence, Executive Director, Child and Adolescent Health Service.

Mr J.W. Leaf, Chief Finance Officer

Dr S.J.R. Patchett, Executive Director Mental Health, Mental Health Division.

Dr M. Platell, Acting Area Chief Executive, South Metropolitan Area Health Service.

Mr B. Roach, Acting Director, Budget Strategy.

Dr D.J. Russell-Weisz, Chief Executive, North Metropolitan Area Health Service.

Mr R.W. Salvage, Director, Director General's Division.

Mr B.C. Sebbes, Executive Director, Fiona Stanley Hospital.

Mr K. Snowball, Chief Executive Officer, WA Country Health Service.

Dr S.C.B. Towler, Executive Director, Health Policy and Clinical Reform.

Ms L. Veneros, Acting Director, Information Management and Reporting.

Dr T.S. Weeramanthri, Executive Director, Public Health Division.

Mr K.G. Wyatt, Director, Aboriginal Health.

Mr C.P. Xanthis, Acting Chief Information Officer.

Mr G. Zimmer, Director, Project Delivery, Fiona Stanley Hospital.

The CHAIRMAN: This estimates committee will be reported by Hansard staff. The daily proof *Hansard* will be published at 9.00 am tomorrow.

The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. This is the prime focus of the committee. While there is scope for members to examine many matters, questions need to be clearly related to a page number, item, program, or amount within the volumes. For example, members are free to pursue performance indicators that are included in the budget statements while there remains a clear link between the questions and the estimates. It is the intention of the Chairman 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 minister may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. For the purpose of following up the provision of this information, I ask the minister to clearly indicate to the committee which 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 committee clerk by 6 June 2008, so that members may read it before the report and third reading stages. If the supplementary information cannot be provided within that time, written advice is required of the day by which the information will be made available. Details in relation to supplementary information have been provided to both members and advisers and accordingly I ask the minister to cooperate with those requirements.

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 with the Clerk's office. Only supplementary information that the minister agrees to provide will be sought by 6 June 2008.

I will allow members to pursue lines of questioning, if they so desire, within reason, to give everybody a fair opportunity. I will give the member for Murchison-Eyre the first call, as he needs to catch a plane. We are being very generous today; the member for Murchison-Eyre has the first question.

Mr J.J.M. BOWLER: I refer to the line item on page 556 for the Kalgoorlie Regional Resource Centre. I draw attention to two aspects of that line item. The first is that it still shows $40 million, and the minister has said repeatedly in this chamber that the inflationary factors will be built into it. Surely the department knows what that inflationary cost will be. I am worried that the department is still saying $40 million when the minister is saying that it will be $45 million or $46 million, or whatever it may be. Secondly, this year's allocation is only $2.8 million. The minister would be well aware of the concern at the continued delays to this project in the goldfields. The minister is also the Attorney General. Is there any chance of switching the funding for the new courthouse of $11 million to the hospital, and giving the $2.8 million for the hospital to the courthouse?

Mr J.A. McGINTY: As the member knows, the old Warden's Court on Hannan Street is the most imposing civic building in Kalgoorlie. To have it completely restored as a heritage building, adapted to a modern-day purpose in a way that is compatible with the commercial and retail precinct will make it a major asset for Kalgoorlie in the future. We want to do that properly. I am not in favour of transferring money from the courthouse—which would see something less than a completely optimal development in Hannan Street—to the hospital. Having said that, I think we will achieve a somewhat similar end result because, although $40 million was the amount of money allocated to the upgrade of the Kalgoorlie Regional Hospital, we are planning that it will in fact be $49 million, which takes into account some building cost escalations, plus the 12-month delay that we implemented at the last budget because of the state of the construction industry. We want to make sure that Kalgoorlie does not miss out, and that it has the full range of services and improvements that were originally proposed. We have managed to bring forward some of those works to start this year. Later this year—we expect in September or October—the construction will start with a significant package of forward works that will deal with a number of issues. That will enable the subsequent stages of the redevelopment of the Kalgoorlie Regional Hospital to proceed without delays. Those are the sorts of things that we have in mind, and we are making sure that the additional money will be part of that package when the contracts are finally let.

[4.10 pm]

Mr J.J.M. BOWLER: I am heartened by that, minister, and I will take that message back to my electorate. However, why does that entry not show $49 million rather than $40 million, or are we using this forum today to get another $9 million out of the Treasurer?

Mr J.A. McGINTY: No. It shows $40 million because at the budget cut-off date, which was about a month before the budget was brought down, that was the amount that had been allocated to this project by the expenditure review committee, cabinet and the Department of Treasury and Finance. As I have indicated, later this year, in September or October, we will start the forward works package, which will include construction of a new lift, replacement of an emergency generator and work on drainage issues near the emergency department. Once those works are completed, a lot of the other works will flow as part of the balance of what is currently officially a $40 million program but is expected to be, with building escalation and the scope of works that is to be completed, a $49 million program. It is really just a result of the state of the construction industry at the moment. One of the themes I expect to arise constantly today is the fact that building now costs more, particularly in regional Western Australia, than was originally budgeted for, but we can work on that figure.

Dr K.D. HAMES: This is a theme question rather than a specific item question. I refer to the first dot point under the heading "New Federal Partnership" on page 554, which indicates that health reform has been identified as a key priority. That gives me the chance to ask a question about the state's relationship with the federal government and the impact of the change to the Medicare levy exemption. The minister has said that he expects an additional 60 000 people to drop private health insurance and use the public system. I want to ask a few short questions about the increasing number of people who will access the public health system. It has been said in recent days that this will have an impact particularly on maternity hospitals. As the minister knows, with the increase in demand for maternity services, all the hospitals are overloaded. Does the minister think those services will be the hardest hit by the change to the Medicare levy exemption?

Mr J.A. McGINTY: The member is perfectly correct when he says that both public and private maternity services are fully engaged at the moment. To the best of my knowledge, there is not much spare capacity in maternity services anywhere, and that makes the maternity services plan, which was released in January or February this year, so much more important for considering different models of care for maternity services. If there is a drop in the number of people with private health insurance, we expect there to be increased pressure on the state's public hospitals. One of the groups that are expected to drop out are younger people because they often do not have the same need for private health insurance as do older people. The estimates at the moment vary widely. I saw somewhere today that about 100 000 people—it might have been one million people—are expected to drop out of private health insurance.

Dr K.D. HAMES: Australia-wide, yes.

Mr J.A. McGINTY: Yes, Australia-wide, and that would take it to 100 000 in Western Australia. That is the figure that I was thinking of. The expectation has been revised to about 50 000 people in Western Australia. The figure varies widely. We are not sure what the figure will be. I think we have a very robust public health system, but the pressure will be mainly on elective surgery. That is primarily the reason that people have private health insurance.

Dr K.D. HAMES: Why does the minister not think that maternity hospitals will see a significant increase in numbers, given that that system is already at full capacity?

Mr J.A. McGINTY: There is no doubt that there will be pressure there. However, I do not think the pressure will be as great as it is for elective surgery. We are not sure yet because we are not sure who will disengage from private health insurance and therefore become reliant on the public system rather than the private system.

Dr K.D. HAMES: How much extra funding will the minister be requesting from the federal government to cope with the demand on the public health system? Does he have any idea of that at this stage?

Mr J.A. McGINTY: No, because we do not know how many people will drop out of private health insurance and what will be the additional demand on the system. If predominantly healthy young people drop their private health insurance, there will not be an immediate direct effect of any great proportion. If pensioners, who are great consumers of health care services, drop their private health insurance, we would expect a straight transfer from private hospitals to public hospitals to occur. We will wait and see.

Dr K.D. HAMES: However, it is not likely to be pensioners because they would be on low incomes and therefore would not be able to afford private insurance; it will be people who have higher incomes or who have relatively high superannuation benefits.

Mr J.A. McGINTY: I suspect that the impact will be indirect. If young people, who are not consumers of health care by and large, pull out of private health insurance and sicker people with higher demands retain private health insurance, the relative cost of servicing those people will not be cross-subsidised by the fit young people in the system. We might well find that the cost of private health insurance goes up and therefore even more people drop out. The alternative view is that people are under fairly significant pressure at the moment with increased mortgages and high petrol and grocery prices, and they might be making economic decisions. I am thinking of both pensioners and families with private health insurance, and they may dispense with that to meet their family budget. Those are the areas of concern at the moment. The final result is unknown. There is a mechanism in the Australian Health Care Agreement for compensation to be paid if there is a commonwealth government policy initiative that shifts the burden, such as a shift in private health insurance. When the last Australian Health Care Agreement was signed five years ago, a two per cent shift in private health cover was the trigger for compensation to be paid.

Dr K.D. HAMES: I am glad that the minister has acknowledged that his earlier statement that it was there was incorrect. I have searched through the document and it is not there.

Mr J.A. McGINTY: There is a compensation mechanism in the current Australian Health Care Agreement. It used to be more specific; it is now more general. However, if there were a significant shift in private health insurance, it would in my view trigger the compensation mechanism in the Australian Health Care Agreement. The impact of that is uncertain. We will obviously need to monitor it. However, as the member knows, the public health system is a very resilient beast, and I am sure that it will be able to cope with whatever pressures are thrown at it.

[4.20 pm]

Dr K.D. HAMES: If I may come back to the issue of why I think there will be a lot more pressure on maternity units, the age group in which we would expect most people to drop out of private health insurance is the age group when women expect to be pregnant. Lots of pregnancies are planned but certainly lots are not planned. Of that 50 000 people dropping out it could be expected that 25 000 would be women. How many women get pregnant by accident out of 25 000 I do not know, but if my wife is an example, there are a few around. It was only once.

The CHAIRMAN: Thank you for sharing that, member.

Dr K.D. HAMES: My wife will not be impressed with my telling you that. Nevertheless, we dropped our insurance at one stage when we were much younger at exactly that time. I have asked the question before. The AMA has predicted an increase in Medicare and HBF private insurance costs at 10 per cent a year. Does the minister support that view?

Mr J.A. McGINTY: I do not know is the honest answer to that question. It will depend upon all those factors to which I have just referred. If only the chronically ill remain privately insured, I suspect that is most probably

right. It just depends on the balance of people who make perhaps the economically rational decision once the tax incentive to have private health insurance is removed from a lot of people earning less than $100 000 or families earning less than $150 000. What that behaviour might be remains to be seen. I think the AMA is taking a one end of the spectrum case, and I suspect it is somewhere short of that, but, frankly, we will have to wait and see.

Dr G.G. JACOBS: I have a question on spending on hospitals relating to page 558 and new works. I draw the minister's attention to the Princess Margaret Hospital for Children redevelopment/replacement. Roughly $207 million has been allocated, but none of that money will be spent until 2010. Is that delay in large part due to the indecision on what the government will do with Princess Margaret Hospital for Children and whether it needs to follow previous reports, which perhaps suggest that Princess Margaret Hospital for Children should be relocated and collocated with Sir Charles Gairdner Hospital on a greenfield site? That $207 million is a lot of money but none of it will be spent until 2010.

Mr J.A. McGINTY: We expect that a rebuilt Princess Margaret Hospital for Children will cost many times that amount. We expect to be in a position, certainly before the election but some time in the next month or two, I would hope, to announce the future of the children's hospital. I think that is the only recommendation from the Reid report in 2004 that has not been actioned in the sense of a decision made, and the site, dollars and time frame associated with it. One of the issues that we need to address is the construction industry capacity. With about $7 billion being spent this year and $26 billion being spent over the forward estimates period, the government is obviously undertaking massive public works expenditure on a range of issues, including the Fiona Stanley Hospital, for instance. The second issue is that the construction of hospitals will be incredible for the next five years, with not only Fiona Stanley Hospital, but also the new hospital at Midland, $500 million spent on Sir Charles Gairdner Hospital, and, as I announced in Parliament last week, $150 million in total spent on Port Hedland hospital. We will get underway with the Vasse hospital, and the Denmark hospital is just about finished.

Dr G.G. JACOBS: Will the minister get underway with the Esperance hospital, because it appears to have fallen off the radar?

Mr J.A. McGINTY: That is in the figures, as the member will see. The capacity to build hospitals is important as well as the capacity to be able to build other public works. We need to weigh up the capacity. We need to weigh up, firstly, the site and, secondly, the financial capacity, by which I mean we have a net debt to revenue ratio of 47 per cent, which we imposed in order to maintain our AAA credit rating. As the member heard when the Treasurer announced the budget, we are getting into the ballpark of the 47 per cent ceiling on the amount of capital works that we can undertake, so we need to make sure that we factor in the timing. It is therefore a question of hospital construction capacity, construction industry capacity, and financial responsibility capacity, as well as the needs of the children's hospital. We hope to be able to make an announcement when we have resolved all those complex and interrelated issues in the not too distant future.

Dr G.G. JACOBS: The minister is saying that this $207 million has been earmarked for 2007 to spend on Princess Margaret Hospital for Children when the government decides what it is going to do. Meanwhile, the Reid report has already recommended, as the minister has said, that Princess Margaret Hospital for Children has some needs now, before 2010. I understand that the minister would not want to spend good money in a place that he felt he could not redevelop and on a hospital he was going to resite anyway. However, is his indecision not preventing him from getting on with either redeveloping Princess Margaret Hospital for Children on the current site or moving it?

Mr J.A. McGINTY: The indecision will not be for much longer, if it is an indecision. As I have indicated, we expect to be in a position in the very near future to be able to make announcements. We have money set aside for works to be done to maintain the existing infrastructure while the new Princess Margaret Hospital for Children is being built. Page 557 indicates that money is set aside for various things to be done and, in particular, a total of $10 million is to be spent on Princess Margaret Hospital for Children as holding works. If I may, I will give the member a simple example flowing on from the question that was asked a moment ago by the member for Dawesville on maternity services. This year, for the first time, more than 30 000 babies will be born in Western Australia. Three or four years ago about 25 000 babies were born in Western Australia and it was pretty much on a plateau. There has been a spike for whatever reason, whether it be the baby bonus, boom conditions or whatever. The consequences of that are not so much in the maternity area but in paediatrics, because if more babies are born there are more sick babies and more babies who need paediatric services in the years after their birth. For instance, even though we agreed with the Reid recommendation to relocate King Edward Memorial Hospital to a tertiary hospital site, we announced that we would be spending $10 million on King Edward Memorial Hospital, expanding the neonatal intensive care unit and special handling nursery, simply to be able to meet current demand. That is being spent there now. We have done the same at Royal Perth Hospital. No doubt there will be questions on this as well, notwithstanding our intention to shift the tertiary services to Fiona Stanley

Hospital and to basically demolish the hospital. We are spending money, for instance, on upgrading the Fiona Woods burns unit. That will all shift to Fiona Stanley Hospital when it opens in 2013-14. It is the same with the trauma unit. It will be located at Fiona Stanley Hospital as well. Because, as the member knows, hospitals will continue to see hundreds of thousands of patients a year, we must continue to provide services for patients today, rather than let them run down between now and when they will be rebuilt.

Dr G.G. JACOBS: Excuse the naivety of this question, but where is the $207 million of that coming from?

Dr K.D. HAMES: It will be the extra. The minister has told us it will cost $500 million. The budget has $207 million. Where is the other $300 million coming from?

[4.30 pm]

Mr J.A. McGINTY: It will need to be allocated from the consolidated account at the time when we are heading into construction. The $207 million had its origins in this, if my memory serves me correctly: $30 million was set aside for a contribution towards the Fiona Stanley Telethon Institute for Child Health Research being relocated jointly with the new children's hospital and $207 million was allocated for the hospital itself to be relocated. That amount of money was allocated some years ago prior to the current construction boom that has seen prices escalate out of all proportion. However, because we did not have a specific, agreed final proposal for the children's hospital, that amount has been left sitting there. It is appreciated that it is not adequate to build a new children's hospital. I suspect that something in the order of what the member for Dawesville referred to or even more than that will be required to construct a new children's hospital. They are all matters that we will address when the full announcement is made. That way we will then have committed to every one of the Reid recommendations from 2004. It will come as an additional allocation to the health capital works.

Contained in the already-approved capital projects is $5 billion to be spent over the next six years on health capital works. That is phenomenal. Over the past decade, we have averaged about $100 million a year capital works spending on health. That is reflected in the state of the buildings today. We need to, and have done, significantly increase the capital spend on our hospitals so that the benefits of the boom are translated into better hospitals, among other things. The one remaining link to complete the entire project—I do not think we will need to commit to any new hospitals for quite some period after that—is the children's hospital issue. I hope that is not far away.

Dr K.D. HAMES: It has taken eight years to build them all.

Mr T.K. WALDRON: I will not ask about hospitals in Joondalup. I refer to the third dot point under "Healthy Partnerships" on page 558, which reads —

> A strong focus will remain on improving rural and remote health service delivery through continued implementation of the WA Country Health Service's Foundations for Country Health Services 2007-10 Plan.

I do not know whether the minister can provide the answer now or by supplementary information. What additional funding will be allocated to the WA Country Health Service and what is the dollar increase from last year's allocation? What allocations in the 2008-09 estimated allocation and the 2007-08 actual allocation have been made for the following services in the wheatbelt: mobile dental services, mental health services, specialist health services and preventive health services? I am looking for details of the funding under the WA Country Health Service. I will understand if it must be provided by supplementary information.

Mr J.A. McGINTY: I think questions of that nature are best asked by way of questions on notice. If something comes out of the discussion or material, that information should be available, but it is not something that is ever reported separately—to me at least.

Mr T.K. WALDRON: I am happy to put that on notice, but at times, for members who represent those regions, it is often difficult to work out what funding is going where. If we can get an indication, it will give us a guide for what is happening in those specific, pretty important, areas.

Mr J.A. McGINTY: As the member for Wagin is aware, the big spends in country health are going into the regional resource centres. Last week, the Premier was in Port Hedland and announced the awarding of a tender for construction, to start next month, of the Port Hedland Regional Hospital. All up, including the already-built aged care facility, which is worth about $15 million, it will add to $153 million being spent on a brand-new hospital. It is long overdue. The existing hospital is in demountables, put there after the old hospital was demolished by a cyclone in 1975. The amount of, I think, $53 million will be spent on Broome District Hospital. We have built the new hospital in Geraldton. In response to the member for Murchison-Eyre, I just mentioned $49 million for the Kalgoorlie Regional Hospital. There is $40 million in the budget but we expect a further

$9 million on top of that. We will spend in excess of $50 million on Albany Regional Hospital and there will be significant expenditure on Bunbury Regional Hospital. The big expenditures will occur in those regional resource centres, and that will enable people to be treated in the regions. I appreciate that the member for Wagin is looking at matters in the smaller towns. I would appreciate it if the member could put that detailed question on notice.

Mr T.K. WALDRON: I will put it on notice. We appreciate that those major resource centres should be built, and I support them. That is why I asked about the wheatbelt. The services I asked about in that question are very important to the people in that region.

Mr J.A. McGINTY: Totally.

Mr T.K. WALDRON: While we acknowledge the need for hospitals in Perth, and the major resource centres, we think towns like Narrogin should become minor-major resource centres, if we like. I will continue to push that with the minister. I do not want to take up other members' time.

Mr J.A. McGINTY: We have $600 million to spend on country hospitals. I have given an indication of the major areas of expenditure in the six major regional resource centres. However, that is not the end of it; next month I am heading to the north central wheatbelt, I suppose we would call it, to open a new hospital there; and then I am going down to the electorate of the member for Stirling, the member for Wagin's colleague, to open the new Denmark District Hospital. We are about to start a new hospital in the Leader of the Opposition's electorate.

Mr T.K. WALDRON: Once again, the minister is referring generally to places on the coast. It is the inland area that I am concerned about, but I do not want to harp on it today because there are other things to consider.

Mr J.A. McGINTY: They will all be significant expenditures on country health, but I appreciate that there are other places.

Mr T.K. WALDRON: I will keep reminding the minister of those other places.

Ms S.E. WALKER: On page 555, under the heading "Healthy Hospitals, Health Services and Infrastructure" the first dot point reads —

> The management of demand for WA Health's services remains a critical challenge.

The Shenton Park Cottage Hospice had 28 beds, which were closed down on the basis that the hospice was in the wrong place and that Crawford Lodge in Nedlands was turning away 400 people from the country who went there with assistance from the patient assisted travel scheme. The Shenton Park hospice was closed on the basis that the government was going to build hospices in Rockingham and Joondalup, where it was considered more appropriate to locate hospices. No new hospices have been built. The Shenton Park hospice remained closed until I went there several times this year, including on Christmas Day, only to find it cobwebbed and with no building going on. I am also told that, in the Nedlands area, bed and breakfast places are accommodating people from the country who are coming to the metropolitan area to visit hospitals. Where in the budget papers is reference to the new hospices for Rockingham, Joondalup and the other areas for which they were promised when the Shenton Park hospice was closed? Where did the 28 beds go?

The CHAIRMAN: Let us get the answer to those two questions and I will then come back to the member.

Mr J.A. McGINTY: The decision about the cottage hospice was made because it is a facility owned by the Cancer Council.

Ms S.E. WALKER: It was a publicly owned facility, as the minister knows.

Mr J.A. McGINTY: The land might be public, but the facility is the Cancer Council's facility. It made the decision a couple of years ago. The hospice is now closed.

Ms S.E. WALKER: With the minister's assistance.

Mr J.A. McGINTY: Well —

Ms S.E. WALKER: I am not arguing about how it was done.

The CHAIRMAN: Let us listen to the minister's answer.

Mr J.A. McGINTY: The intention was to mainstream palliative care in the sense that hospice-type facilities would be constructed as we built new healthcare facilities. As an interim measure to replace the cottage hospice beds, beds were opened at Kalamunda, Bethesda and one other place specifically for palliative care. The intention is—I know there is provision in Joondalup, and I am fairly sure at Rockingham, which is under

construction at the moment—that specific beds will be provided at Rockingham for palliative care as part of the redevelopment, which is significantly underway at the moment.

Ms S.E. WALKER: When will that be?

Mr J.A. McGINTY: Construction will finish at various stages over the next couple of years. The Rockingham development is probably the most advanced of all our general hospital developments. There will be four dedicated palliative care beds at Rockingham. I understand that dedicated beds are to be built at Joondalup as part of the current redevelopment in Joondalup. The intention was to move from having standalone palliative care facilities to incorporating them into the hospitals. I have seen those sorts of models in a number of country areas. Busselton and Albany spring immediately to mind as places where the hospice facility is part of the hospital. Those hospice facilities are often managed separately from the hospital. However, they are run brilliantly. The hospice that is on the same site as St John of God Hospital in Murdoch is another example of a facility that is very successful. The Joondalup facility will provide between eight and 10 beds specifically for palliative care. Those hospice facilities are being built as part of the hospitals rebuilding program that we are currently undertaking.

[4.40 pm]

Ms S.E. WALKER: So basically—the minister did not really answer my question—the reality is that that hospice has been closed down, and there will not be a replacement facility for about five years. What has happened in the meantime to cater for the dire need for accommodation for the 400 country cancer patients who are supposed to be using that renovated hospice? Is the minister putting money into what now appears to be a renovation; and, if so, how much?

Mr J.A. McGINTY: Work is taking place there at the moment.

Ms S.E. WALKER: Yes, but what is happening?

Mr J.A. McGINTY: The plan was that that hospice would be renovated to provide accommodation for country cancer patients when they come to Perth for treatment.

Ms S.E. WALKER: That hospice has been closed for a year. The people who are running bed and breakfast facilities in my area are reporting to me that people who are coming to Perth for treatment at hospitals such as Sir Charles Gairdner are having to pay for accommodation at their premises. What is happening with that hospice? When will it be available to accommodate country cancer patients who need to come to Perth for treatment?

Mr J.A. McGINTY: I would answer the question in respect of the former Cottage Hospice if it were one of the health department's projects. However, it is not. What the Cancer Council is doing is its business. I am not regularly briefed on what a private organisation is doing with its construction. There are enough capital works going on in Health to keep me fully occupied. In terms of what the Cancer Council is doing, the member should address her question to the Cancer Council. In terms of what the Department of Health is doing, I have indicated that dedicated hospice-type beds or palliative care beds will be made available at both Rockingham and Joondalup hospitals. In the interim, additional palliative care beds have been opened at other facilities to ensure that the demand can be met. In terms of the member's question about the demand for accommodation for—in particular—country cancer patients, I do not have any information on that issue that I can give to the member today.

Ms S.E. WALKER: The minister had that information at his fingertips when he closed the hospice!

Mr J.A. McGINTY: When the Cancer Council closed that hospice —

Ms S.E. WALKER: The Cancer Council did not close that hospice. The minister closed that hospice.

Mr J.A. McGINTY: When the Cancer Council closed that hospice, I was given information about the current state of play. Frankly, no-one has raised this issue with me in the past year or so.

Ms S.E. WALKER: As the minister is fully aware, that facility on that land is publicly owned —

Mr J.A. McGINTY: The land is publicly owned, but not the facility.

Ms S.E. WALKER: The building was funded through fundraising, and it was leased or given over to the hospice on the basis of a memorial on the title for use as a hospice. The minister is in charge of that. Has the minister changed the memorial on the title with regard to how the Cancer Council can use that facility on behalf of the public of Western Australia?

Mr J.A. McGINTY: I have not; whether others have, I do not know.

Ms S.E. WALKER: Does the minister know?

Mr J.A. McGINTY: Sorry?

Ms S.E. WALKER: Does the minister know?

Mr J.A. McGINTY I have already told the member I have not. I do not know whether others have.

Mr A.D. McRAE: Madam Chair, this is not part of this division.

Ms S.E. WALKER: This has nothing to do with the member for Riverton. The member should mind his own business. This is an important issue for people in Western Australia, yet all the member can do is defend the minister, because he knows the minister should not have closed that hospice.

The CHAIRMAN: Order, members! This is a legitimate question under the dot point that deals with health services, managing demand, at page 555 of the *Budget Statements*. Therefore, I have allowed the question. The member for Dawesville.

Dr K.D. HAMES: I refer to page 556 of the *Budget Statements*. One of the items under the heading "Hospitals, Health Centres and Community Facilities" is funding for the new Albany Regional Resource Centre redevelopment, stage 1. An amount of $44 million has been allocated for that project. I refer also to the *Albany and Great Southern Weekender* of 15 May, which quotes the minister as saying that $50 million has been allocated for that project, but by the time tenders come in, the project will cost $55 million. The minister then went on to make the comment that an amount of $5 million from the federal government appears to be in doubt. I do not know about that $5 million. In light of those comments by the minister, is the amount $44 million, $50 million or $55 million? If the amount is either of the latter two figures, then I have to say that I do not understand the minister's budget process. I say that because, when we were in government, we would go to Treasury and get a budget for a project, and that was it. If we then needed to incur additional expenditure for that project, we certainly would not go out and announce that additional funding until we had obtained cabinet authorisation for that additional expenditure. The minister has already used a different process for the Kalgoorlie hospital redevelopment, because he has said that he is planning to get an extra $9 million from somewhere for that project. What is the exact figure? That is my first question.

Mr J.A. McGINTY: The amount of $44 million appears specifically under the heading "Albany Regional Resource Centre — Redevelopment Stage 1" in the budget papers. That is the figure to which the member has just referred. There will be an additional amount marginally in excess of $5 million. That will bring the amount, in round figures, to $50 million. That amount of $5 million will be taken from the currently unallocated capital works for country health to bring the total amount up to $50 million. That is the agreement that is in place for how that hospital will be funded. Therefore, there are two items that appear in the budget—one specific and one indirect—as general country capital works for Albany. As I mentioned when we were in Albany recently, we said that we did not want to scale back on the works that will be undertaken at Albany hospital. However, in order to maintain those works—this is very much like the answer that I gave to the member for Murchison-Eyre in respect of Kalgoorlie hospital—the expectation from the Department of Housing and Works and the Department of Health is that when tenders come in for the totality of those works, they will be in the order of $55 million. We have currently allocated, in round figures, $50 million from those two sources of funding. We expect that—in order to make sure that all the things that we have said will be done are done—the cost will come in at $55 million.

Dr K.D. HAMES: Therefore, I can assume that if we come into government, I will have $55 million to spend on that hospital, based on the minister's estimate of the figures. What is the difference between the cost of the regional resource centre redevelopment and the cost of building a new hospital in Albany? What is the difference between what the refurbishment of the existing hospital will provide and what the new hospital will provide?

Mr J.A. McGINTY: The cost of building a new hospital the size of Albany—this is at best a broad estimate at this stage—is up to $200 million. That is the figure that I have received. That figure is indicative only. I would not put it any higher than that.

Dr K.D. HAMES: I heard it would be $70 million.

Mr J.A. McGINTY: That was a very early figure that was given, but it is not one that in my view, in the current construction market, is in any sense reliable.

Dr K.D. HAMES: The cost of Busselton hospital is $77 million.

Mr J.A. McGINTY: We expect that figure to be a little higher as well.

Dr K.D. HAMES: For the same-size hospital?

Mr J.A. McGINTY: I am just giving the member the figures that I have been given. When I have been to Albany and have been talking to people about these sorts of things, that is the figure that I have been given. Albany will be a regional resource centre; Busselton will not. Bunbury is the regional resource centre that covers the Busselton area. We would expect a lot more facilities to be provided in a regional resource centre than would be provided, for instance, in a hospital in a country town.

Dr K.D. HAMES: What will be the bed numbers at Albany hospital after the refurbishment, and at Busselton hospital?

Mr J.A. McGINTY: Busselton hospital will have 75 beds. I am not sure about Albany. The number of beds will possibly be in the same order. It will depend on what other facilities are provided. A large number of people in Busselton have had to go to the regional resource centre in Bunbury for their treatment. Only this week, we have opened a dialysis service for people in Busselton. Previously, people in Busselton who needed dialysis had to travel to either Bunbury or Perth. A lot more services are provided at a regional resource centre than are provided at a country hospital.

Dr K.D. HAMES: That figure of $200 million seems to be way out of the ballpark.

Mr J.A. McGINTY: It may well be.

Dr K.D. HAMES: The figure for Fiona Stanley Hospital is $180 million. If the Albany resource centre will have only 70 beds, as the minister has said, there is no way it will cost that sort of money. When we consider the figures that the minister has just outlined for Geraldton and Port Hedland—which I assume will also be regional resource centres—the figure of around $70 million predicted would seem to be reasonably accurate.

[4.50 pm]

Mr J.A. McGINTY: The Port Hedland hospital will be a lot smaller than Albany hospital, but, even excluding the aged care component, the cost would still be about $138 million for a much smaller hospital than Port Hedland. However, construction costs are higher in the Pilbara because it is the Pilbara. I do not know for sure what the construction costs would be for a completely new building at Albany. The highest figure I have been given is $200 million. I have been given figures of somewhat less than that, all of which are significantly in excess of the amount that we are spending on refurbishing the hospital.

Dr K.D. HAMES: Part of the question was not answered: what is the difference between the services that will be provided in the refurbished centre compared with the services that would be provided in a new hospital? I know that the minister had estimates for a new hospital at some stage.

Mr J.A. McGINTY: I do not believe there would be many more services in a new hospital, other than that the services would be new compared with the services that the refurbishment will provide. That is my general answer to the member's proposition. I am unaware that there would be more beds, for instance, or anything new; it is just that everything would be new rather than additional. That is my broad understanding of the issue.

Dr G.G. JACOBS: I refer to page 556. On Mothers Day, 11 May, the minister announced a $10 million pledge for King Edward Memorial Hospital for Women.

Mr J.A. McGINTY: Yes.

Dr G.G. JACOBS: On page 556 of the *Budget Statements* there is $6 million under "KEMH—Holding"; $700 000 for negative pressure isolation rooms; and $350 000 for an emergency generator upgrade. That does not add up to $10 million. Have I got it wrong or has the minister got money somewhere else for King Edward Memorial Hospital that is not in the *Budget Statements*?

Mr J.A. McGINTY: I will get some advice on that.

I thank the member for his forbearance. There is a total of $18 million towards the bottom of page 556 to which the member referred.

Dr K.D. HAMES: Where on page 556?

Mr J.A. McGINTY: About three-quarters of the way down the page. There are a number of entries under "KEMH". The first is "KEMH—Holding", for which the figure is $18.101 million. It has come from that figure.

Dr K.D. HAMES: However, there is only $6 million in the next financial year.

Mr J.A. McGINTY: No, that is the estimated total cost; not necessarily for this financial year.

Dr K.D. HAMES: Next to that $18.101 million there is $6.097 million in 2008-09.

Mr J.A. McGINTY: Yes. The intention is to spend $6 million in the coming financial year out of the total allocation of $7 million. Although I indicated at the press conference that I held that it would start, from memory, in October, that was effectively for construction outside the existing building shell and to put a floor over what is currently a delivery area in order to expand the existing neonatal intensive care unit and special care nursery. There will in fact be some shifts around the hospital, starting in, I think, July, to accommodate the ultimate move. To specifically answer the member's question, that is where it comes from, that $18 million. I have not been in that area for some time, but I must say it did strike me as being overcrowded, with minimal space available between the cots for the babies.

Mr M.P. WHITELY: I refer to the third dot point from the bottom on page 591 under "Major Initiatives For 2008-09", which states —

> Development of new services for clients with Attention and Hyperactivity Related Disorders will commence.

Mr J.A. McGINTY: I anticipated this question from the member.

The CHAIRMAN: I cannot imagine why!

Mr M.P. WHITELY: I thought the minister might; it has been a long time coming. I might point out that the reference to "services for clients with Attention and Hyperactivity Related Disorders" is somewhat of a misnomer, but I will leave that aside for the moment, as I acknowledge the intent of the services that are to be delivered. Is it possible to outline the amount of funding that will be provided in the 2008-09 and out years, and when the new services will open their doors?

The CHAIRMAN: Hang on; hold that thought! Let us deal with one question at a time. I will come back to the member for Bassendean.

Mr J.A. McGINTY: I will defer to Dr Steve Patchett, the head of mental health services, to answer these questions.

Dr S.J.R. Patchett: The funding for these ADHD services began in 2007-08 with $750 000.The funding for 2008-09 will be $1.5 million and for 2009-10 it will be $3.3 million. That is reflective of the phasing in of the ADHD program, beginning in the north metropolitan area with an ADHD service. I take the member's point that perhaps the nomenclature "ADHD" is debatable, but I will use it for the purpose of this discussion. The funding therefore begins next year with a clinic in the north metropolitan area and in the following year, 2008-09, with one in the south metropolitan area. We will then have in the first instance, in the roll-out of these services, two ADHD specialist clinics in the metropolitan area.

Mr M.P. WHITELY: Can I seek a little more information? How many full-time equivalent staff members are anticipated to be employed at these services? I realise that the minister may not be able to give an exact breakdown, but could I have some indicative breakdown of their professional background? Another question is: how will the obvious important integration of these services with general CAMHS—child and adolescent mental health services—and child development centres be achieved?

Dr S.J.R. Patchett: I do not have in front of me the specific breakdown of the number of full-time equivalents and will need to take that question on notice. However, as the member is aware, the intention with these ADHD clinics is to bring together paediatric services and specialist child mental health services into a combined front, as a number of issues on ADHD in the past have been around different models for assessing and treating ADHD. The intention of this program is to make the diagnosis and management of ADHD consistent. The FTE establishment is therefore reflective of a joint approach between mental health and paediatric services. It includes, for example, a child and adolescent psychiatrist working in each of these clinics in conjunction with a paediatrician who has expertise in ADHD. The other allied health staff in each of these clinics will also be reflective of that joint approach.

Mr M.P. WHITELY: Is it possible to get that breakdown by way of supplementary information, to the extent that the detail exists about FTEs, and the way their likely make-up is represented?

Mr J.A. McGINTY: Yes, we will undertake to provide that by way of supplementary information. That information will be the staffing arrangements for ADHD clinics.

[*Supplementary Information No A27.*]

[5.00 pm]

Mr T.K. WALDRON: The fifth dot point under "Major Initiatives For 2008-09" on page 575 states —

> The WACHS will expand the Nurse Practitioner service model in country regions through continued recruitment strategies and extension to other clinical specialities including renal nursing.

How many more nurse practitioners does the minister expect will be appointed; how many of these will be in the wheatbelt and when will that occur?

Mr J.A. McGINTY: I cannot answer that question about what I hope will happen. I am a very great fan of nurse practitioners, particularly in country health. They have an enormous role to play. I am personally supportive of maximising the employment of nurse practitioners in those country health facilities that do not have full-time medical staff. Having said that, I do not think I have a figure of how many we are hoping for or planning for; it is a question of availability. I certainly want to maximise the number. Having said that about country health, which is a very significant area for the employment of nurse practitioners, these people, particularly when they have worked in a particular medical specialty, are often the best possible practitioners to deliver a specialist service. I am talking about beyond being a generalist in a country hospital in a particular area. We need to see far more of these nurses encouraged to undertake this particular qualification to build on the experience that they already have. There are currently 65 nurse practitioners registered with the board.

Mr T.K. WALDRON: How many are operating? Are some operating in the northern part of the state?

Mr J.A. McGINTY: Yes, and I have met the ones operating in those areas. Of interest to the member will be the fact that all rural and remote country health services in WA are designated as nurse practitioner sites. There is the capacity to employ nurse practitioners at those sites. We want to have 24 nurse practitioners working in the WA Country Health Service by the end of this current financial year; that is, 30 June 2008. We might fall a little short of that. I cannot add much more to that answer. We are keen to get them and keen to get them qualified and registered and working in country health, in particular.

Mr T.K. WALDRON: The dot point refers to other clinical specialists, including renal nursing. If specialists with renal nursing skills are employed in country areas, will the minister look at the possibility of dialysis machines in a couple of the major inland hospitals?

Mr J.A. McGINTY: Does the member's electorate including Katanning?

Mr T.K. WALDRON: It certainly does. A number of people in that region travel three times a week to Bunbury or Albany to access dialysis.

Mr J.A. McGINTY: When I was in Albany a week or two ago I spoke about the need to provide some dialysis service to people in the Katanning region. I followed that up by asking the health department to look at whether a facility could be set up at Katanning District Hospital—there are water quality issues there as well—for people to come in and undertake home dialysis. The advice I got so far has not been encouraging of that proposal but it is very much dependent upon demand.

Mr T.K. WALDRON: Perhaps it would be good to look at the Narrogin region because it is a lot easier to travel one hour to Katanning than it is to travel two and a half hours to Bunbury or Albany.

Mr J.A. McGINTY: That is the very reason I raised the issue with the health department and asked it to identify the number of patients requiring dialysis from that general area. As I indicated, the report I got back was not encouraging of the capacity to establish a dialysis facility at the hospital. I certainly asked the health department to look at that. It really comes back to a question of demand. If the demand is there, it would do well to take pressure off the major regional hospitals by establishing that facility locally as well as being of benefit to the patient.

Ms S.E. WALKER: I refer to page 555 and the dot point that states —

> The management of demand for WA Health's services remains a critical challenge.

I am referring to parking at Sir Charles Gairdner Hospital in Nedlands. Is it true that staff were threatening a mass walkout earlier this year because of an increase in parking fees? Are they still having difficulty parking at the hospital? Are the visitors also having difficulty parking? I will ask about disabled parking afterwards.

Mr J.A. McGINTY: I was unaware that there was any threat of a mass walkout.

Ms S.E. WALKER: Apparently it came across during a 6PR interview on 29 April 2008. Does that help the minister's memory?

Mr J.A. McGINTY: It was not something that I took seriously if I was aware of it. No-one ever conveyed to me that there was likely to be a mass walkout of all staff associated with parking. I understand that people raise these issues in somewhat provocative terms from time to time. There is a very real issue with the parking at all the hospitals in the member's electorate. That will be exacerbated by the very major construction program that will be dominating those hospitals for the next few years. The issues at Princess Margaret Hospital for Children have been compounded by the loss of a nearby car park that was used by staff and visitors to the hospital. We intend

to construct some decked parking at Charles Gairdner hospital over the next few years that will increase the number of parking bays but there will be a reduction in the number of parking bays for several years.

Ms S.E. WALKER: When will that be completed?

Mr J.A. McGINTY: It will be completed by 2010.

Ms S.E. WALKER: Will there be problems for another two and a half years?

Mr J.A. McGINTY: There will be ongoing difficulties between now and the 2010-11 financial year. Not everyone will be accommodated. I will answer the question in a fairly general way and then go into it in greater detail if the member requires. For Charles Gairdner hospital, Princess Margaret hospital and King Edward Memorial Hospital for Women, all of which are experiencing very acute parking difficulties, we have entered into an arrangement for people to park free at Graylands Hospital and a free bus service will run regularly to get people to those hospitals in order to meet some of that need. That obviously adds to the travelling time of people getting to work but that was the best thing we could do because of the shortages that will be experienced over the next several years.

The other tension that exists on the question of parking is that there is obviously pressure to encourage people to use public transport or pooled vehicles rather than single occupant private motor vehicle access to these sites.

Ms S.E. WALKER: Pressure by who to use the transport system?

Mr J.A. McGINTY: The Department for Planning and Infrastructure. It is a policy issue.

Ms S.E. WALKER: The minister's government?

Mr J.A. McGINTY: Yes. That pressure is there and for that reason, a proposal was put up to increase the parking charges, which are less than $1 day in some cases. For example, at Fremantle Hospital in my own electorate, the parking fee is less than $1 a day. I will give the exact figures for all-day parking charges at some other hospitals. Sir Charles Gairdner Hospital charges $1.50 a day; Princess Margaret Hospital for Children, $1.44; King Edward Memorial Hospital, $1.44; Royal Perth Hospital, $2.45; and Fremantle Hospital, 96c. There was a proposal to increase the parking charge to the equivalent of the base public transport fare, so that there would be no economic advantage in not using public transport, whereas there is an economic advantage for people using their own cars at the moment. That is not something I am happy to proceed with, because it will represent a very significant loss of income for the employees. We have worked that through and, although it has not been finally resolved, it is not a proposal that will be proceeded with in the short term, particularly while we have these other acute issues associated with construction and the loss of car parking bays.

[5.10 pm]

Ms S.E. WALKER: Has disabled parking at Sir Charles Gairdner Hospital been taken over by a private contract; will this result in an increase in fees; will there be fewer disabled parking bays; and how will this affect pensioners?

Mr J.A. McGINTY: There is no current proposal for parking to be managed other than by the hospital. As part of the consideration of what is to be built—I am talking here about the multistorey car parks proposed for Sir Charles Gairdner Hospital—we will obviously look at all options, including whether it is economically advantageous to establish a public-private partnership. However, no decision has been made about that. That is just part of looking at all the options available. If something were to be done it would not come into effect until the 2010-11 financial year, but no decision has been taken so far. I will give the figures the member asked for on the car parking bays at Sir Charles Gairdner Hospital.

Ms S.E. WALKER: Is the minister referring to parking for the disabled?

Mr J.A. McGINTY: No, this refers to other bays. There are currently 2 035 staff bays and 889 visitor bays, giving a total of 2 924 bays at the Sir Charles Gairdner Hospital site. After stage 1 of the development at Sir Charles Gairdner Hospital, there will be 2 436 staff bays and 1 151 visitor bays; a total of 3 587 bays. There will be an overall increase of 663 bays.

Ms S.E. WALKER: I was asking about disabled bays.

Mr A.D. McRAE: The member for Nedlands has gone from being shadow Attorney General to being a shire councillor for Nedlands.

The CHAIRMAN: The member for Riverton is being unhelpful.

Mr A.D. McRAE: The questions should relate to health issues.

The CHAIRMAN: Members have an opportunity during estimates to obtain information from the minister. The minister is providing information and I call the member for Riverton to order.

Mr J.A. McGINTY: The only thing I will say about the disabled bays is that there are no plans to reduce the current number of disabled bays at the hospital. I certainly would not support that. If anything, we will see an increase in the number of bays available. I expect that we would also see an increase in the number of disabled bays. That is a detail that I have not yet been briefed on or given any consideration to.

Mr J.N. HYDE: My question relates to the final dot point on page 555, about initiatives to better manage demand on public hospital services. I am asking about ophthalmology services. There are currently long waiting periods in public hospitals for ophthalmologists. As the member for Perth, I am particularly concerned about Royal Perth Hospital, but the situation is the same in other hospitals. What initiatives are planned, particularly in the area of electronic referral and tele-ophthalmology systems?

Mr J.A. McGINTY: I am not quite sure; I could ask Dr Lawrence to respond.

Mr J.N. HYDE: I was going to send the minister an email earlier today, but I have not had the chance.

Mr J.A. McGINTY: I ask Dr Robyn Lawrence if she might be able to throw some light on the question asked by the member for Perth.

Dr R.A. Lawrence: I am not sure whether the member is referring to waiting times for outpatient clinics or for surgery. Certainly, in the area of elective surgery, many initiatives are being undertaken both as part of our normal program and as a result of the commonwealth blitz funding.

Mr J.N. HYDE: I am particularly concerned about the beginning of the process—the initial referral.

Dr R.A. Lawrence: An outpatient reform program is underway, reviewing all of those initiatives. The first phase of that has been to go through the list and administratively work up a process similar to what we have done for elective surgery—to ensure that patients are on the right list at the right time. As part of that, down the track, we have developed what we call priority access criteria, to help direct patients to the right place at the right time. Down the track, although we have not actually progressed it beyond costing it up, which we did last year, there is a plan to have a portal for electronic referral. That is not in process as yet; we are still in the early phases of that project to try to shorten the waiting times. That has occurred in many of the disciplines. I cannot give the member any more specific information about ophthalmology.

Mr J.N. HYDE: My understanding is that, through the Office of e-Government and e-health, there is a potential for a 60 to 70 per cent cut in the waiting list. Instead of people waiting six or seven months to see an ophthalmologist, they can see a nurse technician on day one, and we are therefore able to cull 60 per cent of people straightaway, if we get the system up.

Mr J.A. McGINTY: They are perhaps matters for the future, but there is nothing that we can usefully give figures on in the budget estimates today.

Mr R.C. KUCERA: I advised the minister several weeks ago, flagging an issue in the budget in relation to medical research. The only part of the *Budget Statements* I could find that related to medical research was the fourth dot point on page 558, which refers to implementing a strategic plan for health and medical research in Western Australia. My question relates to the funding for the National Research Centre for Asbestos-Related Diseases at Sir Charles Gairdner Hospital, conducted by Professors Bill Musk and Bruce Robinson. Some longitudinal research programs are being conducted there. Can the minister advise what the level of funding will be for the forthcoming year? What is the position with that research institute given that, as I understand it, because of the leading edge research being conducted there, it is now considered to be the national institute for Australia? In short, can the minister advise me what the funding arrangements will be for research programs this year?

Mr J.A. McGINTY: I do not have that information with me.

Mr R.C. KUCERA: I am happy to take it as supplementary information. There is a letter at the minister's office in relation to this.

Mr J.A. McGINTY: I undertake to provide by way of supplementary information the level of support offered to the research into mesothelioma being undertaken by Bruce Robinson and Bill Musk at Sir Charles Gairdner Hospital.

[*Supplementary Information No A28.*]

[5.20 pm]

Dr K.D. HAMES: The amount of funding for Fremantle Hospital is referred to on page 556. There is $15 million in a holding account and $13.2 million for new works. Rather than asking a series of questions and getting into trouble for it, I ask the minister to talk in general terms about Fremantle Hospital and how he has retreated from his plan under the clinical services framework to increase the number of beds at Sir Charles

Gairdner Hospital to 1 000 beds. I understand that it will be left fairly much as it is. The minister has told me that the plan for Fremantle Hospital is to retain its 400 or so beds. How will that be different from the hospital's current capacity? I understand that it will not be a tertiary hospital, but what exactly will be taken away? Will there still be students at that hospital? Given that Royal Perth Hospital will be closed and Fremantle Hospital will be retained as it is, except that the most complex tertiary procedures will not be performed there, I want to know exactly what Fremantle Hospital will be.

Mr J.A. McGINTY: Under the clinical services framework, the plan was that the number of beds at Fremantle Hospital would be reduced from 501, which is its current capacity, to 252 beds and then the number would be further reduced to 217 beds in the longer term. The basis of that plan was that a facility for approximately 200 beds was to be built at the Sir Charles Gairdner Hospital site to service people from south of the river who did not need tertiary care. As a result of some reworking of those figures, those beds have been transferred to Fremantle Hospital.

Dr K.D. HAMES: Can the minister clarify that? He said 200 beds, but the original plan was for 1 000 beds. It currently has 630, which means that an extra 400 beds would have been required.

Mr J.A. McGINTY: This is the answer to the Fremantle Hospital question.

Dr K.D. HAMES: Okay. The minister just said something that seemed incorrect to me.

Mr J.A. McGINTY: Fremantle Hospital currently has 501 beds. It was proposed to have 252 beds, but the proposal now is for 489 beds. Fremantle Hospital will stay substantially as it is, but its configuration will change through the loss of tertiary services to Fiona Stanley Hospital. The proposal is that tertiary services will not be provided at Fremantle Hospital. When Fiona Stanley Hospital opens, essentially the same number of beds will be retained at Fremantle Hospital, but the configuration will change. The role change will be to a specialist rehabilitation and mental health hospital, with secondary medical and surgical same-day and multiday surgical work. Kaleeya Hospital will maintain its surgical-maternity function as part of Fremantle Hospital. The amount that we expect to expend to accommodate the new function will be for upgrading the rehabilitation and mental health areas in particular.

Dr K.D. HAMES: Apart from taking out those top-level tertiary services, which services that are currently provided at Fremantle Hospital will not be provided in the future?

Mr J.A. McGINTY: The services that will be removed are best described as the tertiary services. The issue that remains to be resolved is the nature —

Dr K.D. HAMES: That is not such a straightforward answer, because there are a lot of secondary components that lead to it being classed as a tertiary hospital.

Mr J.A. McGINTY: We intend to retain a medical function, in addition to the rehabilitation and mental health functions that it was originally designed to perform. Perhaps the most critical public issue that is still to be resolved is the nature of the emergency care that will be offered. To the best of my knowledge, that has not been finally resolved.

Dr K.D. HAMES: So it may stay as it is now?

Mr J.A. McGINTY: No; there will be changes. The nature of those changes will be quite different. For instance, when patients with conditions requiring tertiary care are not being admitted, the nature of the patients admitted to that hospital will be quite different. How that will finally wash out remains to be seen, but we have plenty of time to resolve that issue.

Dr K.D. HAMES: Will the paediatric services that are currently provided there, including emergency department paediatrics, still be provided, and will the hospital still be used by students?

Mr J.A. McGINTY: I can certainly answer the last part of that question. With the approximately 250 per cent increase in the number of medical graduates —

Dr K.D. HAMES: It will need to be used for them.

Mr J.A. McGINTY: We will need to expand the training offered at general hospitals, which Fremantle Hospital will become, and not have it focused at the tertiary hospitals. Under the current thinking for the services to be provided at Fremantle Hospital, paediatrics will be provided at Fiona Stanley Hospital, not Fremantle Hospital.

Dr K.D. HAMES: The reality is that Royal Perth Hospital will be closed not just as a tertiary hospital. It will be a substantially different hospital because it is close to Sir Charles Gairdner Hospital, yet Fremantle Hospital will be retained substantially as it is now, although its tertiary services will be closed, in close proximity to Fiona Stanley Hospital.

Mr J.A. McGINTY: No; nothing could be further from the truth. Fremantle Hospital will change radically. All the tertiary services will leave. Paediatrics will leave. A certain amount of surgery that does not require tertiary backup will be done at Fremantle Hospital. That sort of surgery is currently done at Osborne Park and Kaleeya Hospitals, and I expect that to continue. Although the number of beds will be marginally reduced but will substantially be the same, the nature of the services offered at Fremantle Hospital will be radically different. If the member is suggesting that there is a connection between Fremantle Hospital and my electorate, I remind him that the government went to the last election promising to reduce Fremantle Hospital to about half its current size and promising that it would provide the range of services that have now been proposed. The adjustment has come out of a very rational process designed to provide the correct clinical framework under which that work will be done. Frankly, it makes more sense to have secondary beds to service people south of the river at Fremantle Hospital than it does to have them at Sir Charles Gairdner Hospital.

Dr G.G. JACOBS: I refer to service 2, "Specialised Mental Health Services", on page 568. The budget papers refer to specialised mental health care provided in designated mental health wards in acute hospitals. I draw the minister's attention to a situation in my home town. The designated mental health ward, rooms 16 and 17, in the acute hospital setting at the Esperance integrated health service has been closed for more than 10 years now. The unit was used to treat acutely disturbed patients, most of whom would settle within 24 to 48 hours. An amount of $194 million is being spent on the delivery of the service. However, this designated ward is not staffed and that puts a burden on the Royal Flying Doctor Service of Australia, which, as has been well publicised, has extra work. It must engage in the inherently dangerous practice of transferring acutely disturbed patients by the RFDS to Graylands Hospital. I suggest that that designated ward needs to be adequately funded so that it has the staff to provide the appropriate services, which would relieve a lot of the pressure on a system that is having trouble coping.

[5.30 pm]

Mr J.A. McGINTY: If I may answer the question in this way by saying that one of the primary problems that we have at the moment throughout health, particularly in mental health, is the workforce and the ability to be able to recruit and retain a mental health workforce to be able to do the sorts of things that we want to do. For instance, in the northern half of the state there was no mental health inpatient capacity. We recently announced that part of the redevelopment of the Broome regional resource centre would involve the building of a 14-bed inpatient unit. About 30 extra mental health staff will be required to staff the facility, but it was designed to take pressure off the Royal Flying Doctor Service and to improve patient treatment and outcomes in an area where there are not only a very significant Indigenous population, but also other populations who previously had no real service there. We are seeking there for the first time to be able to provide that. It requires 30 staff to manage that unit properly. It will result in a very significant reduction in the number of patients who are required to be transferred to Perth. We can do that at regional resource centres where we are reasonably confident with the upgrading of the mental health facilities. Similarly, in Bunbury recently I opened not only a new community clinic, but also a doubling in size of the mental health inpatient unit at that hospital, designed to give a greater capacity to be able to retain people in the south west. The appropriate area to do those sorts of things is at the regional resource centre because, as the member knows, the burden of mental health is one of the most rapidly growing burdens in the health system.

Dr G.G. JACOBS: One of the concerns with the hub and spoke model is that the spoke of the Esperance integrated health service is 450 kilometres from the hub. For us in the community those distances are of major concern. We still have to get the patient in this supposed spoke to the hub, which is still a significant distance away. If it would help, I would suggest that the staffing of a mental health unit in this sort of setting would not be 24/7, 365 days of the year. Such a unit did operate prior to the past 10 years, when staff were called for a patient as the need arose. It may have been 30 days a year, but it is still 30 patients fewer than would have to be transported in an inherently dangerous practice via the Royal Flying Doctor Service.

Mr J.A. McGINTY: Yes. I will simply take that as an observation rather than a question.

The CHAIRMAN: Yes, it was a statement rather than a question.

Mr T.K. WALDRON: Reference is made on page 601 to new capital works and to the upper great southern district, including Narrogin, development and restructuring at an estimated cost of $9 million. I assume this refers to the last stage of the Narrogin Regional Hospital. It has appeared for most of the time I have been in this place, but will there be a commencement date for that final stage of the Narrogin Regional Hospital and is the minister aware of the issues that are caused by not having that final stage completed at the hospital? It is a fine hospital and a great hospital, but that final stage would make it a truly regional hospital.

Mr J.A. McGINTY: May I defer to Mr Kim Snowball?

Mr K. Snowball: That is indeed on the schedule. I have not got in front of me the date for the finalisation of the project, but we are now at the stage of finalising the business case and also looking at the timing for tenders and so on to be able to firm up that date.

Mr T.K. WALDRON: It has been at that stage for some time now. One of the issues is where the nursing station is in the hospital. The final stage would make that central location for the nurses operate efficiently. With the growth of population in the area, the fact that it has been at that stage for some time, the hub and spoke model we have heard about and the increasing numbers because the smaller hospitals in the area are unable to deliver the services they once did, it is now becoming quite crucial. The reason I keep raising the issue is because instead of it appearing, it needs to come on for a definite date as soon as possible. I would appreciate the minister's thoughts on that.

Mr J.A. McGINTY: We can certainly appreciate the point that the member has been putting and will take it on board. Our process is that we prepare a business case that then goes to the Department of Treasury and Finance. Once that has been approved, we can lock in certain dates. Until that has been done, we cannot do it. However, I think the director of country health has indicated to the member that we have at long last got to the stage where a business case is being prepared, and, hopefully, some good news will flow out of that. I am unable to be more specific at the moment.

Mr T.K. WALDRON: That is encouraging.

Mr J.A. McGINTY: Yes, I think that is right.

Dr K.D. HAMES: I refer to page 558 and to renal health services in the Kimberley. I know Mr Towler knows everything about this question, but I would encourage in advance a shorter rather than a longer answer, because I know what he is like! I have been talking to Henry Councillor and to Dr Carmel Nelson about that program. They saw me when they came to see the minister. The program seems to be excellent. There is not a lot in the budget here specifically for Aboriginal health. As the minister knows, renal disease in Aboriginal communities is an enormous problem. The excellent program was formerly partially federally funded. The minister has extra money in the budget, which I thought was great. I rang up Henry Councillor and Dr Carmel Nelson to make sure they knew. They said that the amount covered the existing program but that they desperately needed to expand the program with satellite services. Is the minister intending to provide those and where is the minister up to in those discussions?

Mr J.A. McGINTY: The member is quite right in saying that what has been approved in the budget did not meet the full expectation of what people would have liked to see for renal services in the Kimberley. I certainly acknowledge the importance of renal services for the Indigenous community in the Kimberley. The $5 million that was approved provides for the establishment of Kimberley Renal Support Service premises and also for new programs, including improved detection and management of chronic kidney disease across the Kimberley, improved education and training for patients and carers on home-based dialysis and services run through the Kimberley Aboriginal Medical Services Council with staff based in Broome and Kununurra. There was a hope that we would be able to meet a far greater proportion of the demand of people who are currently coming to Perth for dialysis and in that way have a double effect of looking after people in their own lands in the Kimberley as well as taking pressure off the Perth hospitals. That is a view I fully support. The other comment I would make is that a new service is being extended to Fitzroy Crossing as part of the new collocated cultural health services, which is run by the Aboriginal organisation Nindilingarri Cultural Health Service, which is collocated with the hospital. It will be offering home dialysis services for people from the Fitzroy Valley who come to the centre for that service. There is capacity being built into that, which was opened only a few months ago. That will see an expansion of the range of people. As the member would appreciate, only a range of people can be relatively independently offered dialysis, and there are certain conditions for which that is not amenable. It remains an unresolved issue, but this will be a useful start in meeting some of the demand in the Kimberley.

Dr K.D. HAMES: I notice so far in the minister's statements that he has announced amounts that are not in the budget and that he expects to go over on five of them so far; that is, Princess Margaret Hospital for Children by $300 million; Albany by $5 million; Kalgoorlie by $5 million; Busselton is undecided yet until tenders come in; and RFDS to be negotiated. I do not disagree with any of those, but I hope that I could add a sixth to them, and that is to provide the satellite services. There is a huge saving to be made in the cost of those people coming to Perth from those remote areas. That is a huge cost, but there is also an emotional cost. The program works, and I strongly urge the minister to encourage Dr Towler to have meaningful negotiations and to find the money. It is not a huge increase when compared with the other five amounts that the minister has already announced today and in the past few days.

[5.40 pm]

Mr J.A. McGINTY: Would the member like Dr Towler to address the committee on this issue?

Dr K.D. HAMES: I would like him to say something, yes.

Dr S.C.B. Towler: I thank the member for the opportunity to speak on some aspects of this subject. As the member is probably aware, we have developed in Western Australia the renal health network, which has looked extensively at the provision of both dialysis services and the management of chronic renal disease within the state. A number of developments have emerged over the past two years. The improved use of contracted services for dialysis has resulted in reductions in the cost per episode of care. The new renal framework is looking for opportunities to change the early management of advancing renal disease. In many other jurisdictions in Australia, it is standard for people to be managed transiently on ambulatory peritoneal dialysis before progressing to formal dialysis services. The chronic renal disease model based around these new home dialysis centres that are linked to other health services also includes plans for renal assessment and management of renal disease in its emergent phase, which delays the onset of the need for dialysis. Also, in the Kimberley a number of conversations are going on about a relationship with the Royal Darwin Hospital and a number of clinical disciplines, and renal medicine is one that is being considered for inclusion in that regime.

The points that the member has made and the minister has supported about the advantages of keeping people in the country are very significant. The development of the home dialysis assisted service model is being enhanced, and I am sure, subject to suitable funds being available in the future, that the demand for renal services will be addressed. I am sure the member is aware that, on the national agenda, substantial conversations are going on currently about improving services to Aboriginal people across Australia. I am sure the Kimberley will feature in some of those discussions, and renal services, I think, will be highlighted. The national epidemiology, which has been acknowledged, shows that there is a substantial demand.

Dr K.D. HAMES: Further to that, how much money was being asked for to expand to that satellite service? Does the minister know?

Mr J.A. McGINTY: My recollection is that it was three or four times the amount that it was finally allocated over a period of four years.

Dr K.D. HAMES: Next year the minister has got —

The CHAIRMAN: The member for Dawesville with a further question, or a statement?

Dr K.D. HAMES: No; I am just looking at what is in the budget this year. There is about $3 million for this year, and I know that there is more in the out years. Is that the amount to which the minister is referring?

Mr J.A. McGINTY: No, because it has not been allocated. It is $12.3 million.

Dr K.D. HAMES: Is that per year or over four years?

Mr J.A. McGINTY: An amount of $5 million was allocated over four years—that is what is in this budget—and my notes say that there will be a further $12.3 million. Again, that would be over the —

Dr K.D. HAMES: Four years.

Mr J.A. McGINTY: Yes. If that amount were spent, it would have these four impacts: region-wide regional dialysis services focusing on renal education, pre-dialysis training, early detection and the management of kidney disease; additional support for the home dialysis of 20 patients; construction of a six-station satellite dialysis unit in Derby for 24 patients; and construction of a four-station supported community dialysis unit in Kununurra, staffed initially for eight patients.

Dr K.D. HAMES: It sounds like a great service. Can I just leave it there but ask the minister to not just rule it out but further consider it?

Mr J.A. McGINTY: Yes.

The CHAIRMAN: Can I discourage members from making statements and encourage them to keep their questions concise.

Dr G.G. JACOBS: There was a message there for me somewhere too, Madam Chair.

The CHAIRMAN: Yes, there was a message for all members.

Dr G.G. JACOBS: I will keep to the point. I refer to the patient transport services that are mentioned on page 576 of the *Budget Statements*. The minister may be interested or not interested to know that I receive more queries in my electorate office about the patient assisted travel scheme than anything else. In fact, the nearest medical facility may not be the most appropriate because the hub—in this case Kalgoorlie—does not provide

appropriate treatment. Under service 7, "Patient Transport Services", the figure is $69.8 million. Can the minister itemise that into amounts for PATS, the Royal Flying Doctor Service and St John Ambulance Australia? From a local perspective—because I know that health services have an apportionment of money for PATS—how much does the Esperance integrated district health facility get each year for funding PATS for the region? I have a request. The preamble to the table refers to those three areas I mentioned. Next time, why could we not have that in three line items so that we would know the answer to what I am asking?

Mr J.A. McGINTY: That is RFDS, St John and PATS?

Dr G.G. JACOBS: Yes, as described in the preamble to that table: St John Ambulance Australia, the Royal Flying Doctor Service (Western Operations) and the patient assisted travel scheme. However, the minister has them all together.

Dr K.D. HAMES: It is $72 million in total. What is the breakdown?

Mr J.A. McGINTY: Yes. We will certainly take on board for next year what the member said about the breakdown. I agree that each has different interests, and they could be particularised. Hopefully, the health department will be able to provide a breakdown in future years. The expenditure for PATS in Esperance is not something that we could reasonably be expected to know here, so if the member could put that question on notice, we will happily answer it.

Dr G.G. JACOBS: What about the bigger picture, though? The minister must be able to break up how much of that $70 million is designated for PATS generally in Western Australia, how much is designated for the western operations of RFDS and how much is designated for St John.

Mr J.A. McGINTY: I can provide the member with the information on PATS. In the 2006-07 financial year, PATS—that is, the patient assisted travel scheme—subsidised 51 200 trips statewide, at a cost of $15.6 million.

Dr G.G. JACOBS: And the others, minister?

Mr J.A. McGINTY: If I can get that other information, I will, but I do not have it at my fingertips at the moment.

The CHAIRMAN: Is the minister agreeing to provide that by way of supplementary information?

Mr J.A. McGINTY: No. I think we indicated that it would be a question on notice.

Dr G.G. JACOBS: In discussions in this place last week, we talked about RFDS. The minister said that the state government contributed $19 million to RFDS for inter-hospital transfers.

Mr J.A. McGINTY: That is right, yes—$19.1 million.

Dr G.G. JACOBS: Is $19.1 million the total commitment in this budget for RFDS?

Mr J.A. McGINTY: I think that is in the current financial year. This budget deals with next financial year. There was an increase, but, as I indicated in this place, that was subject to the negotiations that have been ongoing for most of this year with a view to resolving the appropriate level of funding for RFDS. We have certainly put together now the RFDS figure. It is $19.1 million in the 2007-08 financial year. We know what the figure for PATS is and we know what the figure for RFDS is. Therefore, the balance would be for St John.

Dr K.D. HAMES: That is roughly $37 million or $38 million.

Mr J.A. McGINTY: That sounds about right, because we made a big commitment at the last election to extend, at a cost of $11 million, if my memory serves me correctly, the availability of either free or heavily subsidised transport for pensioners using the ambulance service.

[5.50 pm]

Dr G.G. JACOBS: One of the columns in that table is headed "Reason for Significant Variation". Can the minister please explain what is meant by the words "Decrease in Commonwealth program funding" that appear under that heading? What was the reason for that decrease in commonwealth program funding?

Mr J.A. McGINTY: It has to do with vaccines. An extraordinary payment was made to the state this year for vaccines. Therefore, it appears as though there has been a significant reduction, whereas the real abnormality is the additional moneys that had been allocated to vaccines in the course of 2007-08.

Dr G.G. JACOBS: What have vaccines to do with patient transport?

Mr J.A. McGINTY: Sorry. I thought the member was talking about the variation. It has to do with an abnormality —

Dr G.G. JACOBS: The minister has misunderstood my question. In the table for service 7, "Patient Transport Service" —

Mr J.A. McGINTY: What page are we on?

Dr G.G. JACOBS: We are on page 576.

The CHAIRMAN: That is a timely reminder, members, to make reference to the page number.

Dr G.G. JACOBS: I did that, Madam Chair.

The CHAIRMAN: I understand that, but perhaps that should be done for each question.

Dr G.G. JACOBS: Sorry; I thought I had indicated the page number. What is the reason for the decrease in commonwealth program funding?

Mr J.A. McGINTY: We are not sure what that is. I undertake to provide by way of supplementary information the reason for the decrease in commonwealth program funding for patient transport services at page 576 of the budget papers.

Dr K.D. HAMES: On that same issue, that is not the only page on which there is a reference to a decrease in commonwealth program funding. Rather than ask the minister a question about each of those items, would it be possible for the minister to include as part of his supplementary information the reason for the decrease in commonwealth program funding in each of those areas?

Mr J.A. McGINTY: Yes. We will undertake to provide details of the reasons for the decrease in commonwealth program funding for the range of programs that are listed in the budget papers.

Dr K.D. HAMES: I thank the minister.

[*Supplementary Information No A29.*]

The CHAIRMAN: The member for Wagin.

Mr T.K. WALDRON: I refer to page 565 of the *Budget Statements*. Under the heading "Major Achievements For 2007-08" there are five subsections—elective surgery, service planning and development, specialist services, obstetrics, and workforce. All those subsections, with the exception of workforce, are replicated under the heading "Major Initiatives For 2008-09", which commences at page 567 of the *Budget Statements*. I do not think this means that no major initiatives will be undertaken in 2008-09 to attract and retain a workforce in public hospitals. However, that item does not appear. Can the minister outline what major initiatives will be undertaken over the next year in this important area ?

Mr J.A. McGINTY: I will defer to Dr Peter Flett.

Dr P. Flett: Workforce is the biggest issue that is facing Health in the future. That issue is related primarily to the ageing population leaving the workforce, and the number of people who are entering the workforce; and we cannot join the dots, because they are going in different directions. At the same time as we are facing the issue of a diminishing workforce, we are facing the issue of an increasing workload. What are we doing about that? I have already mentioned the increase in the number of interns—new doctors—who are coming through each year. That will peak in 2010 to about 230. We are also increasing registrar training for new people coming through to increase the number of specialists. That is very important, because we need to replace the ageing specialists as they retire. There has been a substantial ramping-up in all those areas that are listed there. From a nursing perspective, we are now taking on two levels of nurses. The first is nurse assistants. We are actually going back to what was done some 50 years ago. We are recruiting staff from the streets, with no qualifications. Those people come in at a basic level, and they learn the basics of nursing. They are then given the opportunity to move into the higher levels of nursing if and when they interested.

Mr T.K. WALDRON: Are those nurse assistants being trained in the hospitals?

Dr P. Flett: Yes. In fact, we have already taken in the first group at Fremantle Hospital, and those people have commenced training. Those people will be directed to not only the general hospital stream, but also paediatrics and mental health. We have an open book on continuing the recruitment of these types of nurses. That will then free up the enrolled and registered nurses to move to a higher level. The reason we are doing this is that we are experiencing significant problems in recruiting nurses not only within this state and Australia, but overseas. That brings me to the next point. We are this year undertaking to open an office in the United Kingdom for the recruitment of not only nurses but also doctors across the whole of the health service, including allied health. In health, as in any other industry, shortages are looming in the future. Therefore, we are pulling out all the stops with that recruitment program. We are also planning to substantially increase the number of nurse practitioners. We are also considering the employment of physician assistants. It is still very early days, but we are hoping that

this will assist with the problem of the supply of doctors in the future, which is another problem that we will need to face. Another serious problem that we face in the north west is the staffing of doctor and pathology services. I have been talking with Ken Wyatt about this matter. We are running a big campaign to recruit and train Indigenous workers, initially as nursing assistants, but also to give them the opportunity to work in both pathology and nursing.

Mr T.K. WALDRON: That was an excellent answer. It is particularly encouraging to hear that nurses are being trained in the hospitals. Dr Flett referred to the north west. Will that training also be taking place in the larger country centres to encourage local people to stay in the regions?

Dr P. Flett: Absolutely. That is exactly the reason we are doing it. We want to train people where they live so that we do not face the problem of having to recruit people from other areas and get them to go to the regions. Hopefully, these people will then be resident in these areas and make a long-term service commitment. We are taking that approach for the whole of Western Australia, because that is the way of the future—it is the only way.

Dr K.D. HAMES: On that same issue, has the minister given any consideration to giving nurses who are currently undergoing training within the university system the opportunity to work on a part-time basis in hospitals rather than work in restaurants, or wherever they are working?

Dr P. Flett: We are taking every possible flexible approach that we can take to this matter. Gone are the rigid rules of the past. Yes, if that opportunity were available, we would do it.

Mr J.A. McGINTY: If I may add to that, we already have in place an arrangement whereby nurses who are training to become registered nurses can register as enrolled nurses and be employed as enrolled nurses while they are undergoing that training. That initiative was brought in about nine months or one year ago. That links in very much with what the member is saying, because it gives nurses in training the opportunity to gain practical experience in hospitals.

The CHAIRMAN: Given the time, I will leave the Chair and return at the ringing of the bells. However, I do not have any members on the list for when I return other than the member for Dawesville. The member for Wagin has just indicated that he also wishes to ask some questions when we return.

Meeting suspended from 5.59 to 7.00 pm

Dr K.D. HAMES: I refer to page 557 of the *Budget Statements*. Under the "Other Projects" heading is the line item "Commonwealth Elective Surgery Initiative (Elective Surgery Blitz)" with an estimated total cost of $2.8 million, and $2.1 million for 2008-09. The Minister for Health put out a media statement in which he said that Western Australia received $15.4 million for an elective surgery blitz. The commonwealth budget produced by the Howard government has $5 million last year for an elective surgery blitz and $10 million this year for the elective surgery blitz. I am totally confused and I hope the Minister for Health will explain the difference between these different figures.

Mr J.A. McGINTY: The $2.8 million figure the member for Dawesville just referred to is capital and it appears under a capital heading. That is for the purchase of surgical equipment. The $15.4 million —

Dr K.D. HAMES: The *Budget Statements* do not say the $2.8 million is capital; it is listed under works in progress.

Mr J.A. McGINTY: That is capital works in progress.

Dr K.D. HAMES: Where should I look for the $15.4 million?

Mr J.A. McGINTY: I am not sure that $15.4 million is identified separately. It will be identified as income; however, we are focusing that expenditure on Osborne Park Hospital, Kaleeya Hospital, Princess Margaret Hospital for Children and I think —

Dr K.D. HAMES: Surely it will be listed as commonwealth income somewhere? The government's budget papers say that the $15.4 million has been received.

Mr J.A. McGINTY: According to my notes, we have allocated the $15.4 million to the following initiatives: Princess Margaret Hospital for Children, Osborne Park Hospital, Kaleeya Hospital, WA Country Health Service, and also to the private sector. The breakdown apart from the capital component is, as the member has rightly indicated, $5 million in the current financial year and $10 million in the next financial year. Therefore, it is designed to be spent during the 2008 calendar year, which is where the allocations were made. The breakdown of what we intend to expend is: Princess Margaret Hospital for Children, $1.1 million this year, $2 million next year; Osborne Park Hospital, $2.1 million this year, $4 million next year; Kaleeya Hospital's allocation is all in

capital; WA Country Health Service, $800 000 this year, $1.6 million next financial year; and the referral of public patients to the private sector, $400 000 this year and $700 000 next year.

Dr K.D. HAMES: Where can we find those figures?

Mr J.A. McGINTY: That is simply an internal allocation. The member for Dawesville will not find that detailed breakdown in the budget papers but it is referred to on page 603 under "Income" as "Grants and subsidies". The 2006-07 actual amount was $327.748 million. The $15 million is a grant from the commonwealth; therefore, the $5 million for this financial year appears under that heading.

Dr K.D. HAMES: That does not quite match the minister's press release. The press release was dated 14 January 2008, so it was after the new federal government was elected. The press release is entitled "WA receives extra $15.4million from Federal Government for surgery blitz", which seems to match statements made that the federal Labor Party would allocate $15 million out of a total $150 million; therefore, Western Australia got 10 per cent of that. However, the minister said that the $5 million that I referred to was in last year's budget, which was the Howard government's budget and has nothing to do with the Rudd government.

Mr J.A. McGINTY: I do not think so; that is not my understanding at all.

Dr K.D. HAMES: However, that $5 million was in last year's budget, according to the figures.

Mr J.A. McGINTY: We were never told that we would get money and we have not received any from the commonwealth under that heading.

Dr K.D. HAMES: This year's commonwealth budget has a line item for 2007-08, but I guess it could be that the commonwealth government only gave it at the end of the year after it was elected.

Mr J.A. McGINTY: This year's Rudd budget?

Dr K.D. HAMES: This year's Rudd budget has $10 million for the next financial year and $5 million for the current financial year.

Mr J.A. McGINTY: That is the allocation of the $15 million —

Dr K.D. HAMES: Therefore, the commonwealth government might have given $5 million already, I guess.

Mr J.A. McGINTY: I do not think that is the case; in fact, I am certain that is not the case. It was simply a split of the $15.4 million allocated to Western Australia between the two financial years. I think we have allocated $2.6 million of that to capital, and that is basically for surgical equipment. The balance of that money will be used to employ staff, get more operations done or make payments to the private sector.

Dr K.D. HAMES: The other day the minister said that he had a meeting to discuss opportunities for alternatives. What figures has the minister discussed and what alternatives is he looking at?

Mr J.A. McGINTY: The issues that we have focused in on —

Dr K.D. HAMES: Given that we expect an increase in the number of people coming onto waiting lists as a result of the federal government's changes to the Medicare levy exemption, this is obviously critical.

Mr J.A. McGINTY: I certainly think there will be an increase in the number of people who will be relying on the public system rather than private health insurance through the private sector for their elective surgery in the future. I met with people from all the metropolitan hospitals where elective surgery is performed. A key initiative we discussed in that meeting was for surgical teams from tertiary hospitals to go to some of the general hospitals on the periphery of Perth where there is capacity for day-long operating theatre lists. Under that proposal, they would take an entire surgical team with them and utilise spare theatre and bed capacity at those hospitals, which would free up the tertiary hospital sites. Another key initiative is that extra surgery could be undertaken at private hospitals, and adjusting the payment to surgical teams to encourage more operations to be performed. In other words, we would consider the remuneration so that it is more in line with the private sector experience that is output based rather than time based. Other initiatives are to move more elective surgery away from the tertiary hospitals to the general hospitals to avoid competing with emergency surgery; to increase the ambulatory surgery initiative and same-day surgery; and to make sure that we maintain the focus of spending the $15.4 million from the commonwealth on the long-wait cases. They are the major areas.

[7.10 pm]

Dr K.D. HAMES: It sounds like the minister has been reading my notes!

Mr J.A. McGINTY: Every good idea that the member for Dawesville comes up with, I take and try to implement!

Dr K.D. HAMES: I am concerned about what the minister is doing by going to the private sector and how that will work. I would much prefer to keep those distinct. We have already got enough pressure on the private insurance system without people finding that if they wait long enough on the public hospital system, they will be in a private hospital next to someone who has paid to have the same operation. What private hospitals is the minister intending to contract out? I gather their capacity is chock-a-block already as well, but which private hospitals is the minister considering to contract out?

Mr J.A. McGINTY: Wherever there is capacity. Some of the major private hospitals have no capacity, so we are not bothering with those. Peel Health Campus and Joondalup Private Hospital were both privatised by the previous government, and there is capacity to get more surgery done in the hybrid public-private system.

Dr K.D. HAMES: They are still public hospitals. The surgery would be done on those patients as public hospital patients. As the minister knows, Peel Health Campus has the capacity to do a lot more than it is doing now, as I have been telling the minister for three years.

Mr J.A. McGINTY: Where there is the capacity and the price is right, we are happy to enter into those arrangements with those places. One of the benefits of the public-private model that the previous government adopted in the 1990s was that it blurred the lines between the two in such a way that there is now a greater capacity to be able to get public patients operated on in private hospitals than in the purely private model.

Dr K.D. HAMES: The minister would then go to a Mercy Hospital or a St John of God Hospital to contract out for surgery. Does the minister not think that that will reduce the numbers on private insurance?

Mr J.A. McGINTY: We are interested in looking after those people on the waitlist, and getting their surgery done as quickly as we can. Frankly, it does not overly concern me where that surgery is done as long as it is done. My main concern about elective surgery is increasing the throughput. I want to see more surgery done. If the price is right at various private hospitals, I will happily use that. There are certain changes that we need to make, particularly greater utilisation of the suburban hospitals. I will give the example of Armadale, which has great capacity. There is still capacity at Kaleeya Hospital and there is a bit more capacity at Osborne Park Hospital. One of the things we need to do is shift the emphasis onto our rate of same-day surgery. The rate of use of the ambulatory surgery initiative is still too low, and I think we can increase that. That initiative does not then put the demand on the hospital for the beds in the same way that multi-day surgery does. We are doing too low a ratio of same-day cases. There are those sorts of changes that we want to see happening.

Dr K.D. HAMES: I have a final question on that. As the minister knows, there is an enormous difference between the efficiencies of a Royal Perth Hospital or a Charles Gairdner Hospital in terms of waitlist surgery and the numbers they do in a session compared with, say, a Peel Health Campus, which is just about as good as we can get. What will the minister do to improve the efficiency of those tertiary hospitals, remembering that they also have a teaching role that makes it more difficult?

Mr J.A. McGINTY: The teaching role certainly slows down the productivity there. I am keen to see those cases that do not need tertiary support and tertiary care transferred out to the general hospitals where they are far less likely to be interrupted by emergency departments and the need for surgery to be cancelled to make way for a more pressing emergency. That is why we have established the two surgery centres at Osborne Park and Kaleeya Hospitals, neither of which has an emergency department to interrupt the surgery. They are able to plough through the cases, case after case, to maximise efficiency. An initiative that we spoke about last week was the method of payment to more closely align with the private sector experience of having payment related not to the session, but to the number of operations performed during that session. I refer to things of that nature that relate to efficiency and design.

Dr K.D. HAMES: That is our policy for the next election! Thanks for that!

Mr J.A. McGINTY: I think I have stolen them! Has the member got any other good ideas?

The CHAIRMAN: Has the minister finished his answer?

Mr J.A. McGINTY: The member for Dawesville has not answered my question—whether he has got any other good ideas I can plagiarise!

Dr K.D. HAMES: Only a couple!

Mr T.K. WALDRON: I refer the minister to page 568 under the heading "Specialised Mental Health Services". The total appropriation for 2008-09 is $194 504 000. This figure indicates increased funding for mental health service delivery. How much of the increase in funding will apply to hospitals or health services outside the metropolitan area? Can the minister provide a breakdown now, or by supplementary information, for the mental health spending in each region for 2007-08 and an estimate for 2008-09?

Mr J.A. McGINTY: Is that between country and city?

Mr T.K. WALDRON: What percentage of that increase will apply outside the metropolitan area to our country mental health services?

The CHAIRMAN: We will deal with that question first.

Mr J.A. McGINTY: We do not have the breakdown between country and city. Could the member put that on notice?

Mr T.K. WALDRON: Okay. Can the minister provide a breakdown then of the mental health spending in each region for this year, 2007-08, and for 2008-09? I am trying to find where the allocation of the $194.5 million is to apply to mental health services.

Mr J.A. McGINTY: We have sought to address essentially five key areas through the increased mental health funding. The first deals with emergency care to ensure we have extra acute beds available in hospitals, particularly in emergency departments, and also in community response teams. We have doubled the community response capacity for acute episodes of mental health issues. That deals with the emergency issue. The second issue is the beds. There is a significant increase in the number of beds available under this strategy, as we have either renovated or built new beds to be added to the system; some are at Graylands, some are at Bentley that I opened recently, and there are additional beds at Armadale. There are more than 100 all-up. That includes the step down facilities—namely, places like Hawthorn House, the former Hawthorn Hospital, which has been adapted to become a mental health step down facility for the post-acute stage of illness. That is the second component of the strategy.

The third component is accommodation and, frankly, I think this is the most important component. To be able to offer people secure, supported accommodation must do wonders for their mental health. It is important for these people to know that there is no longer a worry about not having regular accommodation to go to. We have invested quite heavily in opening facilities in the country, that is, Geraldton, Busselton and Albany; and Bunbury is about to open. We have also got facilities in a number of suburbs around Perth. I would like to see that expanded quite significantly.

The fourth component is community-based mental health services, which, to my mind, are an equally important area—that is, to move away from the acute setting and be able to keep people well in the community. A question was asked before about people affected by attention deficit hyperactivity disorder, and eating disorders are another. There are many aspects of mental health in the community that we need to do a lot more for, and I think that is the area in which our mental health services are deficient at the moment.

The final area is staff development; that is, recruiting more staff, making provision for safer workplaces and matters of that nature. The member's question related specifically to the country. Under those various headings, Broome, for the first time ever, has a new secure mental health facility covering people in the Pilbara and Kimberley. People can be taken to Broome, if they can be treated there, rather than being flown on the Royal Flying Doctor Service down to Perth. There has been a big boost in staff to go with that facility. We have already opened a fairly significantly expanded in-patient facility in Bunbury, which has roughly doubled the size of the existing facility and which covers the south west. They are probably the two most significant capital works components. Some of the new hospitals being built in the major regional resource regions will have mental health facilities associated with them.

[7.20 pm]

Mr T.K. WALDRON: The member for Roe raised the issue of Esperance. When a mentally ill or badly drug-affected patient is transported from Narrogin to Perth, the patient must be accompanied by two police officers. Does that issue concern the minister? Often in those cases, especially in drug-related cases, the person is okay by the next day. The member for Roe mentioned the unit at Esperance and there is a mental health unit in Narrogin but perhaps it is not secure enough. Will the government address that matter?

Mr J.A. McGINTY: There is an issue of taking up the time of the police. The police want the hospital staff to take a greater responsibility for the transportation of mental health patients, which raises its own legal and practical issues. At least two tragic incidents have occurred recently. The first was when Debbie Freeman was bashed in the mental health unit of the Swan health service a number of years ago and the second and more recent incident occurred at the State Forensic Mental Health Service in North Perth when a nurse was stabbed by a patient who was armed with a screwdriver. They are the sorts of problems that are a nightmare to have to deal with. We want to do everything we can to make the workplace safe to avoid those types of incidents. Therefore, the protocols associated with dealing with people with an acute mental illness need to be very rigorous to protect the staff. I would not like to be seen to be cutting corners in staffing or transportation to achieve more local treatment. In a state the size of Western Australia, a difficult compromise must be made.

Mr T.K. WALDRON: I will get back to my original question. Can the minister provide the breakdown of the $194.5 million spent in each region for this year and next year?

Mr J.A. McGINTY: I will undertake to provide by way of supplementary information the regional breakdown of mental health expenditure.

[*Supplementary Information No A30.*]

Dr K.D. HAMES: I refer to the second dot point on page 559 of the *Budget Statements* regarding Aboriginal health. The Hope inquiry into Indigenous deaths in the Kimberley was held recently. Members are aware of the huge Indigenous health problems in the Kimberley. There seem to be very few new initiatives in the budget for Indigenous health care. On page 578 under "Aboriginal Health" just four dot points are listed as major achievements and there are just three dot points listed as major initiatives on page 581. Given the huge disparity between the standard of health in Indigenous communities and the wider community, I would have preferred to see a book written on what is being done to address the problems of Indigenous health care, not just three or four dot points.

Mr J.A. McGINTY: I had a meeting earlier this week with a number of people whom I regard as being the most senior and respected people in a number of areas of health care. They wanted to talk specifically about seizing the opportunity on Aboriginal health to do a far better job than we are currently doing. They spoke to me about the need to seize the moment and called for stronger leadership in this area. The federal government seems uniquely committed to dealing with these issues and making some hard decisions to close the gap in the life expectancy of Indigenous people. I asked the group what can be done, apart from the obvious, which is to respond by saying that it is not exclusively a health issue but is a whole-of-community issue, and to put that to one side and deal specifically with the health-related issues. They told me which they believed was the most important group to target. Initially I thought it was most probably children because the incidence of prenatal mortality among the Indigenous population is about double that of the wider population.

Dr K.D. HAMES: I would have thought it was pregnant mothers.

Mr J.A. McGINTY: Essentially, it is the youth and young adults up to the age of 20 or 25 because they will be raising children or will be intimately involved in raising children. Not only the mothers, but also the young men in those communities are arguably the most at risk of committing suicide and engaging in other destructive forms of behaviour. We want to do a lot more than we are currently doing and to get a real focus from, and a high degree of cooperation with, the federal government to try to address all the issues that we all understand extremely well that currently beset the health outcomes of Indigenous people. If we can achieve a whole-of-government approach on education, health care, law enforcement and those issues, that is the obvious answer. I am trying to find a mechanism or an initiative to do that. Fiona Stanley, who was one of the people at the meeting, suggested that the Aboriginal healing project she has been advocating in a number of fora is the appropriate and symbolic starting point for a number of these changes. It was a very useful exchange and one that I intend to pursue. The absence of dot points is not an indication of the absence of commitment.

Dr K.D. HAMES: I raised this exact same point last year. There was very little in the budget then and very little commitment. Sadly, not much seems to have changed. The Minister for Health has heard about the funding for a renal service and sobering-up clinics. I am aware that this is not just the responsibility of the Minister for Health, but key health care issues need to be addressed. The minister is aware that the Education and Health Standing Committee recommended that more swimming pools be built in remote communities in the Kimberley for the same reasons Fiona Stanley has enunciated. That addresses just a small component of a range of issues. However, the federal government has provided funding to build two more swimming pools. One is at Bidyadanga and one in Warmun. I could not get the Department of Health involved when I started the program in the first place. It seems that despite the recommendation from a bipartisan committee there is no more enthusiasm for projects like these than there was before, even though they have proven health outcomes, as does Fiona Stanley's program.

Mr J.A. McGINTY: Is the member prepared to give any credit to the Premier, who announced the opening of a pool in Fitzroy Crossing a couple of months ago?

Dr K.D. HAMES: I am happy to do that but I am talking about remote Indigenous communities. The health benefits in Fitzroy Crossing are fairly certain but are not proven in the same way as they are in the remote communities. Pools were built in remote communities specifically for health reasons because I had a theory about the irritation of dust in those communities causing nasal congestion and secondary infections, and hence the prevalence of nose, throat and middle-ear infections. I thought that the immersion in water would resolve that, and it turned out that it did. We coordinated the sealing of internal roads and a reticulation greening

program to address those issues. That was a long time ago. I continue to hear Fiona Stanley say how well that program worked. The bipartisan committee supported that program, but nothing has been done.

[7.30 pm]

The CHAIRMAN: As beneficial as that program is, it is not funded out of the budget papers. The member needs to rephrase his question.

Dr K.D. HAMES: Under the Department of Health's response to Indigenous health, will the government support programs, such as the swimming pool program, and will it look for opportunities to further expand that and other programs, such as those promoted by Fiona Stanley?

Mr J.A. McGINTY: The short answer to the question is yes.

Mrs C.A. MARTIN: I refer to the line item under "Works in Progress Commenced before 30 June 2009" at page 556 dealing with "Kimberley — Various Health Project Developments". Can the minister give an update on the hospitals in my electorate? I understand the situation about the Wyndham District Hospital, but I would like an update on it as well.

Mr J.A. McGINTY: This line item does, in part, relate to major capital expenditure for Indigenous communities. The Kimberley is a very good example of what we are doing. Broome is effectively getting a new hospital, with the rebuilding of the hospital at a cost of $55 million, including a mental health inpatient unit and the rebuilding of a number of facilities for Broome to become the regional resource centre for the Kimberley. Derby has effectively got a new hospital. The new facility there, which I opened last year, is a treat for the people of the Derby region. I opened a new hospital in Fitzroy Crossing in February this year, which was built in conjunction with the commonwealth-supported Kimberley Aboriginal Law and Cultural Centre. Last year I opened a new hospital in Halls Creek. The Premier opened a significantly expanded facility at Kununurra. The bricks and mortar issue facing the Wyndham hospital has not been resolved. Every hospital in the Kimberley has either been rebuilt or significantly refurbished. I am getting a lot of feedback these days from people living in the electorate of Kimberley who say that what has happened with the bricks and mortar side of the healthcare facilities in the Kimberley is amazing. That is not enough. We need to do a lot more. I have mentioned the mental health commitment to the region through Broome and what a critical mass of mental health professionals living in the area will do to mental health, generally, in the community. I expect it to have a number of beneficial spin-off effects. The issue now comes down to the community-based areas of activity, which is what the member for Dawesville referred to.

Strong controversial action has been taken on the issue of alcohol abuse in Fitzroy Crossing and I would like that extended to other Kimberley towns where it is appropriate and has community support.

Dr K.D. HAMES: Such as?

Mr J.A. McGINTY: Halls Creek is probably the best example. The health outcomes have been quite spectacular in Fitzroy Crossing. Hopefully, strong communities will realise that and will push for some equivalent limitation on grog, which is destroying so many of those communities. If a restriction on alcohol can help those communities regain control over their communities, then everyone will be a winner.

The incident of tobacco smoking and, therefore, ill health is incredibly high among Indigenous communities, and that worries me. We have not got that right. A series of measures are being undertaken. There has been a start, as we discussed earlier, on renal dialysis and renal issues, particularly those affecting Indigenous communities. A lot more needs to be done at a community level now that the health infrastructure in the Kimberley, by way of hospitals, has been fixed.

Mr T.K. WALDRON: I refer the minister to the second last dot point under "Major Achievements For 2007-08" at page 574, which comes under "Service 6: Non-Admitted Patient Services". It states —

> Management of the emergency on call system has been improved in the Eastern Wheatbelt with the employment, in partnership with private practices, of two doctors in Merredin and one in Bruce Rock.

How many doctors are on call in hospitals between Perth and Kalgoorlie on weekends and which hospitals are they working from?

Mr J.A. McGINTY: The member might be surprised that I do not know the answer to that question.

Mr T.K. WALDRON: I thought one of the minister's advisers might know. The question has been raised with me.

Mr J.A. McGINTY: Nobody knows.

Mr T.K. WALDRON: That was a good question. What funding has been allocated in future estimates to increase the number of state-funded general practitioners from the current three part-time employees?

Mr J.A. McGINTY: Where are the three part-time employees at the moment?

Mr T.K. WALDRON: I do not know. I know that they are in that area.

Mr J.A. McGINTY: Is it somewhere between Perth and Kalgoorlie?

Mr T.K. WALDRON: I gather that the currently funded three part-time employees are in the wheatbelt.

Mr J.A. McGINTY: The member is quite right. A memorandum of understanding has been entered into with the Shire of Merredin and there are three half-time medical practitioners. The Shire of Merredin has indicated that it no longer wishes to undertake the management of the Merredin general practice, and the private GP services in the town have been reduced by half a doctor. Now, only two part-time doctors are providing GP services in the region. The shire has indicated that it is reluctant to replace the doctor. The Shire of Merredin has received a proposal from a general practitioner interested in taking over the general practice in the town. The GP has expressed an interest in providing emergency services to the hospital. In the proposal, the practitioner has indicated his or her preferred model of service delivery to provide a full visiting medical practitioner service to the hospital. A request has been made for a range of incentives to be paid. The cost of what has been proposed falls outside what we would normally consider. That is part of the difficulty at the moment, and it raises a number of probity and accountability issues for the WA Council Health Service as a government agency.

Mr T.K. WALDRON: Are those costs because of the incentives that are required to get the doctor there?

Mr J.A. McGINTY: I think that is what is being referred to.

Mr T.K. WALDRON: This is the same issue that faces local governments that employ doctors.

Mr J.A. McGINTY: That is right.

Mr T.K. WALDRON: Will the department have to make a decision on that?

Mr J.A. McGINTY: We have offered assistance and resources to the shire to provide the minimum requirements of a contracting practice to provide emergency on-call services to the hospital. There is a real difficulty in us seeking to provide private GP services. We can generally be of some considerable support and assistance to the nature of the relationship under the existing arrangements for GP services through the hospital. That is part of the attraction package. That is our part of it.

Mr T.K. WALDRON: Is the government concerned that, in trying to provide doctors for their regions, local governments are getting caught up with a bidding war that can hurt them in the long run?

[7.40 pm]

Mr J.A. McGINTY: We know that a significant number of overseas-trained doctors are recruited to country Western Australia to meet that need. However, one of the bright lights on the horizon from 2009 on is that the number of medical graduates coming out of our medical school will increase from just over 100 a couple of years ago to just over 300. I hope that in the medium term, a number of those graduate doctors will not only decide to become general practitioners, but also find living and working in the bush attractive. We hope that the significant increase in the supply of doctors, and the inclusion of a greater emphasis on general practice and country practice in their training, will produce a long-term benefit in a number of country communities.

Mr T.K. WALDRON: Does the minister think that the scheme to attract more doctors into country hospitals by sending them out there for their training is a good way to attract them into rural practice? It seems a good scheme to me. Will we see more doctors going bush to finish their training in our country hospitals, such as those in Albany and Narrogin, which I tend to deal with, or will they have to come back to Perth to finish before going out to work in the bush?

Mr J.A. McGINTY: Dr Towler is the best person to comment on this matter. He might be able to give us the benefit of his experience when it comes to country doctors.

Dr S.C.B. Towler: Thank you very much for the opportunity to speak about this issue. As the minister has pointed out, we expect to see graduate numbers increase from 135 a year to something in the order of 320 a year, with that graduating number first appearing in 2010. I make particular note of the work that Mr Snowball, the head of the WA Country Health Service, has done to plan long term for practitioner needs in the country sector. We have worked with the WA Country Health Service for the last two years and looked at a number of key initiatives to enhance the opportunities for junior doctors to experience country health as part of their training. Also, the member may have heard of ACRRM, the Australian College of Remote and Rural Medicine, which is now accredited as a training college for doctors. The ACRRM training program will allow us to develop

procedural GPs almost directly out of medical school, once appropriate training places in the rural sector become available.

The development of the rural resource centres now allows us to not only attract specialist practitioners into rural hubs, but also create teaching environments, thereby enhancing rural training opportunities. Currently, some 17 interns already travel to Bunbury, and we have plans to increase that number to 20 next year and to 40 within two years.

I have been involved in the development of the community residency program, which is an opportunity for junior doctors in their second and third year of training to spend half the week in a hospital, and partnering with that an experience in a community health service role, be that a from street doctor in Fremantle to a surgical practice in Albany to public health roles in Kalgoorlie. This year we have 23 placements in that program. The early feedback from those doctors has been outstanding, with many of them expressing not only a genuine interest in general practice, but also a key interest in the rural sector.

I am a little envious of Queensland's recent success in obtaining $100 million from the commonwealth government to facilitate developments in student teaching. However, the combination of initiatives and opportunities we have been able to provide because of commonwealth investment in the rural resource schools will enhance the educational environment and experience for junior doctors in Western Australia.

I think an enormous amount is being done, but it will take time. The WA Country Health Service led by Mr Snowball is now well focused and aware of what is required to develop the appropriate procedural skills. We now see genuine interest from students, because of their rural clinical school experience, wanting to spend time training in the rural sector, and we see a greater preparedness to go back to the rural sector in their junior doctor years. Currently, junior doctors rotate to the country from the teaching hospitals. We are looking to enhance that model. The future is good for country health services. We are also looking at team care models of health care in which doctors work in partnership with other healthcare providers including, as members have already heard, nurse practitioners and—potentially—physician assistants and other health practitioners. They have an important role to play in the future provision of coordinated health care.

Mr T.K. WALDRON: Thank you.

Dr K.D. HAMES: I have a very simple question about service 11, "Home and Community Care Services", or HACC, funding on page 560 of the *Budget Statements*. I note the pleasant 8.2 per cent increase in funding to this service. It might be difficult for the minister to answer this question. The only reason I ask it is because I have written to the minister three times about the Mandurah HACC service and a problem with its funding; that is, a past overspend of funds meant that, despite an increase in the demand for that HACC service, no increase could be made to HACC funding until it had managed to pay off that debt. Is anyone opposite aware of what has happened with that funding for the Mandurah HACC service; and, if not, will the minister provide that as supplementary information? First, I would like to know whether there is an answer to my question tonight. It would appear, from the silence, that no-one knows the answer. Perhaps I will ask for that as supplementary information. However, minister, just be aware that such silence has been the answer to my question before. The Mandurah region faces a huge growth in demand by elderly people for home and community care. Does the minister agree that a model in which past overruns need to be paid back before there is an increase in funding is, in a general sense, a reasonable model?

Mr J.A. McGINTY: My recollection is that this matter was last raised quite a long time ago.

Dr K.D. HAMES: I wrote to the minister about a year ago, and I think I raised it at last year's estimates committee hearings as well.

Mr J.A. McGINTY: My recollection is that the matter has not been raised this year. I am aware of the previous overspend by the HACC service based in Mandurah. However, I cannot provide any more information on this matter than I could when we last corresponded. The real issue is whether the allocation to Mandurah is adequate.

Dr K.D. HAMES: I guess I mean for the minister to put the issue behind us and increase the HACC funding as it is desperately needed.

Mr J.A. McGINTY: I undertake to have internal discussions with the Department of Health about the HACC allocation and whether the current allocation for the Mandurah region is appropriate given the level of services it needs to provide today. That is probably the most constructive thing that can come out of this discussion.

Dr K.D. HAMES: That will do.

Dr K.D. HAMES: I refer to service 5, "Emergency Department Services", on page 571 of the *Budget Statements*. Quite a few items are listed, and I want to use them to explore a little more what is happening in hospitals to try better manage the reduction in eight-hour emergency department waits for patients. I understand

that Western Australia is one of the worst states in Australia for eight-hour waits in EDs. Can the minister tell me the current occupancy rates in emergency departments, remembering that they were 95 to 100 plus per cent and that Neale Fong stated on radio that they should be at 90 per cent. What is the level of those occupancy rates now? Can we just start with that component?

Mr J.A. McGINTY: Hospital occupancy rates are still too high. They are of the order that the member for Dawesville has just spoken about.

Dr K.D. HAMES: Do we know what the occupancy rates are for the three major tertiary hospitals? Someone will know the answer to that question. Russell will know the figures for Sir Charles Gairdner Hospital.

Mr J.A. McGINTY: I will get that information for the member now.

We hope the changes that will be made in the health system—changes that include not only the construction of the new hospitals, but also the adoption of new models of care and the clinical service reforms in our hospitals—will significantly reduce the occupancy rates. ED staff tell us that reducing occupancy rates will be the most significant contributor to relieving the access block—in other words, the longer than eight-hour wait. Earlier this year, seeing that this was a seemingly intractable problem, I set up an emergency department task force comprising some of the most senior people in health. Chaired by the Director General of Health, that group includes the heads of the EDs at Royal Perth Hospital and Sir Charles Gairdner Hospital, and the area chief executives, as well as a couple of other people. I have asked that group to give me advice on what is needed to address that problem, because the singular signal indicator of the health of our emergency departments is the access block issue.

[7.50 pm]

I met with the group at seven o'clock on Tuesday morning this week. They meet weekly to go through all the issues that are involved. Among the issues that we tried to grapple with this week was the care awaiting placement issue. Some people who are occupying hospital beds should be in aged-care facilities. We also looked at the shortage of nurses and, therefore, the inability to open more beds, which is not a funding issue; rather, it is an issue of the availability of nurses. We considered the question of discharge protocols to ensure that when people can be discharged from hospital, they are done so at the earliest available opportunity to free up the bed; and the greater use of general hospitals, such as Armadale-Kelmscott Memorial Hospital, Swan District Hospital and Rockingham-Kwinana District Hospital, and their capacity to take and retain more patients when they have been upgraded. Another issue that we discussed was surge capacity and the ability to place patients who have been stabilised into a particular area of the hospital at times of peak demand. We have been grappling with all those issues. I am being advised by an expert group. The occupancy rate in the North Metropolitan Area Health Service, which is Sir Charles Gairdner Hospital primarily, is 96 per cent. The occupancy rate in the South Metropolitan Area Health Service, which refers to Royal Perth Hospital and Fremantle Hospital, is 90 per cent.

Dr K.D. HAMES: A 90 per cent occupancy rate at Royal Perth Hospital is surprising.

Mr J.A. McGINTY: That is the advice that I have just been given. That is the area health service-wide figure.

Dr K.D. HAMES: That is not the Royal Perth Hospital figure.

Mr J.A. McGINTY: I am told that it is slightly higher at Royal Perth.

Dr K.D. HAMES: In the past we were given figures of 95 per cent and 100 plus per cent for Royal Perth Hospital. That is the reason for the access block. There has been no bed capacity in the hospitals. If there is only a 90 per cent occupancy at Royal Perth, why is there so much difficulty getting patients out of emergency departments?

Mr J.A. McGINTY: The biggest problem is the inability to open beds. To do that, we need nurses.

Dr K.D. HAMES: The spare bed capacity is 10 per cent, and that is normally enough. Most hospitals around the world that have a 90 per cent occupancy rate do not experience the eight-hour waits in ED that are experienced at Royal Perth Hospital. The minister would know that, having been to New York.

Mr J.A. McGINTY: A number of significant issues are associated with this. The advice that I have received from the head of the Royal Perth Hospital emergency department is that it is going through the process of analysing every element of what is done in the emergency department to arrive at best practice, which is likely to result in significant cultural and practical changes within the emergency department. Only part of the problem is in the emergency departments; the balance of the problem is in the hospitals and the inability to get people out.

Dr K.D. HAMES: I do not want to ask Dr Towler too many questions, but he works at Royal Perth Hospital. Is it reasonable to ask him that question, or is that unfair?

Mr J.A. McGINTY: Nothing is unfair! Of course, Dr Towler is an intensivist, not an emergency —

Dr K.D. HAMES: Yes, but he is at the coalface.

Mr J.A. McGINTY: I defer to Dr Towler.

Dr S.C.B. Towler: Part of the issue with any assessment of per cent occupancy is that 100 per cent is an impossibility, because there is always a transition issue. The pattern of demand against ED and bed occupancy, oscillates during the week from a higher level, which peaks on Sunday, Monday and Tuesday, and drops off again towards the end of the week. When we look at average figures, we get into this issue. The flow of patients within the hospital environment is difficult to assess. The greatest demand peaks in the hospital for ED occur late in the morning and early in the evening, which are times of high utilisation. There are issues in the process of the assessment of patients, which means work towards making a clear diagnosis and then look for an opportunity for admission. The streaming of some patients into different patient environments is more difficult. The pressure on most of the hospitals relates to the care of the elderly, particularly in the medical disciplines where discharge can be harder. In an environment such as Perth, where we still tend to send a high proportion of patients, particularly ambulance patients, who have a 70 per cent admission rate, to tertiary hospitals, most of the pressure occurs in the tertiary environment. The access block figures for secondary hospitals in Western Australia have been starting to rise, but they do not approach anything near the figures for the tertiary hospitals. Moves have been made within the area health service to look at better patient distribution. This is going to be a problem. The minister pointed out that the difficulty is keeping all the beds open. We are also trying to address emergency surgery priorities and the issue of meeting elective surgery targets for tertiary-dependent caseloads. A number of issues emerged following a report that was done in New South Wales. I am sure that the member is aware that the growth in presentation rates to ED is much higher than the growth in population. Western Australia is still beset with the lack of appropriate primary care workforce and its distribution. It continues to keep pressure on this environment. The minister's point that very good people have been brought together to form an emergency task force is pertinent. We are looking at solutions that have been considered. Recently we were visited by an acute care specialist from the United Kingdom. The focus at the moment is on trying to improve the performance within the hospital. The minister pointed to the issues of the numbers of elderly people in hospitals and what are called CAP patients. Surprisingly, despite the number of CAP patients, we have a relatively low rate in comparison with other states, and that is because of specific investment in additional capacity to discharge older patients.

Dr K.D. HAMES: Royal Perth Hospital particularly has a low rate compared with Sir Charles Gairdner Hospital.

Dr S.C.B. Towler: Despite the initiative that was put in place last year, which resulted in a substantial reduction toward the end of the calendar year, that capacity has been absorbed and additional capacity is being sought. The federal government is now investing money in transition beds, which is one of the key issues for tertiary hospitals. Older people take longer to convalesce. We want to get them into an environment in which they can recover from treatment and return home rather than giving them long-term residential care. The estimate that Western Australia is some 2 000 beds short on a per capita basis compared with other jurisdictions for long-term aged care placement is still one of the key drivers behind the difficulties of getting patients out of tertiary settings in a timely fashion. The state government has invested directly to create community-based capacity, particularly in high care. Members will have noticed from the home and community care program numbers that although there has been a substantial increase in funding, the number of patients being supported did not rise as much as we wanted them to. That is an indication of the extent of the home support that has been put in place for home packages. The program that was put in place last year has addressed the range of discharge priorities, particularly for people who suffer from confusion and dementia, which often a cause for difficulty in discharge, and involved placing special needs patients into CAP environments and an enhancement of transitional care. Those features were identified in the Reid report as key issues for the state. There has been a strong focus on it. The work in New South Wales has highlighted a number of initiatives that need to be considered. A number of initiatives have been undertaken across health to look at clinical process redesign, and EDs are one of the key areas in which that methodology is being applied.

Mrs C.A. MARTIN: The second dot point on page 577 of the *Budget Statements* refers to the Royal Flying Doctor Service and the development of a five-year plan. Can the minister provide more information about that?

[Ms K. Hodson-Thomas took the chair.]

[8.00 pm]

Mr J.A. McGINTY: There is no doubt that the Royal Flying Doctor Service is working under pressure. The increases in demand for its services require an additional commitment. In this financial year we have contributed

$19.1 million; the commonwealth government has contributed about $12.5 million; and there is a split in the areas of responsibility. The commonwealth has responsibility for emergency evacuations; the state government has responsibility for and pays for inter-hospital transfers. Perhaps there is more detail in all of that, but that is broadly the division of responsibilities.

We recognise that there needs to be an increase in funding for the Royal Flying Doctor Service. Those negotiations have been ongoing since earlier this year when a business case was prepared. The latest information I have got, which might need to be updated, is that the commonwealth has indicated that it is prepared to contribute its share to the replacement of two aircraft. A broad agreement is in place that the commonwealth will pay 40 per cent of the cost of replacement, the state 40 per cent, and the balance raised by the RFDS. That gives a bit of an indication of what the commonwealth government, at least, is saying about the needs for replacement of aircraft within the RFDS.

I met with the RFDS either last week or the week before, to continue the discussions that have been taking place between the WA Country Health Service and the RFDS about a new five-year agreement and what needed to be picked up as part of that agreement; we have not yet reached the stage whereby we can conclude those negotiations.

Mrs C.A. MARTIN: We are not actually talking about a fee-for-service agreement or contract; the RFDS is talking about getting the state government to replace all its planes but there is no fee-for-service charter; is that what this is about?

Mr J.A. McGINTY: The proposal to date has been for additional new aircraft and additional replacement aircraft. To the extent that it involves new aircraft, it involves the recurrent costs that go with that and the employment of additional doctors, nurses and pilots in order to operate those additional aircraft. That is what has been discussed to date. However, part of the discussions that we had with the RFDS when we met a week or two ago was the need for the Department of Health to change its internal processes. At the moment a hospital simply rings up the RFDS because to it, it is a free service. Of course, it is not because there is a very significant investment by the state government in it. However, there is no cost to the hospital, which means that I think there is perhaps a lack of discipline in the way in which the RFDS is used for inter-hospital transfers. The RFDS and I discussed the idea of implementing, over the course of the next 12 months, a different internal Department of Health funding model to the hospitals when it comes to funding inter-hospital transfers. That will put a bit more discipline onto the hospitals. That is a question of how we fund it internally within the Department of Health rather how the Royal Flying Doctor Service will be funded.

Mrs C.A. MARTIN: It is my understanding and experience that when the RFDS is called to a Kimberley hospital to bring people to Perth, usually one of the doctors from our health service travels down; is that correct?

Mr J.A. McGINTY: No.

Mrs C.A. MARTIN: That does not happen?

Mr J.A. McGINTY: No. The RFDS employs its own doctors and nurses to provide that service.

Mrs C.A. MARTIN: Paediatricians are not brought down to Perth or anything?

Mr J.A. McGINTY: It may depend to a degree on the circumstances, but, generally speaking, that is part of the service that we fund the RFDS to provide.

Mr T.K. WALDRON: On page 577 of the *Budget Statements,* under the heading of "Major Initiatives For 2008-09", the fourth dot point states —

> The St John Ambulance Association will establish another two day-ambulances and four career paramedics in the greater metropolitan area.

Are there any forward estimates that include an increase in career paramedics to be located outside the metropolitan area? I know that some were located outside the metropolitan area last year; will there be any more? If so, where is the minister looking at placing further paramedics in country Western Australia?

Mr J.A. McGINTY: To the extent that these matters have been discussed, I can give two examples of locations that have been discussed where a paramedic should be based whose responsibility it would be—rather than relying purely on a volunteer service—to coordinate volunteers and link in, in areas where there are a declining number of volunteers. The two areas that have been discussed in recent times have been Newman and Kununurra. There might be others that have been discussed, but not that I have been party to. In Newman, the increased incidence of fly in, fly out workers and people working very long shifts has reduced the number of available volunteers in that community, notwithstanding that the community is expanding enormously. That is an

area with a changed demographic that needs to be responded to. They are the two areas I am aware of about which there have been discussions about the possibility of that expansion taking place.

From memory, the St John Ambulance contract was entered into three or four years ago. When St John Ambulance received the big boost in funding, announcements were made then about where services would be expanded over time. There has been no change to the general plan that was developed and announced at that time about the expansion of services either in the country or the city.

Mr T.K. WALDRON: Will the minister confirm that paramedics were located to Busselton and Karratha last year; did that happen? I think it did. Karratha was one area of concern last year, and I seem to remember that they were going to be located there; did that happen?

Mr J.A. McGINTY: St John's is a private organisation; we simply fund it. The day-to-day allocation of staff and things of that nature are matters that we leave to it to include within the broad ambit of the agreement. I cannot answer the member's question specifically because it is not an organisation that reports to me on a daily basis about issues such as the deployment of staff. The negotiations for the new agreement with St John's will commence at the end of 2008. From memory, it is an agreement that comes into effect on 1 July, but I am not 100 per cent certain that my memory is accurate on that.

Dr K.D. HAMES: Before I ask my question, I have an attachment to the member for Wagin's question about the union proposal that St John's is to be changed to become a publicly funded service. Is the minister considering that?

Mr J.A. McGINTY: An enterprise bargaining agreement is being negotiated between the union and St John's at the moment. I would need to be convinced that financial and service improvements would flow from any change.

Dr K.D. HAMES: The minister is not convinced at present?

Mr J.A. McGINTY: No.

Dr K.D. HAMES: Good.

My question relates to page 555 of the *Budget Statements*. The third dot point from the bottom refers to elective surgery targets. I remind the minister that the government made that same commitment last year; in fact it was 100 per cent of category 1, and it has gone down to 90 per cent, for which I understand and agree with the reasons. My question relates to the category 2 patients. As the minister knows, there are something like 2 000-and-something of them who have to wait beyond 90 days for surgery. Has the minister done an assessment of the costs of that 2 000 and whatever—perhaps the minister might be able to tell me what the exact number is—having their surgery? I presume the $15 million of federal funding will be used to try to achieve that target, but I want to know what the exact cost is of achieving it.

Mr J.A. McGINTY: Dr Lawrence might be able to shed some light on the cost of that. As a broadly indicative figure, the $15.4 million from the commonwealth was reckoned to be able to do 2 700 additional operations. Perhaps Dr Lawrence can add to that.

Dr K.D. HAMES: That is that figure; the 2 000 and something —

[8.10 pm]

Dr R.A. Lawrence: There were a total of 2 720 cases put up for the funding of just under $16 million—$15.4 million—provided by the commonwealth. In the metropolitan area, as at 11 May there are 1 745 over-boundary category 2 cases. That gives some indication, but we have done no direct costing on a case-by-case basis of that cohort. Suffice it to say that that cohort is a big focus for the commonwealth elective surgery blitz money and we are working very hard on that. They are predominantly in a speciality, as one would expect. Ear, nose and throat, orthopaedics and general surgery are the big groups. There are initiatives for each of those specialties, particularly paediatric ENT surgery, which accounts for a big chunk of that group. A senior ENT surgeon is about to come on board to do a lot of extra sessions, and the sessions will be spread across the metropolitan area. Until he is formally signed up he will remain nameless. The surgeons will be spread out at Princess Margaret Hospital for Children and, hopefully, Osborne Park Hospital, Armadale-Kelmscott Memorial Hospital and Swan District Hospital, in order to pick up some of the extra paediatric work. The aim in putting together the commonwealth package was to have all of those cases completed and back within boundary. The figure of 2 720 essentially reflects how many cases we need to do to have all cases within boundary by the end of the year.

Dr K.D. HAMES: I have a further question about the ear, nose and throat surgery package for children. Where is it proposed for the surgery to take place? There will need to be a fairly intensive effort. Is it proposed to take place in Princess Margaret Hospital for Children theatres or elsewhere?

Dr R.A. Lawrence: It is a combination. Additional ENT sessions have opened at Princess Margaret Hospital for Children and there are also sessions being taken up at Swan District Hospital and, hopefully, Armadale-Kelmscott Memorial Hospital and Osborne Park Hospital to do some of that work. We are also working with WA Country Health Services and some additional cases will be done at Geraldton, as it became clear that some of the long-wait ENT children were from the far north and were not being treated because they would not come to Perth; however, we can get them to Geraldton. We are trying to do as much outreach as possible. The aim of the process was to not only achieve target, but also develop an integrated hub-and-spoke paediatric ENT surgery model so that regardless of where children were seen, we would have one waitlist and they would actually be treated in the location best suited to them. There was a key leadership position driving that process, so it was a two-pronged approach.

Dr K.D. HAMES: I would like to keep going with waitlist surgery questions if I can, unless other people want to jump in. I refer to the numbers of patients waiting to get on a waitlist. Do we know how many there are?

Mr J.A. McGINTY: There are around 12 308 people waiting for surgical appointments as outpatients. That figure, as the member will be aware, has decreased quite dramatically. When the member first asked the question in 2004, the figure was 36 000. There are two big contributors to the decrease. The first is that in the past, the records held by the Department of Health were often duplicated and outdated. A significant effort has gone into making sure that the figures for people waiting for surgical outpatient appointments reflect the number of people who are actually waiting, rather than people being recorded at a number of sites for the same outpatient appointment, or people who have not been removed from the waitlist once they have had their appointment. A fair bit of clerical work has gone into that. There has also been a major project undertaken by Dr Shirley Bowen within the Department of Health to address issues relating to outpatient appointments. For instance, the number of people who simply do not turn up for their appointments is staggeringly high, and that throws inefficiencies into the system. We are also trying to improve the ratio of new appointments to follow-up appointments, and all of those sorts of issues. I will provide the member with figures for the past couple of years on the number of people waiting for surgical appointments. The member quite rightly stated that the figure for 2004 was 36 000. The figure today is 12 308. In November 2005, the figure was 24 697; November 2006, 15 524; June 2007, 14 503; and as I earlier advised the member, the figure as at 30 April is 12 308. A lot of work has gone into this area and people are now getting their appointments far more quickly. We still have particular pressure points, and I am sure Dr Lawrence can provide more detail about those; I am thinking of orthopaedic and neurological conditions, particularly those involving pain. The member has asked a number of questions about those patients. We are grappling with how best to tackle that issue, but overall, significant progress has been made.

Dr K.D. HAMES: Will the minister consider the suggestion I made last year that he look at the possibility of providing surgeons with the opportunity to make patients with acute neurological injuries—for example, a cervical nerve compression—priority one patients? Obviously not all such patients need surgery; in fact, many do not, but what often happens is that those patients are inevitably off work for significant periods, become addicted to narcotics for the treatment of pain, and suffer long-term problems as a consequence. However, the surgeon cannot do otherwise than list them as, at best, category 2 and often category 3 patients. Is that something the minister would consider doing?

Mr J.A. McGINTY: I will ask Dr Lawrence to provide a more detailed answer, but I will say that our preference is to provide a multidisciplinary team approach to patients. It might well be that treatment by an allied health professional is the best way to manage pain and to avoid the side effects the member has spoken about. Many of these people will never require surgery anyway. Perhaps Dr Lawrence can provide a more detailed response on that issue.

Dr R.A. Lawrence: The first point is that such decisions are clinical decisions based on the clinical criteria of what category the patient falls under, and it is not for us to mandate such decisions. Clinical networks and area health services are doing a lot of work to try to streamline that process, particularly for cases involving pain and, as the minister has outlined, different models have been tried. The multidisciplinary allied health clinic approach for screening such patients is seen to be successful in other jurisdictions. There are now also clinical priority access nurses in the three adult tertiary sites who screen all the outpatient referrals to try to stream them in a more efficient manner and to ensure that those who need to be seen first, are seen first. We know that wait times for those patients, when they get on the waitlist, are long in some cases. The commonwealth elective surgery blitz has helped with getting some of the longer-wait patients through. We are tackling the problem from three different angles at the same time, but mandating categories will always remain a clinical decision.

Dr K.D. HAMES: That is not what I am asking; I am asking for the surgeon to be given the opportunity to make the decision. There is the example of the nurse from Bunbury who had an acute cervical disc prolapse. The general view was that she would require surgery; had she been able to have her surgery straightaway, it would have saved her becoming partially addicted to narcotics and spending a long time off work. I do not want to tell surgeons what to do; they will decide for themselves. However, in a situation in which, for example, a patient has an acute cervical disc prolapse and the surgeon believes surgery would be beneficial to the patient, does the surgeon currently have the opportunity to say that the case is urgent to get the surgery done quickly?

Mr J.A. McGINTY: If it is urgent, they certainly have every capacity to do that.

Dr K.D. HAMES: A situation is urgent when the surgeon considers that it would be life-threatening for the patient to not have surgery. That is the criteria for category 1. It may be that a patient's condition is not life-threatening and he can quite safely wait a year for his surgery, but the reality is that there will be a lot of pain and suffering in the meantime. The surgeon has to make a decision about categorisation on the basis of the degree to which the condition constitutes a threat to the life of the patient. For example, when a patient has cardiac arthrosclerosis and needs a stent, we often find that unless he is actually having a heart attack, he will be considered a category 2 patient and sent home. Category 2 patients, as the minister knows, can be waiting considerable periods just for a stent. I want to be sure that, even though it is not life-threatening, the surgeon can get that surgery done quickly if he thinks that is the appropriate course of action.

[8.20 pm]

Dr R.A. Lawrence: Absolutely is the answer. The surgeon makes the call and the surgeon prioritises his own list at the present time. If the surgeon thinks the surgery is urgent, he can add it to his urgent list, he can bring it in as an emergency today or he can categorise it as a category 1 or 2. Category 1 surgery is life or limb-threatening or at risk of rapid deterioration, and surgeons make that call; nobody else does at this point.

Mr T.K. WALDRON: I refer to the patient assisted travel scheme, which I think is a good scheme and does a good job. On page 577 of the *Budget Statements*, the first dot point under "Major Initiatives For 2008-09" states —

> Administration of the PATS will be improved through the establishment of dedicated PATS units in each region.

I presume that is right across the state. I wonder when those dedicated patient assisted travel scheme units will be established and how they will operate. Is the Minister for Health looking at the rate for travel, given that fuel prices are increasing? I know we have been through this before, and the minister did —

Mr J.A. McGINTY: And then the member for Wagin roundly criticised me for not doing enough, and I copped more criticism for giving more than I would have copped for doing nothing.

Mr T.K. WALDRON: I congratulate the minister for doing that but I thought he should have gone further. However, I am asking about those dedicated PATS units mentioned in the *Budget Statements*. I think this idea is a good one and I support it. I wonder whether they are operating now; if not, how they will operate; and whether consideration was given to petrol prices. If petrol prices keep going up, will they be taken into consideration?

Mr J.A. McGINTY: I refer the question to Mr Snowball.

Mr K. Snowball: We are trialling the PATS arrangement in the Pilbara and have been for some time. The central coordination role for the patient assisted travel scheme is to get better consistency in PATS decision-making about whether a person is eligible for the scheme. That role also couples with coordination of specialist visits, so a combination of people are being supported to travel to see a specialist. There is also a role to ensure we get, as much as possible, a good spread of specialist visits into the regional areas. Therefore, that combination is being conducted through the central function. Once that is a proven concept—and so far it has proven to be very successful—we will look at doing a similar thing in other regions as well.

Mr T.K. WALDRON: Will the minister consider the impact of increasing fuel prices on the patient assisted travel scheme?

Mr J.A. McGINTY: Only if the member for Wagin puts his hand on his heart and promises not to flog me like he did last time!

Mr T.K. WALDRON: I hit the minister with a soft feather duster! I urge the minister to consider that.

Mr J.A. McGINTY: I thank the member.

Dr K.D. HAMES: I return to a comment the Minister for Health made earlier about outpatient clinics. I notice that the first dot point on page 574 of the *Budget Statements* is about a reduction in the rate of non-attendance of

two per cent. The fifth dot point states that a text messaging system for appointments at Princess Margaret Hospital for Children resulted in a three per cent reduction in non-attendance rates. I must say that it surprises me that there was such a small reduction rate. I thought a text messaging system would work much better in reminding people of their appointments. Can the minister explain why that system was not more successful in reducing non-attendance?

Mr J.A. McGINTY: I will ask Dr Lawrence to comment on that question. As the member for Dawesville would appreciate, a phenomenal number of outpatient appointments are made each year. Therefore, we are talking about many thousands of people now attending appointments who did not previously attend. Perhaps Dr Lawrence can provide some figures on that and answer the question the member has posed.

Dr R.A. Lawrence: Certainly, the feedback from the short message service system that was trialled at Princess Margaret Hospital for Children was very positive. The patients really liked it and we were very pleased with the result. Although it was only a three per cent reduction, that was quite a dramatic improvement. As a result, we now plan to roll it out across the system. It will be interesting to see how it works in the adult population. I think we are at a point in transition in assessing this because since Christmas the do-not-attend rate, despite the ongoing use of the SMS system at Princess Margaret Hospital for Children, had started to rise a little. Therefore, attendance rates have not been sustained at the marked improved rate that we saw originally. I do not think we know why. That is one of the things we are assessing at the moment before we roll it out to the rest of the system: why did we have a really good improvement that has now plateaued? I do not have any specifics about why it might not have been more successful.

Dr K.D. HAMES: Can the minister tell us roughly what the non-attendance rate is? I know there are too many outpatient clinics to list them all, but could the minister give us a general idea of a few of them?

Dr R.A. Lawrence: Unfortunately, I do not have that figure in front of me; sorry.

Dr K.D. HAMES: Does the minister know as a rough percentage how many people would not attend the Princess Margaret Hospital for Children outpatient clinic?

Mr J.A. McGINTY: While Dr Lawrence looks at that, I must say that the two per cent reduction in the did-not-attend rate is 10 000 outpatient appointments, to give an idea of the scale of it. Dr Lawrence cannot add anything to the Princess Margaret Hospital for Children question.

Dr K.D. HAMES: I would not mind knowing what those non-attendance rates are, and I would have thought that was a suitable question to be answered by way of supplementary information.

Mr J.A. McGINTY: For Princess Margaret Hospital for Children or outpatient clinics generally?

Dr K.D. HAMES: I would like non-attendance rates for Princess Margaret Hospital for Children, Royal Perth Hospital and Sir Charles Gairdner Hospital. That would do.

Mr J.A. McGINTY: I undertake to provide by way of supplementary information the figures on people who did not attend outpatient appointments and changes in those figures over recent years at the tertiary hospitals.

[*Supplementary Information No A31.*]

Mr T.K. WALDRON: On page 587 of the *Budget Statements* the first dot points under "Major Achievements For 2007-08" and "Major Initiatives For 2008-09" refer to the school dental program across the state. I think the minister is aware that some schools are not receiving visits under that service. What is the minister trying to do to overcome those problems? I take into account what the dental service director said before about how we get more numbers and fewer people. I realise it is not easy but there is a problem with some schools not receiving the service regularly. Is the minister aware of that problem and what is he trying to do to improve the situation?

Mr J.A. McGINTY: I will make a couple of comments before I hand over to Mr Peter Jarman, head of the dental service. We are quite pleased with the very significant reduction in the number of people waiting for dental treatment under the general dental scheme. Three or four years ago, about 24 000 to 25 000 people were waiting for dental treatment; today it is just over 10 000 people. Most importantly, there has been a significant reduction in the amount of time people wait for dental treatment. I am not referring to the school dental scheme. As at 30 April, 10 829 people were waiting an average of 8.6 months, which is a massive improvement. By way of comparison, at 1 January 2004 there were 25 000 people waiting an average of 17.5 months for dental treatment. Therefore, we have had a dramatic turnaround in those figures over that period. Dental care is not expensive and a relatively small additional investment has underpinned that significant improvement.

Returning to the member's question about the school dental scheme, it has been a worry that we have not had the staff to maintain the service in some country and city schools. I think one issue involves the remuneration that is paid to dental assistants, dental therapists and to dentists for that matter. The Department of Health is working on

a quite well-developed proposal that it believes will go some way towards helping retain and attract new staff to work in the public dental scheme. We are not competitive with the private dental industry; people earn a lot more working as private dentists, but we want to improve the attraction rate of not only dentists, but also therapists.

Mr T.K. WALDRON: It is good to hear that the minister is looking at doing that because people in my region have told me about some of the pressures that people who work in those dental services feel. The minister is probably aware that these people are under such great pressure that they are probably dropping some of the school education work that they usually carry out, which is a preventive measure that I think is important.

[8.30 pm]

Mr J.A. McGINTY: I am very aware, and that is why I spoke directly with the health department and asked it to work out a proposal designed to do what it can, in the context of enterprise bargaining negotiations, to attract and retain staff. That work has now been substantially done but the negotiations with the union, which is the Community and Public Sector Union-Civil Service Association of WA, is still to take place.

I will ask Peter Jarman to comment on the other issues the member raised about the inability to maintain service in some schools. I think that the school dental service has been a great success story in Western Australia.

Mr T.K. WALDRON: It has.

Mr P.V. Jarman: The reality is that we just do not have enough people to maintain the service. We have an aged working group; 63 per cent of people in the dental therapist group are over 45 years of age. The training programs have been expanded to produce enough graduates to ensure the longevity of the programs, but in the current environment, with the offers that are available in private enterprise, we are unable to hang on to our staff. It is simply a question of not being able to staff the service. We are very hopeful that the workforce plan and remuneration package that goes with it will be sufficient to fully staff the program and get back to where we have been in the past.

Mr T.K. WALDRON: I understand the pressures the service is under and acknowledge what is being done through the pay package. Tonight we have heard about growing birth rates etc, so there are going to be more kids coming through in the future, which will put more pressure on the service. Over the next three or four years, will the minister consider further incentives to attract people outside the package; I am talking about housing and those types of things? That may be more of a whole-of-government issue, I am not sure, but it seems to me that the issue of housing is raised a lot. Is housing something that the minister needs to consider?

Mr J.A. McGINTY: The answer to that is clearly yes. If we ask people to work in the Pilbara, for instance, the cost of housing there is enormous. The health system does not currently have sufficient adequate housing in Port Hedland, for instance, for the staff that it employs. It is a significant factor in attracting and retaining staff. Currently, we have a shortage in the state Dental Health Service of 15 dentists, seven dental therapists and 27 dental clinic assistants. They are the current vacancies. Over the past two years, dentist numbers have declined from 103 in February 2006 to 100 in April 2008. That is making it all the more difficult. As Mr Jarman has said, we need to get staff to be able to continue the services. It is a very labour-intensive area.

Dr K.D. HAMES: I am having trouble finding my next dot point.

Mr J.A. McGINTY: I am sure it is there somewhere!

Dr K.D. HAMES: I refer the minister to page 558 and to the heading "Healthy Partnerships". Would the minister consider options for developing sister-hospital relationships with hospitals in other countries? Earlier this year I was in Da Nang city, near Nui Dat, where the hospital system gets lots of support from overseas, particularly America, but it has relatively primitive conditions. Some of the doctors there wanted to come to WA for training. In fact, we were trying to tee that up through Professor Constable of the Lions Eye Institute. We were also recently in Zhejiang Province in China, along with the Chairman. That province has a sister state relationship with Western Australia, one that has lasted 20 years. Would it not be beneficial for trainee staff in our hospitals to work in Da Nang, for example, where doctors perform 100 cataract surgeries in a day as well as other surgery, and at the same time teach them to use some of the equipment they are not properly trained to use, that is, the latest, modern equipment? That would expand opportunities for our students to have a better understanding and also develop better relationships with places such as Vietnam and China in particular, if not other countries.

Mr J.A. McGINTY: I will give a very brief answer to that. My preoccupation is with day-to-day delivery of health services in Western Australia. I do not ignore the importance of training and, for that matter, meeting international obligations. We do from time to time look at those international connections. My first priority is on service delivery here.

Dr K.D. HAMES: It is possible to walk and chew gum at the same time!

Mr J.A. McGINTY: Sure.

Mr J.N. HYDE: There are physiotherapy students and others in practices in Laos and Cambodia doing exactly that, through the universities.

Dr K.D. HAMES: That is right. I think it would be a great opportunity, particularly for our registrars, to be able to have that experience. We could take doctors from hospitals here who have sufficient English and training skills, as a lot of them have trained overseas. They could undertake further training here and develop those relationships further. It is just a thought.

Mr T.K. WALDRON: I refer the minister to page 569 and to the heading "Major Achievements For 2007-08". The second dot point from the bottom of the page states —

> A review of a pilot HITH service in the Great Southern has been completed and has formed the basis of planning for the expansion of HITH programs to all other country regions.

Could the minister or one of his advisers expand on the review of that pilot program and explain how it went and whether it will be expanded into other areas? I know it is quite a challenge helping out in the home, so I want to know whether it was successful, what the review showed and whether it will be expanded.

Mr J.A. McGINTY: Mr Snowball might be able to shed some light on that.

Mr K. Snowball: Yes, that particular program was extremely successful and this year we have now put the Hospital in the Home program into each of our regions at varying levels of development, but it is in all regions. We are looking at developing a very strong ambulatory care program right through country areas.

Mr T.K. WALDRON: Can Mr Snowball explain how it generally works, in practice?

Mr K. Snowball: It is essentially providing the opportunity for people to receive a level of treatment within the home environment with a visiting service. The service relies on good nurse practice and support from a hospital setting so that there is backup. Basically, there is a regular visiting service—it might be for wound management, post-acute care, whatever the condition. There is a determination within each of those regional centres that if there are enough people who can be accommodated in a home environment, it becomes economically viable to provide Hospital in the Home. That is where we are sitting in each of the regional resource centres where there is the volume of patients to be able to warrant that service.

Mr T.K. WALDRON: There was mention of the fact that the inland areas do not have the demand for major resource centres. Is there a demand, for example, in smaller wheatbelt towns?

Mr K. Snowball: Not to the same degree. Most of the time there is capacity within the local hospitals as well. Part of the rationale of the Hospital in the Home program is to relieve the pressure on inpatient beds. A lot of the smaller hospitals and the district-sized hospitals have capacity in their beds. It is a question of providing the staffing and nursing support within a hospital setting or a combination of the two. If there is the capacity in the hospitals, it is economically viable to support it in that setting if staff are already being paid.

Mr T.K. WALDRON: Is there capacity in some of those country hospitals—I know I have raised matter this before—to better utilise those hospitals and take pressure off other hospitals? I know it is easy to say that there have to be people there, and the minister has emphasised that to me before, but is that something the minister is looking at? If there are enough people to deliver the services, perhaps we could utilise some of that capacity in our country hospitals to take pressure off major resource centres and Perth hospitals.

[8.40 pm]

Mr J.A. McGINTY: Mr Snowball.

Mr K. Snowball: The document "Foundation for WA Country Health Service" has been centred around the provision of centres of excellence in the larger regional centres. That is where we can sustain those services which need a level of specialisation and backup support and which also have the necessary volume of patients to support them. We have seen a progressive shift of patients, particularly from the very small towns and hospitals, into the mid-range and regional resource centres. It is a matter also of having access to the workforce to provide the services. We are struggling to maintain adequate medical and nursing workforce coverage, so it makes sense to concentrate the resources where they can be supported. With regard to the overall effort, wherever we have the capacity to provide a service and it is safe and economically sensible to do so, we try to provide it close to the home. Once those three things are lined up, we would support the establishment of that service in a rural community.

Dr K.D. HAMES: I have a question on the same issue. What capacity does the Hospital in the Home program take out of the tertiary hospitals regarding staffing hours? Given that there are problems of staffing and personnel in the hospital, how much does that program contribute to the problem? What use is made of Silver Chain and how successful is it when it is used, if it is used?

Mr J.A. McGINTY: I will get Dr Lawrence to provide detailed commentary. My concerns about these issues are twofold. Firstly, we have taken resources out of the hospitals to provide the Hospital in the Home service; and, secondly, by and large, we have provided them directly rather than through a non-government organisation such as Silver Chain. They are the two areas of concern. For that reason a review was undertaken recently by a Queensland doctor who came here at my suggestion to look at the way we were delivering a host of ambulatory care services, of which the Hospital in the Home program was a major service. Dr Lawrence might like to comment in more detail on the question that was asked.

Dr R.A. Lawrence: The HITH service is independently staffed. It recruits its own staff to run the service and does not utilise staff from the hospital. The exception is at Princess Margaret Hospital for Children, which runs an integrated model. An additional number of staff is recruited, a proportion of whom are rotated out of the acute ward into the community. That was done to provide strong buy-in from the medical staff because the nursing staff know the patients in the community. The medical staff, who are hospital-based clinicians, have attended some additional sessions when that has been appropriate. That covers the tertiary sites. Silver Chain provides services for the general hospitals. Armadale-Kelmscott Memorial Hospital and Joondalup Health Campus are high users of the Silver Chain Hospital in the Home program. It is fair to say that all those programs have been very successful and that there has been a marked increase in their utilisation, which has provided us with a lot of beds throughout the system. There is still a lot of scope to expand those programs, and we will look at doing that in the coming financial year when it is possible. Despite all that, there is a risk that the workforce is finite and that people will choose to work in the environment that they find most appealing and challenging. While that remains the case, there will always be competing demands and it is a matter of balancing that issue in an appropriate fashion. The services are good and cost-effective. The recent review undertaken by Dr King has demonstrated that the models that we are running can be finetuned but that they are good examples of the hospital in the home service working effectively.

Dr K.D. HAMES: The Minister for Health said that the service has been significantly expanded but I note that the amount of money allocated for it this year is $18.145 million, compared with what was budgeted last year, although that amount was not fully spent, of 18 million. How will the service be significantly expanded when it has been given virtually the same amount of money this year as in the previous year?

Dr R.A. Lawrence: That is a challenge we are dealing with. We have been waiting for the review to be undertaken. The review looked not only at the hospital in the home program but also a suite of ambulatory care programs. The hospital in the home program is designed as an acute hospital substitution program. In an ideal world, we would substitute patient for patient in a hospital. Obviously with our demand profile it is not as simple as that. It therefore becomes a balancing act. The review of ambulatory care enabled us to focus on the services that would give us the best efficiency gains in the short term to deal with acute demand while providing a strategic direction to stem that demand in the future. We are trying to taper that demand and we will hold discussions on it over the next month now that we have the results of the review. We are in the comment and analysis phase, which occurs before it is signed off on and released for implementation. We will discuss where the funds will be focused in 2008-09 and whether additional funds will be needed. It is fair to say there is a strong desire by the clinicians within the Department of Health to increase the amount of money that is provided, and we will mount a strong case to seek additional funding for hospital avoidance programs that are longer-term programs that will result in a payback after two or five years. That is a work in evolution at the moment.

Dr K.D. HAMES: I have a question on a related issue. Dr Lawrence and I have previously had discussions about children with cystic fibrosis and the difficulty of admitting them to hospital when they desperately need it after the parents have done absolutely everything they can at home. Can the HITH program be used to better service the needs of cystic fibrosis patients? Although it is a different subject, can Dr Lawrence also tell me how she has gone with those patients who are desperately in need?

Dr R.A. Lawrence: The HITH program certainly can be used for those patients. However, Cystic Fibrosis Western Australia provides an in-home service for the majority of those children once they have their lines in. The big issue is getting them a bed to get a line in.

Dr K.D. HAMES: I wanted to ask Dr Lawrence that question but I had nowhere else to tag it. Can Dr Lawrence finish the answer?

Dr R.A. Lawrence: I can finish the answer. I am a little removed from this matter because it has been a while since I was at the hospital. A program was in place that was working on a model for that and was determining how that could best be facilitated. Probably the best solution to that problem is the procedure room, which is now fully funded through the blitz. There is also a clinical service design project, which is in the analysis phase at PMH and which is looking at the streaming through the theatre. Superficially, and in the early phases, it looks as though one of the major issues is the add-ons; that is, the children in oncology who need lines in and urgent biopsies. That throws out the whole schedule. That program is looking at how the processes can be streamlined to ensure that we can have the add-ons without disrupting the theatre. Most of those children would be treated as day cases if they could be given a theatre slot. Extra capacity will be provided through the procedure room, and a change will be made to the model to ensure that the children who need anaesthetic get it, and that there is a good transition as the children age so that they do not continue to get twilight anaesthesia until they are 18 if they do not need it. All those things will be streamlined through that process, which should help alleviate the problem. I cannot give the member any more details than that, unfortunately.

Dr K.D. HAMES: Has the minister thought of making better use of Silver Chain for cases like that and, in effect, combining the hospital in the home program and Silver Chain? Children with cystic fibrosis need an intravenous line to be given IV antibiotics for a time. They could be connected to an IV line and then go home and get 24-hour Silver Chain care, as is currently done for patients with terminal cancer.

Mr J.A. McGINTY: In a general sense that is exactly why I asked for the review of our ambulatory program, principal among which was the hospital in the home program, to ensure that we were picking up all the needs and different ways in which it needed to be modified. I have not yet seen the report; others obviously have. It is certainly one that I intend to read, and I also intend to meet with the author to discuss how we can improve ambulatory care in the hospital and in the home. The example the member gave seems to be the sort of circumstance that is admirably suited to exactly this program.

[8.50 pm]

Mr T.K. WALDRON: I refer to the last dot point under "Major Initiatives For 2008-09" at page 576 of the budget papers, which states —

> Princess Margaret Hospital for Children will develop a Rural Anaphylaxis Service to provide clinical time, increase community awareness and improve training, education and support to parents, schools and child care centres

My wife is a teacher and has had to deal with this situation, and what the government is planning to do looks good to me. The budget indicates that the government will develop this service. When is the service planned to be rolled out?

Mr J.A. McGINTY: We have not heard from Dr Towler for a while.

Dr S.C.B. Towler: I would like to thank the member for the opportunity to discuss the anaphylaxis project. Members would be aware that the government has committed $6.1 million to the implementation of an anaphylaxis program across the state in parallel with some work that is being done through Princess Margaret Hospital for Children. I am pleased to be able to say that we have just appointed the independent chair of the working party and the project officer. The implementation plans are in detailed advancement. This is a project between Health, Education and Training, and Community Development. We are seeking to put in place training and support programs for people who may encounter children who have an anaphylactic event. The member would be aware that there have been some tragic cases in the eastern states that led to New South Wales taking the lead in looking at educational programs, which were supported through the ministers' conference nationally. We are picking up the work it has done around training programs.

The anaphylaxis report, which was a multidisciplinary report with key input from some senior clinicians in Western Australia, including Dr Richard Loh at Princess Margaret Hospital, has set a template for how to address this issue. It is a strong direction around education for all practitioners—general practitioners and other practitioners—across the state in the appropriate assessment of people with an allergic risk. I am very optimistic that we will progress with the program quickly over the next six to 12 months and put much of it in place.

I understand that the minister has raised the question of our legislative grants around looking at some of the challenging legislative matters. I am sure that members will get a chance to discuss those. There are challenges when a patient is identified as probably having an anaphylactic event when the child is not pre-diagnosed or has approval for the use of adrenalin. The major cost of this program relates to the deployment of the EpiPen system. Obviously, it is not an issue directly for health, but our early conversations with the Department of Education and Training have certainly made this project a little challenging, because clearly teachers are under some pressure finding the additional capacity to teach and educate. We are confident that the model, which is very

much about taking the training to the teachers, will be important. I look forward to being able to report positively on this initiative over the next two to three years.

Dr K.D. HAMES: I refer to the reference to Shenton Park Rehabilitation Hospital at page 558 of the budget papers. I want to know where the government is at with this hospital. I know that there are huge budget plans for other hospitals, but my great concern is that Shenton Park Rehabilitation Hospital is so old, tired and rundown. Staffing it is difficult. My cousin's daughter, who suffered a spinal injury, was recently in that hospital. My cousin had to spend a lot of time providing support to the nurses. I was there visiting my cousin's daughter, and the hospital did not look any different to when I graduated in the mid-1970s. I understand the difficulties with funding and I know that a large component of the funding has to go to stage 2 of Fiona Stanley Hospital or Osborne Park Hospital. Can anything be done with Shenton Park Rehabilitation Hospital in the meantime? Is there any way of finding alternate funding options—such as the development of land that provides funding or public-private partnerships, which is what has been done by the Labor Party in eastern states and the Labour Party in England? Can something be done to improve the terrible conditions at that hospital?

Mr J.A. McGINTY: I ask Dr Flett to answer that question.

Dr P. Flett: It is well recognised that Shenton Park Rehabilitation Hospital needs money spent on it. Many areas of it are in a poor state. Holding funds have been allocated, but they are insufficient to address the needs of the hospital considering that the hospital will not be rebuilt for some considerable time yet. With that in mind, I have spoken to a number of people, including the Under Treasurer, concerning building a business case, which is being prepared at the moment, to develop more holding funds to address this issue by rebuilding and/or replacing those wards that need to be replaced between now and the time that the hospital will be transferred to the Fiona Stanley Hospital site. That could be 10 to 15 years. We do not have that date yet. Therefore, we will be addressing that possibility to replace those wards—I say replace, not just maintain.

Dr K.D. HAMES: They could not just be fixed up, because they are in a terrible state.

Dr P. Flett: Yes. That is the plan.

Dr K.D. HAMES: On page 557 is a reference to an estimated cost of $378 442 000 for the Sir Charles Gairdner Hospital development, stage 1. My question is about an MRI scanner that has been out of action for a considerable period. When will it be back on track? There was a funding commitment in the past for other MRI scanners in other centres. I do not recall where they were, but I am sure two were flagged for the metropolitan area. What are the plans for more MRI scanners in the metropolitan and country areas? When I was at Carnarvon Regional Hospital, I was told that the hospital was desperately in need of an MRI scanner.

Mr J.A. McGINTY: I will ask Dr Russell-Weisz to answer that question.

Dr D.J. Russell-Weisz: We are currently undergoing a tender process for a replacement MRI scanner at Sir Charles Gairdner Hospital. That process is nearing completion. We have a team looking at the type of MRI scanner that will be purchased for that hospital. It will be a 3-Tesla, one of the modern MRI scanners. We are hopeful that by the end of this year that scanner will be up and running. In the meantime, we recognise that there is a waitlist for patients who would have been seen under the two old MRI scanners, but we have only one. Those patients are being seen either under the current MRI scanner, which is operating longer hours and also at weekends, or in the private sector. We are paying for those scans.

Dr K.D. HAMES: Mr Snowball may be able to talk to us about scanners in country areas. I know the Carnarvon hospital was trying to get an MRI scanner. I recall that the people there were concerned because at that time the boundaries of the area health services had been changed and they had to lobby north rather than south to get a scanner included in its future plans.

Mr J.A. McGINTY: It would not have been an MRI scanner. There are no public MRI scanners in country Western Australia.

Dr K.D. HAMES: Sorry, it was a CT scanner.

[9.00 pm]

Mr K. Snowball: Two 16-slice CT scanners are due for installation in Kalgoorlie and Geraldton in August 2008. A tender for those will be put out this month. There is no funding in the current budget for a CT scanner for Carnarvon. A range of initiatives in imaging are being implemented across the state, which is good news. Ten sites across rural Western Australia will have CT capacity. Operations at those sites will commence early July 2008. New ultrasound machines will be delivered to Geraldton and Albany. New ultrasound machines are on order for Port Hedland, Broome and Karratha and are due for installation at the end of this month. Across country WA there has been a significant investment in imaging technology, with the installation of equipment

and with the connection to broader imaging technology approaches across the health system. Those are good developments in our capacity to diagnose.

Dr K.D. HAMES: Are there CT scanners in the Kimberley?

Mr J.A. McGINTY: Broome is the only place in the Kimberley that has a CT scanner.

Mr T.K. WALDRON: Further to the question asked by the member for Dawesville, I refer to the issue of CT scanners, which I have raised with Mr Snowball. Narrogin is on the list, but it will have to wait. A lady from Imaging the South has advised me that Imaging the South may have a machine available later in the year. I understand that it is not up to the standard of the new machines and that it is about one-tenth as good. Will any consideration be given to purchasing or leasing one of those machines—if they become available—for a place such as Narrogin while it is waiting for a new CT scanner or would that be considered a waste of money? Would we be better off waiting for a new CT scanner?

Mr K. Snowball: The expert advice that I have received about those machines is that it would not be economically sensible to purchase one at this time.

Mr T.K. WALDRON: I have been lobbied about this issue. People in my area are aware that such a machine could become available. The issue may come up again. If it does, I would like to know where we are at in waiting for a CT scanner. A CT scanner strategically located in Narrogin would service a big region and would be a bonus for that area. I understand that we need people to operate it. We have the facility; now we just need the machine and the staff to operate it.

Dr K.D. HAMES: I refer to the heading "Workforce" on page 566 of the *Budget Statements*. I want to talk about nurses in the workforce and their accommodation. Is there shortage of accommodation for nurses in the regions and in the north west? Is there an issue with accommodation? How is it being managed? We have had a previous discussion about transferring management of health department staff accommodation to Government Regional Officers' Housing, but the government decided not to do that. What commitment is the government making to provide country accommodation? A good example is Nickol Bay, which was seeking funds to build nursing accommodation on the hospital site. That seemed to me to be an excellent idea, but the funding was not provided. Is there any commitment for additional funding, particularly given the huge problems in Port Hedland and Karratha?

Mr K. Snowball: There is a critical issue with access to good accommodation in a lot of centres, particularly in the north west, because good accommodation is largely being taken up by the mining companies. There is also a critical issue with responding to the huge growth in those regions. We have done a combination of things. If the situation is critical, we lease accommodation. We have programs in place to construct as well as to spot-purchase accommodation that becomes available. Our difficulty is that accommodation, particularly in the Pilbara, comes up rarely and we have to be incredibly fast to put in an offer, which often goes to ballot. It is very difficult to get accommodation. We are setting up programs in the Pilbara. Mirtanya Maya was an aged-care facility in the Pilbara. With the construction of the new aged-care facility on the new Hedland site, we are looking at converting the old facility into staff accommodation. We are turning every stone in an effort to secure good staff accommodation across the country, particularly in the Pilbara.

Dr K.D. HAMES: When I visited Carnarvon in the middle of last year, I noticed that the nurses' accommodation was on the second storey above a pathology lab. Has that issue been addressed?

Mr J.A. McGINTY: Mr Snowball may or may not be able to answer that question about Carnarvon accommodation.

Mr K. Snowball: I cannot.

Dr K.D. HAMES: I ask the department to look into that, because it was a problem. Does the budget provide funds to deal with accommodation in places such as Carnarvon, where it is required, or Nickol Bay, where there is an opportunity to build on the hospital site?

Mr J.A. McGINTY: The reason for the Nickol Bay proposition was a land shortage, believe it or not, in Karratha. There was spare land on the hospital site and it was decided that that would overcome the land supply dimension to that particular problem. Page 556 of the *Budget Statements* refers to the $27.6 million of recurring funding for country staff accommodation stage 3. In addition to that, we had hoped to use the disposal of the land immediately adjacent to Port Hedland Regional Hospital, which was to be sold to fund additional staff housing in Port Hedland. It is substantially vacant land at the moment. There is a question mark hanging over that issue. We were going to use that to fund additional housing in Pretty Pool in Port Hedland. It is a major issue. The escalating cost of construction is reflected in the escalating costs of housing, particularly in the north

of the state. Fewer houses are being built for the millions that are being invested. That is quite a significant expenditure, but it is still not enough to meet demand.

Dr K.D. HAMES: Does the government intend to fund Nickol Bay?

Mr J.A. McGINTY: I do not know is the simple answer. I can undertake to find out.

Dr K.D. HAMES: I strongly encourage the minister to do so. Why did the government decide not to use Government Regional Officers' Housing to manage hospital staff accommodation? The Department of Health should not have to be a manger of staff accommodation.

[9.10 pm]

Mr J.A. McGINTY: This was an issue that we debated at some length last year and the member for Dawesville made the point —

Dr K.D. HAMES: The minister sounded quite receptive to the concept and was going to look at it further.

Mr J.A. McGINTY: Yes; I was very relaxed about the concept because the provision of accommodation is not part of health's core business, to my way of thinking. The shortest answer that I can give is that people gave the matter earnest consideration after it was raised a year ago and no proposition for change emerged from that consideration.

Dr K.D. HAMES: Yes; I think I pointed out to the minister at that time that such a proposition would never come out of the health department because once an empire is built, people like to keep it.

Mr J.A. McGINTY: I am not sure that that was the dynamic; it might well have been.

Dr K.D. HAMES: Not that people here are about empire building, but that was certainly the case when we were in government. The health department did not want to do it then and there was no good reason —

The CHAIRMAN: This is a lovely discussion, but I do not hear any questions. Are there any more questions? The member for Dawesville has the call.

Dr K.D. HAMES: I refer the minister to page 605 of the *Budget Statements*, and the reference to private sector contracts under the heading "Payments". The same line item and allocation appear also on page 603. In 2006-07 the figure was approximately $145 million, the figure budgeted for 2007-08 was roughly $160 million, the spend in 2007-08 was $162 million and the next budget is for $172 million. That is a significant increase in funding for private sector contracts. In fact, $172 million seems to be a huge amount. Will the minister provide the details about why that figure has increased so much and where all these private contractors are located?

Mr J.A. McGINTY: The contracts are overwhelmingly with the private service providers who meet the additional demands at Joondalup and Peel hospitals.

Dr K.D. HAMES: We are talking about $10 million extra.

Mr J.A. McGINTY: Yes; it is very significant.

Dr K.D. HAMES: What about the rest? We can go back to the core amount, which, even without the additional expenditure, is roughly $160 million. Does that figure include all those contractors employed by the former Director General of Health?

Mr J.A. McGINTY: No is the simple answer to that question. Joondalup Health Campus, I am told, has a value of about $145 million a year. It is a phenomenal investment to buy the public services in that hospital. The increase in demand that is presenting at Joondalup, particularly through the emergency department, is quite phenomenal and leads to a service obligation to meet the costs of treating those patients.

The CHAIRMAN: Member, it goes with the growth in the corridor.

Dr K.D. HAMES: Yes, it appears that I have misunderstood the line item. I thought that that referred to consultants rather than private sector contracts. Where in this budget does the item for private sector consultants appear?

Mr J.A. McGINTY: On page 603 the line "Supplies and Services" is the fourth item under "Expenses". This year's estimate of $334.4 million is the figure that includes the private sector consultants.

Dr K.D. HAMES: That is an even more interesting figure because it represents a $100 million increase from 2006-07. Can the minister provide details about why there is such a massive increase?

Mr J.A. McGINTY: If the member looks at the estimated actual and the budget figures for this year, he will see that we look as though we will spend less than what was budgeted.

Dr K.D. HAMES: Sure; but why did the figure increase so much between 2006-07 and 2007-08? I know that this is somewhat political, but I am sure that the minister understands what I am getting at. I want to know how much money is being spent altogether on contractors such as those criticised for their employment in the director general's office. I also want to know how many others might be employed.

Mr J.A. McGINTY: I will be happy to answer a specific question from the member on that matter. I have pointed out where the line appears in the budget. It is under the "Supplies and Services" heading, which includes a massive array of other issues. The cost of the consultancies associated with Dr Fong that were criticised, some of which have been terminated, was in the order of $250 000 a year. The two that have been terminated, broadly speaking, fitted into that budget category.

Dr K.D. HAMES: Yes, we have argued about those terminations.

Mr J.A. McGINTY: The fact is that those two consultancies are no longer in place because they have been terminated, by one means or another.

Dr K.D. HAMES: Yes.

Mr J.A. McGINTY: I am happy to provide advice if the member wishes to know about other consultancies.

Dr K.D. HAMES: I would like to know how many consultancies would cost, say, more than $100 000 a year. I could ask for this on notice, but it would be much easier if the minister could let me know, by way of supplementary information, who those contractors are and their field. I do not know whether the minister is able to provide information without knowing the details of the individual contracts.

Mr J.A. McGINTY: The problem is one of definition. For instance, do we include a person who supplies services, such as a doctor or a visiting medical practitioner who might receive that amount of money? I would not have thought so.

Dr K.D. HAMES: I would not have wanted that sort of information, but I do not know how else to get the information I require. I would at the very least expect the consultancy provided by Mr Piper for Fiona Stanley Hospital to be included in the consultancy figures. I am not having a specific go at that contract; I just want to know how many contracts are of that nature and what they add up to.

Mr J.A. McGINTY: Again, a significant number of people provide planning services—for example, architects—for Fiona Stanley Hospital and, for that matter, for all the other major construction programs that we are undertaking. Again, I do not think they fit into the sort of category that the member is referring to.

Dr K.D. HAMES: It is not that I want to exclude those categories. If it is easier for the minister to provide a list of every consultancy over $100 000 per annum, I can then draw my own line through the information.

Mr J.A. McGINTY: I can give the member the information that I have, which may or may not answer the question. I am not being vague, but the nature of health means that a vast number of contracts are entered into for the provision of advice and services. A significant array of contracts exist, many of which I do not think would be caught by the information the member seeks, which relates to those non-health delivery or non-capital works delivery services.

Dr K.D. HAMES: That is right; I do not want to know whether there is a contract to provide pathology services to Sir Charles Gairdner Hospital.

[9.20 pm]

Mr J.A. McGINTY: Exactly and that is what I am trying to exclude from the scope of the question. In a review of consultancies in the Western Australian public health sector, we adopted the meaning of consultancies as used in the Premier's Circular 2005-08 titled "Report on Consultants Engaged by Government." Applying this criteria, the contract is valued at $20 000 a year or more, the contract is awarded by an agency that is subject to the State Supply Commission Act, and the contract involves the provision of strategic advice for the government to act on and involves fee-for-service payment. The Department of Health review identified the following consultancies within that scope. First, in the area of infrastructure there were six consultancies with a total value of $26.66 million. Those involving the provision of project direction services for the capital works program account for $25.42 million of that amount. They were consultancies to provide specific services for hospital buildings that were about to be constructed. In the area of legal and finance there was one consultancy valued at $99 000, and that provided legal and contract support for the mental health plan. For the area of medical equipment there was one consultancy valued at $420 000, and that was for medical equipment planning for Fiona Stanley Hospital. Under the heading of "program and service planning" there were 12 consultancies valued at $3.192 million. That is the total of the contracts that fitted within the definition I gave at the outset, but it really is a definitional matter. We know that Jeff Ovens' contract with the former director general was

terminated; we know that Jenny Pickworth's contract to provide legal services, essentially with the former director general, has been terminated.

Dr K.D. HAMES: When was this review done?

Mr J.A. McGINTY: It was done in the aftermath of Neale Fong's departure from the Department of Health.

Dr K.D. HAMES: Had she gone by that stage? Is this an assessment of previous contracts that have been in place, because the minister said that the legal service one would not have included her.

Mr J.A. McGINTY: It would not have included her, because that was no longer in existence by the time the review of the consultancies reported.

The ones that have received some publicity through the media are Jenny Pickworth, of which we are aware. For the sake of completeness, I will quickly run through my notes on each of them —

1. Jenny Pickworth

    - Consultancy was for the provision of legal advice to WA Health mainly for capital works
    - Jenny Pickworth advised the Acting Director General that she was withdrawing her services to WA Health effective 14 February 2008.
    - In 2007/08 Jenny had been paid $238,476.50.

A contract involving Prognosis Consulting, of which Ross Keesing is an employee, was —

> . . . to provide executive health management and planning and consulting services for Health Reform Implementation Taskforce, specifically to lead and provide advice on specific reform projects associated with the capital work and infrastructure and assist in the development of a metropolitan infrastructure programme.

- Contract was awarded following a publicly advertised tender and competitive selection process.

. . .

- Contract period 1 April 2007 to 31 March 2010
- Contract price $1.485 million . . .

A further contract was with Admor Holdings, which was Jeff Ovens' consultancy and which has now been terminated —

- Consultancy was for the provision for consultancy for health system efficiencies to the Health Reform Implementation Taskforce.
- Contract was awarded following a publicly advertised tender and selection process.

. . .

- Contract period was January 2006 to 8 January 2008.
- Contract value was $500 000.
- Following an exemption from tender the contract was extended from 9 January 2008 to 8 April 2008. No further extension was sought.
- The consultancy has been completed.

Another consultancy was with the United Kingdom National Health Service Institute for Innovation and Improvement. The review found —

- This contract is not a consultancy as defined by the Premier's Circular
- . . .
- This is a secondment arrangement with the United Kingdom National Health Service — Institute for Innovation and Improvement
    - Secondee is Mr John Clark
- Contract period is for 18 months, 26 June 2007 to 31 December 2008
- Contract value is $296,000

That is most probably the information the member was seeking. There may be others that the member has not identified —

Dr K.D. HAMES: Now that it is on the record, I will be able to go through that—it is a long way short of $300 million, obviously —

Mr J.A. McGINTY: These are nothing in the overall scheme of that provision of suppliers and services.

Dr K.D. HAMES: I do not intend for this hearing to go until 10.00 pm, as it is supposed to, because I think everyone is getting to the end of a reasonable day, but I will ask one more question, which again relates to page 605. These are items in the budget that I do not understand. The heading is "Cashflows from investing activities", and the minister will notice that it goes from $251 million in 2007-08 to $490 million in 2008-09; which is an increase of $240 million. The proceeds from the sale of non-current assets is roughly the same, but on the next line the figure for the equity contribution receipts—I do not know what they are—goes from $108 million to $326 million. Will the minister explain what that is all about?

Mr J.A. McGINTY: I will ask John Leaf, chief finance officer, to explain the matter.

Mr J.W. Leaf: On page 602 of the *Budget Statements* there is a table called "Capital Contribution" that basically reconciles what is happening in the cash flow statement, the balance sheet and the income statement. The member can see that the total capital works program investment grows in 2007-08 from $272 million to $501 million, which largely explains the increase in the investment in non-current assets. That is funded through a range of various capital contributions. There are three items, and one is "Funding Included in Department of Treasury and Finance — Administered Item" of $242 million.

Dr K.D. HAMES: What does that mean?

Mr J.W. Leaf: I am explaining how the contributed equity change that appears on the balance sheet comes about. The cash flow statement is a reconciliation between what happens in the balance sheet and in the income statement. The most efficient way to answer the question is to explain how the investment in fixed assets is funded. If we look at page 604, we can see that the contributed equity between 2007-08 and 2008-09 increases by $541 million; if we look at the investment in non-current assets—land and buildings—we can see that it increases from $2 399 million to $2 463 million. Work in progress, which is the line under non-current assets deemed "Other", increases from $178 million to $459 million.

The reconciliation of that investment in non-current assets, which is essentially where the cash is being expended in the purchase of non-current assets and the equity contributions, are dealt with in that table on page 602. There is a capital contribution of $214 million, a contribution from Fiona Stanley Hospital funding of $84 million—this is all in 2008-09—and funding for the administered item of $242 million. That adds up to $541 050 000, which is the increase in the contributed equity. If the member looks at the fourth item from the bottom on page 604, he will see that contributed equity increased from $985 million to $1.5 billion. I apologise for that being a fairly complicated answer, but —

Dr K.D. HAMES: Did the minister understand that?

Mr J.A. McGINTY: I find it easier to understand Dr Towler!

Mr T.K. WALDRON: I am with the minister!

Dr K.D. HAMES: I did not understand that, but it does not matter because hopefully I can show it to someone who will.

The CHAIRMAN: Is that the member's last question?

Dr K.D. HAMES: Yes.

Mr T.K. WALDRON: The adviser has blown him away.

The appropriation was recommended.

Committee adjourned at 9.28 pm