Division 35: Health, $2 856 866 000 -

Mrs D.J. Guise, Chairman.

Mr J.A. McGinty, Minister for Health.

M. A. Chuk, Acting Director General.

Dr B.L. Lloyd, Deputy Director General.

Dr A.R. Groves, Director, Office of Mental Health.

Ms S. McKechnie, Director, Resource Management.

Mr P.J. Aylward, Executive Director, Development.

Mr J. Burns, Chief Executive, East Metropolitan Health Service.

Dr S.P. Kelly, Chief Executive, South Metropolitan Health Service.

Ms D.E. Twigg, Acting Area Chief Executive, North Metropolitan Health Service.

Mr G. Palmer, Area Chief Executive, Women's and Children's Health Service.

Dr P.R. Della, Chief Nursing Officer.

Dr D. Neesham, Director, Dental Health Services.

Dr A.G. Robertson, Director, Clinical and Aged Care.

Mr M.H. Moodie, Chief Executive Officer, South West Area Health Service.

Mr M.P. Jackson, Executive Director, Population Health.

Assoc Professor S. Allsop, Acting Executive Director, Drug and Alcohol Office.

Mrs C.H. O'Farrell, Chief Executive Officer, WA Country Health Service.

Mr T. Murphy, Director, Office of Aboriginal Health.

The CHAIRMAN (Mrs D.J. Guise): This estimates committee will be reported by Hansard staff. The daily proof *Hansard* will be published at 9.00 am on Monday.

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 fund. This is the prime focus of the committee. Although 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* when 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 ask 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 11 June 2004, 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 the 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 11 June 2004.

If members wish to ask a further question along a similar line of questioning, I will allow that. I ask for members to ask for it in that form, because it is different from asking for supplementary information. I will also allow, within reason, other members to pursue a similar line of questioning. However, that will be at the Chair's discretion.

Mr J.A. McGINTY: I take this opportunity to apologise for the absence today of the Director General of Health, Mike Daube. His mother died yesterday and he is preparing to depart to the United Kingdom today. He asked me to extend his apologies to the committee for his non-attendance.

Mr M.F. BOARD: Good morning minister and advisers. I ask the minister to pass on our best wishes to Mike Daube, Ruth and their family. I am sorry that bad news has come for him at this time. Our first question relates to the total appropriation for this division, which is outlined on page 543 of the *Budget Statements*. I also refer to the *Economic and Fiscal Outlook* for 2004-05, which provides a summary of the fiscal outlook. The health appropriation is outlined on page 61 of the *Economic and Fiscal Outlook* and shows a projected increase for the 2004-05 year of $163.2 million above the out turn for this year. I also take the minister to pages 65 and 66, which indicate that $100.5 million will be taken up in wages; $18 million in increased costs, including ambulance and transport services, and home care services; and $25.6 million in estimated increases to diagnostic costs and other costs to patients and so forth. Together, they add up to $144 million of the $163 million. I addressed this issue in the Parliament some two weeks ago when I asked whether the majority of the increase would be taken up in wages and increased costs and might not be used to deliver increased services in health or, in other words, an expansion of health services. The minister told me that I was wrong and that I was in fantasyland. Could the minister indicate whether those figures are correct; that is, that $144 million of the $163 million will be taken up in direct increases without being applied to additional services?

[9.10 am]

Mr J.A. McGINTY: Those figures are correct. We are obviously working under significant cost pressures in health. However, there is some very good news. Last year the department spent $164 million more than its initial budget allocation and, at the beginning of the current financial year - 1 July last year - I was advised by the Department of Health that it expected to again exceed its budget by $136 million this year. From such a dire start to the financial year I am delighted to be able to report today that I expect the Department of Health, for the first time in at least a decade, to end this financial year either with a modest surplus or in a breakeven position. That is a quite staggering turnaround, given that the health budget has been exceeded every year since at least the mid 1990s. My memory is not clear on what happened prior to that. The department has advised me that as at 31 April, it has estimated an end-of-year surplus of approximately $1.3 million. Over a budget of $3 billion that is obviously very fine and not a great margin for error. However, to have turned around the expected deficit of $136 million is a credit to everyone who has been involved. That has been done by applying a strict financial management regime, which has resulted in our being able to deliver for the first time in recent memory a health system that is financially sustainable and enables us to divert moneys to areas that meet the community's expectations of a high-quality health service. To do that, we have reprioritised funding into the areas of greatest need to provide that direct benefit to the public. The $136 million budget risk that was identified at the beginning of the financial year 10 months ago has been addressed with strategies that include imposing tighter staff recruitment controls, particularly in some administrative areas; improving staff management and reporting; reducing the reliance on agency nurses and introducing a capping of the fees for those agency nurses who are employed; reviewing and reassessing all contract processes and arrangements with non-government organisations, resulting in more than $9 million of funding being redirected towards core health services; and focusing strongly on accountabilities in the health services and the delivery of services within budgetary limits. This has been facilitated by changes to health service accountabilities and responsibilities and the introduction of clear, transparent and timely financial reporting. We have also seen procurement reforms and we have optimised revenue from the Commonwealth. This year, although the cost pressures that the member referred to have been greater than we expected them to be, and will be again next year, we are coming from a position in which we received less per capita than the national average through the Medicare scheme. We are now moving towards maximising those revenues from the Commonwealth, which are nothing more than a payment for services rendered in any event.

Mr M.F. BOARD: I recognise that minister, and that was a good summary of where the minister would like to be -

Mr J.A. McGINTY: That is where we are at.

Mr M.F. BOARD: The fact remains that the budget has increased by $163 million, which will be absorbed by increased costs in wages and some driving costs. Given that there is at least a seven per cent, and probably a nine per cent, increase in the driving costs of health services anyway, the system is going to be under increasing pressure. Many of the announcements and publicity about the Reid report and additional services will not be met by this budget allocation.

Mr J.A. McGINTY: The best way to answer that is to refer the member to page 543 of the *Budget Statements*. The provision for the coming financial year provides for a 6.8 per cent increase over the expected out turn for 2003-04. I think that answers the member's question.

Mr M.F. BOARD: I think the answer is that it will not find its way down into increased services. Unfortunately, 6.8 per cent maintains the status quo. The minister's answer is that he expects even greater efficiencies and a reprioritisation of the delivery of health services to get better outcomes. That says to me that we have been delivering services in the wrong areas or we had the wrong priorities. Can the minister elaborate on that?

Mr J.A. McGINTY: Yes. I have been of the view that we need to deal with areas of low priority and stop funding them. That caused some controversy when we announced that some nine months ago in the non-government organisation sector. We have applied rigorous financial regimes and accountabilities on the department in a variety of other areas. An area of particular concern to me has been staffing levels; the number of full-time equivalents employed within the department. We now have in place a range of controls over that, including targets that I expect to see the various budget holders implement. The net result of that this year is what we now anticipate a remarkable turnaround and the delivery of a balanced budget position or a surplus of $1.3 million. Nobody expected that nine months ago. I expect that regime to be continued into the future so that we can announce an expanded range of services - it might be that in a minute, one of my colleagues might ask me a question about one of those services. I use as examples the way in which we have addressed the waiting list problem, the emergency department problem and a range of other services that we will see expanded during the course of this year.

Mr M.F. BOARD: I suggest that announcing a surplus in the health budget may put more pressure on the minister than he thinks.

Mr J.A. McGINTY: The genuine public expectation is that the health budget will be managed responsibly to come in with a balanced budget. Frankly, a $1.3 million surplus in health, which is what is currently projected, is as close as we can humanly get to a balanced position with a $3 billion budget.

Mr J.B. D'ORAZIO: Why does the member for Murdoch not just congratulate the Minister for Health? Why does he not just say well done?

Mr M.F. BOARD: Hang on, we are keeping this nice at the moment.

Dr J.M. WOOLLARD: On page 565 under output performance measures, the public mental health bed days for 2003-04 are 77 500. The reason given for that variation from previous estimates is an improved methodology for the calculation of bed days. Can the minister provide details of what the bed days for 2001-02 and 2002-03 would have been using the new methodology?

Mr J.A. McGINTY: I am happy to do that. The actual bed days under the new methodology are 102 902 for 2001-02 and 101 554 for 2002-03.

Dr J.M. WOOLLARD: As mental health units are experiencing a crisis in demand on beds, with occupancy rates often in excess of 150 per cent, is the minister aware of the 1998 report of the royal college of psychiatrists that recommended that bed occupancies should not exceed 85 per cent if a safe environment is to be maintained?

Mr J.A. McGINTY: Yes. The report stating the figure of 85 per cent is consistent with the ideal that obviously everyone works towards; we do not achieve that. However, on occasions, demand for secure beds within the health system exceeds 100 per cent occupancy. Due to requirements under the Mental Health Act, we have to admit these patients. This is closely monitored, with the area directors reporting on bed status five times a day.

Dr J.M. WOOLLARD: Basically, the minister has accepted that higher rates lead to pressure for premature discharge, which leads to disturbed behaviour in the community. Bearing that in mind, why did the department shelve the new state mental health plan that was due for publication earlier this year?

Mr J.A. McGINTY: It has not been shelved. It is being considered. Two documents are under consideration in mental health. I am doing my best to get my head around the concept involved in them. One is entitled "Partnerships Create Good Outcomes - Western Australia's Mental Health Strategic Plan 2004-08". The simple answer to the question is that I do not want to have a document that makes promises that cannot be delivered, which is why I am taking some time over it. The other document is a review of the Mental Health Act by Professor D'Arcy Holman, who has recommended a number of significant changes to the Mental Health Act in Western Australia. The member will recall that in 1996, Kevin Prince, the then Minister for Health, steered through the Parliament the new Mental Health Act, which was a giant leap forward at the time. This review by Professor D'Arcy Holman is designed to take us even further forward. Understanding both documents is

conceptually and intellectually a difficult task for me, and I am doing my best to get my head around them. Mental health is undoubtedly a great challenge for everyone.

Dr J.M. WOOLLARD: Do those documents contain guidelines for safe practices in mental health units; and, if so, when are they likely to be implemented? Until they are implemented, will the Government utilise the United Kingdom's Department of Health guidelines as a benchmark for safe practice in mental health units?

[9.20 am]

Mr J.A. McGINTY: Guidelines for safe practices exist and are being developed by local mental health services to address local requirements. This permits mental health services the flexibility to ensure that the guidelines are appropriate for local needs. For example, safe practices for rural and remote communities will be different from those for metropolitan inpatient services. The Office of Mental Health is currently working in collaboration with mental health services to develop and implement statewide guidelines to complement the already existing national standards for the mental health work force, the national standards for mental health services and the clinical governance framework. These will include guidelines for safe practices in mental health units and will be available to all staff from the Office of Mental Health web site. As well, the 14 recommendations of the chief psychiatrist's finding in the review of the critical incident at the Swan Valley Centre will be implemented as soon as possible. In relation to the safety and quality partnership group, a national mental health working group is developing national guidelines with a focus on safe work practices in the mental health services across Australia. The Department of Health is a member of this group. International models form part of the reference for the development of national guidelines which will be set in the Australian context, including Western Australia.

Dr J.M. WOOLLARD: The minister just said "will be". I was just wondering when.

Mr J.A. McGINTY: They are being worked on at the moment. I cannot give the member a more specific time frame than that.

Mr M.F. BOARD: Is the minister able to tell us what percentage of the health budget will be spent on mental health services in the next financial year?

Mr J.A. McGINTY: From memory, it is just above seven per cent.

Mr M.F. BOARD: What was it last year?

Mr J.A. McGINTY: It was about the same figure.

Mr M.F. BOARD: Is there any intention to raise that figure? The previous Government before the last election tried to commit 10 per cent of the health budget to mental health services, because of the rising demands. Under the Government's projections is it attempting to raise the percentage of expenditure on mental health services?

Mr J.A. McGINTY: Yes. We are currently working with the relevant departmental officers to find ways to relieve the great pressure on mental health services. We have had a series of discussions with those officers, and I also attended a meeting of about 30 psychiatrists a few weeks ago under the auspices of the Australian Medical Association. We are trying to come up with a way of meeting the various problems. My understanding of the pressures is that there are not enough secure beds in the system. We came up with a proposal to deal with that, which did not find favour with the majority of psychiatrists working in the system who, I think, wanted to make sure that there was an expansion of the number of beds in the system rather than a shift from open beds to secure beds. Secure beds are a major problem that must be addressed. I am hopeful that within the next few months we will receive a response, if not a total answer, that will result in an expansion in the number of secure beds. The other problem is at the other end of the scale; that is, step-down facilities into the community. We are poorly serviced by step-down facilities, and that often leads, according to the advice I have received from a range of psychiatrists, to an aggravation of the mental health conditions of people, requiring hospitalisation. We need to be raising our game at each end of the spectrum. I will be looking at diverting resources -

Mr M.F. BOARD: I know there are people who want to move on, but the minister raised the issue of mental health beds. I was a bit confused reading the Reid report, which indicated that in the long term we would need only 370 additional beds in the public health system. We will explore that during the course of the morning. However, he also indicated that we need an extra 330 mental health beds. From what I could see, he did not indicate whether these were separate beds. Could the minister please clarify whether the mental health beds specified in the recommendations of the Reid report were separate from the 370, or were they in fact 330 of the 370 beds that the system would need in total?

Mr J.A. McGINTY: I am not sure of the exact figures quoted. A lot of the Reid report was premised on not continuing to do things the way that they have traditionally been done. In fact the policy of the member's own

party, launched a few months ago, said exactly the same thing: that we must do things differently with more emphasis on community-based services, thus avoiding the need for people to be hospitalised. That is very apparently the case with mental health. This is the point I was making a minute ago. The more community-based step-down facilities we have, the less likely it is that some of those people will require acute hospitalisation. It is a change in the way those things are done that I think will have some effect on reducing the demand. If we just kept doing things the way they are done at the moment, we would just keep on adding beds, which is not possible.

Mr M.F. BOARD: It is an important point and maybe the minister could provide supplementary information. Could the direction the Government is taking be clarified? The minister has accepted all the recommendations of the Reid report bar one, and therefore he is accepting the projection on bed numbers. Could the determination of the total number of public health beds and the percentage that will be mental health beds be clarified? Will they be additional beds?

Mr J.A. McGINTY: I will ask Dr Groves to comment on that, so that we can give the answer today.

Dr GROVES: The best way to clarify the situation is to recognise that mental health demand is probably growing faster than any other aspect of health care in this State. That is a national problem and is consistent with the international trend. I think the member is aware of the data about the global burden of disease, and the particular illnesses that are becoming more prevalent throughout the world, and their impact on health systems. The work the department has done has shown that if that demand is projected out at the rate it has been developing over the past 10 years, within the next 12 years we would expect that about 530 additional mental health beds would be required. However, the Reid report states that contemporary models of mental health service delivery elsewhere show that all that demand does not need to be met by the provision of additional beds. The sort of approach the minister has talked about involves more community-based services and step-down accommodation, and reducing the length of stay by more assertive case management, which were the approaches discussed in the Reid report. As a result, it is difficult to determine how many of the additional beds will be mental health beds because it needs to be played out in the detail of how many will be community-based beds, which are not generally talked about it in terms of hospital beds. It is probably best to talk about them not as being beds at all, but as packages of care. That is the sort of detail we will need to clarify as we implement the recommendations of the Reid report. Although some of them will be, as the member has pointed out, hospital-based beds, others will be packages of care in the community. Sometimes this is talked about as beds, but it is really packages of care for people in the community to try to avoid them being looked after in a hospital bed at all.

Mr M.F. BOARD: Do we add the 330 mental health beds to 370 public health beds, or are they one and the same?

Mr J.A. McGINTY: I thought Dr Groves had answered that but if the member requires further clarification -

Mr M.F. BOARD: It was not clear to me. He said that it could be or it may not be. I need to know whether we are looking at 700 beds or only 370, of which the great proportion will be mental health beds?

Dr GROVES: We are looking at 370 new beds, of which a proportion, but clearly not a major proportion, will be mental health beds. The rest of those 330 beds that are not actually in hospitals will be made up through care packages in the community.

Mr M.F. BOARD: That relies on heavy resources going into other services to account for that demand, which is not reflected even in the forward estimates in this budget. That is the point I make.

Mr J.A. McGINTY: I think I have made the point that, because strict financial controls have been put in place, we now have the capacity to use in areas such as mental health services, which I regard as high priority, money that would otherwise have been eaten up in areas of low priority. In the months ahead I expect to hear some significant announcements on mental health services and the reallocation of resources, which also will result in a rise in the proportion of the budget spent on mental health services.

Mrs C.A. MARTIN: I refer the minister to page 561. What is being done to combat the high incidence of sexually transmitted infection in the Kimberley?

[9.30 am]

Mr J.A. McGINTY: Sexually transmitted infections have a number of serious consequences, including infertility, ectopic pregnancy and complications associated with pregnancy, particularly both inflammatory and ulcerated STIs, which substantially increases the risk of HIV-AIDS transmission. Rates of infection are highest

in rural and remote areas of Western Australia, and young people are particularly vulnerable. In 2003, young Aboriginal people aged 15 to 19 years were infected with gonorrhoea at 180 times the rate of non-Aboriginal people in that age group. Rates of chlamydia infection were 18 times higher in that group than elsewhere. The Kimberley, which the member represents, with many remote communities and approximately 35 per cent of the State's Aboriginal population, carries a substantial burden of the infections, although rates of infection in Aboriginal people are also high in the goldfields and the Pilbara regions. Despite a dramatic reduction in syphilis during the 1990s, there was a resurgence of syphilis in the Kimberley region in 2000 and 2002. Control of this outbreak required a large commitment of resources. A full-time STI regional coordinator in the Kimberley made important contributions to improve the response to the syphilis outbreak and to STI control generally. Strategies include training and support to medical practitioners and community nurses, and engagement with communities, with particular emphasis on contact tracing and follow-up. STI control strategies require adequate and sustained resources to reduce the rates of infection, in turn lowering the risk of HIV-AIDS infections in the Aboriginal communities.

The Department of Health has been working with stakeholder groups to develop new strategies to address the high rates of STIs among Aboriginal people. These include establishing regional sexual health teams in the east and west Kimberley, the Pilbara and the goldfields to raise awareness about the prevention of STIs; support of Aboriginal-controlled community health organisations; services to improve sexual health case identification and screening programs; and professional support. Each team will consist of a senior nurse, an STI specialist and a male and female Aboriginal health worker. These positions will be placed either in Aboriginal-controlled community health organisations or the area health service population health units. The strategy includes sexual health programs with appropriate performance indicators within the contracts for NGO and Aboriginal primary health care areas. The member refers to a major problem. We are moving to divert funds to set up the new teams to ensure we are in a better position to control the problem.

Mrs C.A. MARTIN: Approximately 100 children in the Kimberley aged under nine years are affected by STIs at the moment. What programs are in place to deal with that matter?

Mr J.A. McGINTY: This has been done at two levels. The program I just talked about attempts to deal with the issue at a health level. However, the response must also be at a criminal justice level. The concluding touches are being put to a protocol between the Department of Health, the police and the Department for Community Development to ensure that the recommendations of Magistrate Gordon from the Gordon inquiry are implemented to provide a form of mandatory reporting of STIs in children under the age of 13 years. The community - I mean the broader community, as well as specific communities affected - would want this action taken. The member makes the point about children as young as nine, but some are younger than that.

Mrs C.A. MARTIN: The statistics were for children under nine. It is 100 children.

Mr J.A. McGINTY: Those figure are very alarming. That is why the Government will implement the Gordon recommendation for mandatory reporting to the police and DCD of the appearance of STIs among children under the age of 13. Also, when there is a suspicion of abuse, the same reporting to the police and DCD will be required for children aged between 13 and 15 years. That relates to the differentiation in the Criminal Code between children under 13 years and those under 16 years.

Mr M.W. TRENORDEN: I refer to the general appropriation on page 543 of the *Budget Statements*. I will ask the standard question. I do not expect the minister to answer now but he may by supplementary information. What is the budget estimate for the WA Country Health Service for 2004-05? The estimated actual expenditure for the same service for 2003-04 was $443.3 million. What will the Country Health Service receive? There are two questions. I think the minister will want to provide answers by way of supplementary information. I want what I asked for last year. The appropriation is $2.8 million. What is the estimated actual expenditure for each country health service for 2003-04? I thank the minister for finally providing the information for last year. What is the budget estimate for each country health service for 2003-04?

Mr J.A. McGINTY: It was anticipated at the beginning of the current financial year that the Country Health Service would have a deficit of $3.65 million. The end of financial year projection is a balanced position. The anticipated $3.65 million deficit has been brought back to zero by virtue of financial control in the Country Health Service. There is only one Country Health Service. The expenditure for this year is $430 million

Mr M.W. TRENORDEN: If that is this budget, it is a reduction.

Mr J.A. McGINTY: I refer to the current financial year. What is the allocation for the next financial year? We have made those allocations to each of the budget holders. I do not have the figure with me. I undertake to

provide by way of supplementary information the allocation to the WA Country Health Service for the 2004-05 financial year.

[*Supplementary information No A52.*]

Mr M.W. TRENORDEN: To ensure that I know what is coming, the minister will give an overall budget figure -

Mr J.A. McGINTY: Yes.

Mr M.W. TRENORDEN: - and the same as last year in an allocation for each service.

Mr J.A. McGINTY: There is only one Country Health Service.

Mr M.W. TRENORDEN: The minister supplied last year, and I require it for this year, the allocation for each health delivery service.

Mr J.A. McGINTY: I do not think we have that figure.

Mr M.W. TRENORDEN: The minister gave it to me last year.

Mr J.A. McGINTY: We do not have it for this year. The financial year has not started. I will give the member what I have; that is, the allocation for the Country Health Service.

Mr M.W. TRENORDEN: I need to know the figure for each health outlet. This is the estimates process.

Mr J.A. McGINTY: I will give the member what I have.

Mr M.W. TRENORDEN: I need to know the estimate for each of the country health delivery areas in next year's budget. If we do not know that, how do we know what is happening in country health?

Mr J.A. McGINTY: One of my pet hates in life is people who repeat themselves, so I will not indulge in repeating the answer.

Mr M.W. TRENORDEN: Does the minister tell me he will not provide the information?

Mr J.A. McGINTY: I do not have the information.

Mr M.W. TRENORDEN: The minister has the information.

The CHAIRMAN: The minister has indicated what he will provide.

Mr J.B. D'ORAZIO: I refer to the fourth dot point on page 544 concerning emergency departments. What will be the effect of the new strategy with ambulance diversions - I am glad we have got rid of the awful word that I will not mention again - and the operation of emergency departments? New strategies have been implemented. Will the minister explain what effect this has had and what can be expected to happen in the future?

[9.40 am]

Mr J.A. McGINTY: As members are aware, more than 430 000 attendances are made at metropolitan emergency departments each year, and attendances are growing by three per cent a year. The number of inpatient beds in Western Australian hospitals has declined from 2 063 in 1990 to 1 595 in 2003. That is a decrease of 468 beds throughout the system. That has been the single greatest contributor to the problems confronting emergency departments. It led to what is often referred to as access block; that is, an emergency department requiring inpatient admission but unable to get a bed in the hospital and therefore clogging up the emergency department, leading to ambulance diversion when ED demand exceeds safe physical capacity. We have implemented a number of strategies. I have spent a lot of time dealing with this issue in the 10 months I have been Minister for Health. I appreciate the input that the member for Ballajura has given me on this issue.

The most significant initiative we undertook was to provide an additional $10 million to deal with periods of peak demand in the forthcoming winter period. We opened 132 additional beds during the 2003 winter-spring period. This year, an additional 332 beds will be opened progressively across the metropolitan area; that is, the 132 beds from 2003 plus 200 other beds. That is what the doctors - in particular Dr Peter Sprivulis - told us was necessary to enable emergency departments to cope. The aim is to have a mean bed occupancy rate of 98 per cent during peak periods. In the past it has exceeded 100 per cent, which has led to these problems. As at 19 May, 149 of these beds have been opened, 51 in tertiary hospitals and 98 in secondary hospitals.

As a second initiative, we have negotiated a new contract with St John Ambulance that will provide an extra $34.7 million over five years for 30 new ambulances and 100 new ambulance officers and communications staff. That is a massive 49 per cent increase in government funding to the St John Ambulance service. I compliment

St John Ambulance for the excellent job it does. This initiative will result in improved ambulance response times and provide funding to employ ambulance network coordinators. I am hopeful that in the future St John Ambulance will play a more proactive role, in conjunction with the Department of Health, in appreciating when a particular hospital is under pressure and will send ambulances to hospitals where patients will receive the most immediate and appropriate care. That initiative will complement the additional beds and, therefore, significantly reduce ambulance diversion times.

We have also implemented a live electronic information system linking emergency departments with St John Ambulance. This system will enable St John Ambulance to distribute ambulances according to emergency department capacity at a particular time. We are also about to open four after-hours bulk-billing general practitioner clinics adjacent to major hospital emergency departments at Royal Perth Hospital, Joondalup Health Campus, Fremantle Hospital and Rockingham-Kwinana District Hospital. We have also provided $22 million worth of upgrades to hospital emergency departments, most notably Rockingham and Sir Charles Gairdner Hospitals. There are now more than 1000 additional salaried nurses on the payroll compared with three years ago when we came to government, which has provided us with the capacity to handle this issue from a nursing perspective. We are extending the role of the HealthDirect call centre so that some non-urgent calls to St John Ambulance will be referred to HealthDirect. We are introducing financial incentives for hospitals to open beds to meet demand, and financial penalties for ambulance diversion. We are extending the residential call line, which will enable nursing homes and hostels to receive advice over the phone on patient treatment rather than automatic transfer to an emergency department. We have also provided the influenza vaccine program for at-risk people and those over 65 years of age and accompanied the program with a major promotional campaign. We have established a range of other strategies, including the Rehabilitation in the Home program to decrease the use of hospital beds in emergency departments.

The effect of all those strategies has been quite dramatic. In April there was a halving in the number of times ambulances were diverted from teaching hospitals. There were 225 hours of diversion in April 2003. In 2004, with the strategy starting to kick in, that number had fallen to 105. Interestingly, in March and April this year, the relevant figures were 250 hours of diversion in March and 105 in April. The figures so far for May are extremely encouraging. Until 19 May, only 30 hours have been spent on ambulance diversion at teaching hospitals in Western Australia. I hope this trend continues. Of course, there will always be an emergency or problem that will occur. I was concerned that the transfer to Royal Perth Hospital of the four badly burnt Pilbara workers might have led to an increase in diversions because of the pressure on Royal Perth Hospital. However, I am told that did not occur, as emergency departments are coping tremendously well. I hope, if that trend continues, that a combination of all those initiatives will successfully meet the problem.

I pay tribute to the doctors and nurses in emergency departments who have spent a lot of time telling me what needs to be done. I spent time sitting in the back of an ambulance going around hospitals and appreciating what it is that ambulances do. I believe that coalface input and providing the money to meet the needs that have been identified by doctors and nurses have provided significant hope that the health system will be able to cope this winter.

Mr J.B. D'ORAZIO: As the member who has been asking these same questions for the past two and a half years, I congratulate the minister for working out the problem and solving it.

The CHAIRMAN: That was a nifty try at another question, member for Ballajura. I am sure the minister appreciated the sentiment. Does the member for Murdoch have a further question on this line and another substantive question?

Mr M.F. BOARD: I do. Let us keep our fingers crossed. I think the weather has helped the minister along the way.

Mr J.A. McGINTY: A bit of good planning too.

Mr M.F. BOARD: Yes, some additional resources are going into the health system and we appreciate that. However, there was the revelation to the Education and Health Standing Committee that ambulance diversion occurs not because of pressure on hospital beds or emergency departments but because of budgetary constraints in hospitals. That revelation came from emergency department doctors. The minister indicated in the House that that practice was abhorrent and would not happen again. What protocols has the minister put in place to ensure that hospitals will not go on bypass or diversion solely because of cost-shifting arrangements?

Mr J.A. McGINTY: To supplement the answer I gave to the member for Ballajura, I will ask Dr Shane Kelly, who is the person responsible for emergency departments, to respond to the question from the member for Murdoch.

Dr KELLY: Additional funding has been provided by the Government this year for the additional beds that the minister said are being progressively opened across the metropolitan area is being provided to hospitals that open those beds in accordance with the bed-opening schedules. We have introduced a relatively complex formula for distribution of those funds that rewards hospitals for having beds open and for accommodating emergency patients. The formula provides financial penalties for keeping patients waiting too long in emergency departments and for ambulance diversion time. For the first time, therefore, the health system has some appropriate financial incentives, rewards and penalties that will encourage budget holders to ensure they are meeting the demands at their emergency departments. That is our main focus. It is fair to say that we are much more advanced than any other State in that regard and we are the first State to have taken this initiative to this extent. Thus far it has obviously provided some very good outcomes, as outlined by the minister.

[Mr P.W. Andrews took the Chair.]

Mr M.F. BOARD: That is really an economic rationalist model coming from the minister's side.

Mr J.A. McGINTY: Is the member complaining?

Mr M.F. BOARD: I cannot understand it. The minister is giving incentives to hospitals not to go on bypass. They will get some sort of reward for that. Surely it should be a cast-iron principle that no hospital, regardless of its financial incentive or penalty, should divert patients. If they have a bed, they should simply accept that patient. Why should money come into the equation? I do not understand how that has crept into emergency departments. It does not make sense to me.

[9.50 am]

Mr J.A. McGINTY: If - and I say if - it occurred, it is not acceptable. We deal with these issues in a variety of ways, including through carrots and sticks. Dr Kelly outlined the new financial incentives to open beds to cope and the penalties that will apply if that does not happen. That is a clever way to make sure that if this was a problem in the past, it will cease to be a problem in the future. We essentially accepted the recommendations of the committee before they were even made. I was made aware of them to make sure we built into our model every element of how we could best make our emergency departments and hospitals work in the area of emergency medicine. I do not wish, at the early stages of winter, to start claiming a victory on this. In fact, we need to monitor it on a day-to-day basis because, as the member knows, things can emerge that are least expected. We have done everything that the experts have told us will help us to enable our emergency departments to cope this winter. They are always under pressure but we want to minimise that pressure to let them get on with the job.

Mr M. McGOWAN: I have a question about something that has been topical lately in Western Australia. It has been reported in the media that people have had to travel to Melbourne to obtain lung surgery. Such people are generally suffering from lung cancer, often caused by extended periods of smoking. There appear to be some complaints that patients have to relocate to Melbourne to obtain surgery. What is happening in Western Australia to try to assist those people?

Mr J.A. McGINTY: My interest in organ donation and transplants has been driven by personal experiences. Although it is always bad policy to be influenced by personal experiences, I remember a man, who was a friend of my son, who died at the age of 26 while waiting for a lung transplant in Melbourne. A very good friend of mine died about 15 years ago waiting for a heart transplant. It is appropriate the member for Southern River is in the Chair at the moment, as I know of his personal experience with organ donation and transplants. This is an area in which we have performed badly and in which we can perform immeasurably better. We have taken a number of initiatives to maximise organ donation in Western Australia. I have talked about that in the Parliament in recent times. The second part of the equation is to provide services in Western Australia for the transplantation of organs. We have a world-class heart transplant unit operating at Royal Perth Hospital. Because we have been able to get the health budget under control, we are now going to move immediately to offer to Western Australian patients lung transplant services as well. It is a major initiative starting effectively immediately. It will cost approximately $1.5 million a year. It will affect approximately 12 patients a year who would normally be sent to Melbourne or Sydney for lung transplants. The funding will cover at least one additional physician, who will be required in the new unit, as well as social worker support, physiotherapy and allied health worker support, additional intensive care unit costs through increased bed usage, additional nursing support and consumables, drugs and equipment. We were spending almost that amount of money paying for people to live in Melbourne or Sydney while they waited for up to two years to have their transplant operations. Their lives were subjected to enormous disruption, as were their families. The previous view was that we needed a critical mass of 20 patients a year to justify the operations in Western Australia. There will be no decrease; in fact, I expect an increase over the coming years in the number of people who need this sort of

transplant surgery. We are moving to immediately implement it. There are currently four patients waiting in Perth for lung transplants who eastern States doctors have not recommended leave home because of the long waiting periods. I understand there are approximately 10 or 12 patients in the east waiting for transplant surgery. Each transplant costs between $70 000 and $100 000, comprising the costs I referred to earlier. As I have indicated, patients waiting for transplant operations in the east have their reasonable living expenses met by the Department of Health. It is my view that, although this is something for which we do not yet have the critical mass that has been historically accepted as justifying lung transplant services, people in an affluent community such as Western Australia who have the misfortune of acquiring a disease and who need a lung transplant should have one, as we have the expertise. I pay tribute to the surgeons working at Royal Perth Hospital and Sir Charles Gairdner Hospital who have the ability to deliver lung transplant services. We want to use their ability in the system. In an affluent society, that is what we should be able to afford for people who require the services.

The Reid report recommended that Royal Perth and Sir Charles Gairdner Hospitals be merged. We will be working within the specialties in the hospitals to have one service. I have been pleased at the response from the physicians at the hospitals and their commitment to integrate the service to provide one heart and lung transplant service to the people of Western Australia. It will be an enormous step forward in the provision of medical services to the community in Western Australia.

Mr M. McGOWAN: Well done. That is remarkable. Will the patients who are currently in Sydney and Melbourne be brought home to Western Australia as a consequence of establishing this facility?

Mr J.A. McGINTY: As I indicated, there are people competent to do this work at both Royal Perth Hospital and Sir Charles Gairdner Hospital. The initiative came to me from two people: Dr Robert Larbalestier at Royal Perth Hospital, who heads the heart transplant unit, and a lady, Yvonne Bali, who received a lung transplant some years ago. I found it quite emotional the way in which she described to me the effect the dislocation of having to move to the east and wait for an operation had on her life and that of her family and many others like her. I believe that in her case she waited 16 months in Melbourne for an appropriate lung to become available for a transplant operation. We will discuss with the doctors whom we can bring home. The test will be a clinical one. We need to determine the availability of appropriate organs to be transplanted. I hope to see some patients return home but others may wait if they are close to receiving an appropriate organ. In future, we will avoid the pain and disruption. One in five people who needs a lung transplant dies while waiting for an organ to become available. I hope we can reduce that figure.

Mr M.F. BOARD: I refer to page 548 and the Reid and winter bed strategies. The strategies are dealt with in many parts of the appropriation. It is very confusing that there were approximately 132 beds last year but there will be an additional 200 beds this year. That makes 332 beds to meet the winter demand as part of the winter demand strategy. That is fine; I compliment the minister on that. Reid said that only 370 beds were needed over 13 years' growth in the system. We have already seen mental health take up some proportion of that, regardless of what we know. We will spend an additional $1.7 billion doing that. In fact, an additional $1 billion is in the normal capital works budget. We are looking at $2.7 billion over 13 years to come up with 370 additional beds in the system, most of which will be used in the winter bed strategy this year. I cannot see where the real growth in the system will be. The department is either completely relying on the private sector or non-bed use for medical service delivery. An extra 370 beds have been put into the system this year just to meet the winter demand in 2004, let alone in 13 years. I believe that the Reid report has grossly underestimated the need for public hospital beds in the future. Would the minister comment on that?

[10.00 am]

Mr J.A. McGINTY: I will, and I will ask Dr Brian Lloyd to add to my comments. During the past 15 years, at least, Governments of both political persuasions have dramatically reduced the number of beds available in the system. The most significant thing that the Reid report does -

Mr M.F. BOARD: The minister criticised the former Government for that.

Mr J.A. McGINTY: - is turn that decline around. The number of available beds will now be increased. The reduction in the number of beds in government hospitals in the metropolitan area went too far. That is one reason we are experiencing problems in the emergency departments.

Mr M.F. BOARD: The number of beds was increased in other hospitals.

Mr J.A. McGINTY: This Government is committed to increasing the number of available beds. That is the starting point that needs to be acknowledged. I suspect Reid's projections for the next 10 years are on the conservative side. We will increase the number of available beds in the general hospitals. Rockingham-Kwinana District Hospital is a good example. Currently, it has approximately 70 beds. That number will

increase to 300. The number of beds will be increased in Armadale-Kelmscott Memorial Hospital, Swan District Hospital and Joondalup Health Campus, which has more than 70 beds. The new southern tertiary hospital, which will be in the member for Murdoch's electorate, will provide an additional 600 beds.

Mr M.F. BOARD: We support that.

Mr J.A. McGINTY: The member supports that part of the Government's program. After looking into the system and understanding the way in which it works, we found that more beds are needed. For example, the Government will not reduce the number of beds at the Fremantle Hospital to the recommended number of 150. Although the number of beds will be reduced, more than 150 beds will be provided to cater for various types of services. Depending on the hospitals' experience, we will also consider what adjustments will be necessary. If our preventive and community-based strategies are successful, the growth in the number of beds will not be as great as it would be if we did nothing and left the system as it is. I ask Dr Lloyd to comment further on that.

Dr LLOYD: The Reid work that has been done to date was based on the premise that we have a moderate mismatch between the number of available beds and the way they are staffed and are able to meet service demands. In many of the secondary hospitals, the bed occupancy rates are much lower, particularly towards weekends, than in the major hospitals. Therefore, there is adequate bed capacity in one area but a tighter bed capacity in another. The premise behind our approach was that as we prepare to undertake this further building, we set in motion major clinical service planning work to determine exactly what number of beds is required in various parts of the system for secondary and tertiary hospitals. Therefore, more secondary beds will be used for the secondary work rather than that work being conducted at Royal Perth Hospital, Sir Charles Gairdner Hospital or Fremantle Hospital. We expect to match the work - or at least the staffing - to do that. In addition, as we review what we are doing over the next 10 years, we can look at other forms of efficiency that would allow the better use of beds than the way they have been used in the past because of the way they are staffed and the way doctors have chosen to go to certain places to do certain procedures. My understanding of the data is that there is spare capacity; it is just in the wrong place to meet the urgent demands.

Mr M.F. BOARD: Does that take into account the population growth, the ageing population and all the dynamics that will result in increased pressures on the system?

Dr LLOYD: It will also include an analysis of changed work practices and work approaches, and better support systems out of hospital so that patients who would have been released from hospital but for the lack of fully operational support systems in the community can stay at home and receive those support systems rather than spend a week in hospital.

Mr M.F. BOARD: I fully support that. That also has been part of the Liberal Party's push. It is starting to sound a bit like the Health 2020 report.

Mr J.A. McGINTY: Are we getting close to a bipartisan approach on health policy?

Mr J.B. D'ORAZIO: I refer to the first dot point on page 546 of the *Budget Statements*. The Public Accounts Committee and I, as its chairman, conducted a couple of inquiries into the Department of Health. One thing that staggered me was that the department's computer system had three different programs, none of which talked to the other. What provision has been made in the current budget to upgrade the hospitals' computer information technology? It is not before time.

Mr J.A. McGINTY: This is one of the little-heralded but tremendously good news stories in this year's budget. The budget has provided funds for a massive reconfiguration of the Department of Health's information system and information technology in the coming financial year, in line with the recommendations of the Reid report of the Health Reform Committee. The budget provides $335 million to overhaul the health data and information services and to improve and maximise health care delivery around the State. About $70 million has been budgeted for the first four years of that program. Information technology investment planning will commence in the 2004-05 financial year, and it is anticipated that the commencement of delivery of services will occur in the 2005-06 financial year. The focus of the investment will be the new integrated statewide clinical information systems and the supporting infrastructure, which will be fundamental for health professionals to access accurate and relevant data at the point of care and to ensure continuity of care for their clients. Electronic patient records will be central to plans for providing improvement in safety, quality and efficiency of health care delivery, while still protecting patients' privacy and security. New capabilities will be developed in areas such as standardised integrated clinical information systems across the Department of Health, including electronic patient records, clinical decision support and scheduling, and discharge summaries and referrals. There will be standardised health information security and privacy processes, procedures and information technologies across health; increased use of telehealth to deliver health services to rural and remote locations; portable information

technology; and wide area network broadband capacity. Clinical information services such as the Department of Health's Clinical Information Access Online will continue to provide access to national and international medical literature and research. The new broadband services are being delivered to hospitals in 53 regional Western Australian towns under a contract between the Department of Health and Telstra as part of the $8 million national communications fund project. That rollout is expected to be completed in February 2005. Broadband will provide a significant help to the department's current telehealth services. The Department of Health's information infrastructure will be not only physically rebuilt in line with the Reid recommendations, but also backed up with state-of-the-art technology to make sure that all the systems operate efficiently.

Mr J.B. D'ORAZIO: I congratulate the minister on the upgrade. However, will the minister please explain whether the Department of Health will have an integrated information technology system? The problem has been that the three separate systems do not talk to each other. It will be a huge benefit if that is to be overcome. Is that what the department is trying to do? Will one system be put in place to replace the three systems currently used that do not talk to each other?

Mr J.A. McGINTY: I will ask Mr Aylward to respond to the member's question.

Mr AYLWARD: For the first time, this process will set out a fully integrated system for the clinical and corporate systems. In addition to the comprehensive range of systems the minister spoke of is a program to upgrade and replace the corporate information systems in the areas of finance and human resources. That, of course, will be one of the fundamental building blocks for ensuring continued financial accountability. That could have been reported to the Public Accounts Committee when it inquired into the trust account issues.

Mr J.B. D'ORAZIO: Will the new system be integrated rather than be three systems which are independent of each other and which cannot talk to each other?

[10.10 am]

Mr AYLWARD: Yes, it will be fully integrated through both the clinical and financial systems.

Mr J.B. D'ORAZIO: Congratulations. Well done. That is a huge benefit. It currently costs $100 million a year to maintain that.

The CHAIRMAN: Before we go on, I always insist that the minister at least name the person who will respond before an answer is provided. Questions should not be directed to the advisers.

Mr J.B. D'ORAZIO: I apologise, Mr Chairman.

The CHAIRMAN: No problem at all. I believe the Leader of the National Party has a further question on that point.

Mr M.W. TRENORDEN: Could the minister supply, by way of supplementary information, details of the 57 sites and the services that are intended to be supplied? I congratulate the minister on the system upgrade. It is at least 15 years overdue. Other jurisdictions in other parts of the western world have been doing this for a long, long time. I am amazed that we have not been able to get it into the Western Australian system before now. I would like to know what are the 57 sites the minister is talking about, what the broadband capacity of each of those sites will be, and the other services that the department intends to deliver to each of those sites. I would also like to know what will be the back-up for those services. In other words, I would like to know where the information will come from, as I hope most of it will be clinical activity.

Mr J.A. McGINTY: The reference was to the department, in conjunction with Telstra, delivering broadband services to 53 sites.

Mr M.W. TRENORDEN: Sorry, I got the number wrong.

Mr J.A. McGINTY: I undertake to provide to the Leader of the National Party, by way of supplementary information, the identity of the 53 regional WA towns that will benefit from the contract between the Department of Health and Telstra, and details of what will be provided.

[*Supplementary Information No A53.*]

The CHAIRMAN: Before we go to the member for Murdoch, I make the suggestion that we break for morning tea at 10.45 am.

Mr M.F. BOARD: As we are talking about technology, I indicate that I did not see anything in the issues and trends on medical records. I may have missed it. One of the problems in Western Australia is that medical records do not follow the patient to different clinics and medical records are not being shared, particularly in primary health care. That is a great barrier to the greater usage of general practitioners, particularly after hours. This might be found to be the case with the newly initiated clinics, if they get off the ground. What is the

department doing about the sharing of medical records? Is the minister prepared to follow the Commonwealth's lead in the trial of patients carrying their own medical records by way of swipe-card technology?

Mr J.A. McGINTY: The answer is yes. We have been able to work fairly closely with the current federal health minister and will continue to work closely with whoever is the health minister after the federal election. I am sure that the cooperative, almost bipartisan, approach on a range of issues such as this will continue. That is quite at odds with the traditional war on and partisan approach to these issues. The issue of patient records is very much part of this proposal. Dr Fiona Stanley and others have made the important point to me that we need to include primary care records as well as hospital records in the overall system. That is the nature of what I referred to when I said that we would be looking to standardise integrated clinical information systems across health, including electronic patient records, clinical support, decision support and the scheduling of discharge summaries and referrals, and to standardise health information, security and private processes. It will be a new approach. We are certainly putting in the dollars over the next few years.

Mr M.F. BOARD: The minister is talking about the public hospital system. Will that be expanded to GP clinics, GPs and even pharmacies so that records can be loaded onto the patient's information card?

Mr J.A. McGINTY: I will get Dr Lloyd to respond to that question.

Dr LLOYD: The member has raised an important point. We are almost at a threshold with this technology. As I am sure the member is aware, New South Wales and Victoria have just entered into tender arrangements to pilot major electronic health records systems, and are aiming to move up to budgets in the order of $300 million for this sort of technology. There is no really good model around the world for the system the member spoke about, but it is the Holy Grail for most people. There are some ethical, legislative and technical barriers to the transferral of data around the community so freely, particularly for certain sorts of illnesses. We are very keen to move down that track.

Mr M.F. BOARD: The issue of giving ownership of the records to the patient may overcome that.

Mr J.A. McGINTY: I ask Dr Lloyd to respond.

Dr LLOYD: I totally agree. We are also keen to transmit other bits that may not be easily stored on such a card, such as a series of X-rays. A patient could roll up to Kununurra District Hospital and want to know what happened at Royal Perth Hospital the day before, or the doctors will want to see the X-rays and results. That is the model we want to be able to deliver, or vice versa. The next couple of years will prove to be very exciting as we explore that potential. Hopefully, some of the major pilot programs will have been completed at other people's expense and will allow us to get on to that development.

Mr M.F. BOARD: As we are talking about the budget, is there a specific allocation of funds for the development of this area, outside the public hospital system?

Mr J.A. McGINTY: At this stage it is an allocation for this system to be introduced. It has not been further broken up.

Mrs C.A. MARTIN: I am thinking along the lines just of the Kimberley and how big it is - 30 000 people live there - and the sort of technology that is required to share information. There are a lot of issues. Services in that region are provided by private GPs, private service providers, such as the Mercy Community Health Service at Balgo, Aboriginal medical services and hospitals. The high mobility of the population requires a remedy that will provide a good health service for those people. One week someone can meet somebody in Kununurra and the next week at the Sandfire Roadhouse. It is the same person. Some people have Hansen's disease, which means they need to be regularly followed up; that disease is not curable but it is manageable. People within that area need to know where these people are, so that when they are due for their next lot of medication, it is available. That is a glowing example of a place in which something like this could be trialled. Are we looking at that?

Mr J.A. McGINTY: I refer the question to Dr Lloyd.

Dr LLOYD: As the member will know, the budget was recently allocated. Department of Health groups are now reassembling to focus on that work. A lot of work has gone on. I refer to the system we developed in mental health. We now have a unique system in mental health that allows information on a patient who has had treatment in Perth and who ends up in Bruce Rock, Kununurra or Fitzroy Crossing to be made available to the carers, so that continuity of care in this important area can be provided. That work is still at a fairly early stage, but it has created a model for us to take the rest forward. There are some problems in people carrying their own cards, because they may not have the card with them when they arrive at Fitzroy Crossing District Hospital, Balgo or wherever. We still need a system that will enable us to get that information where it needs to be if the

card is not available. My impression is that we aim to have an "either/or" or an "either and or" system to deliver that right across the State. However, the basic system that is holding the really important information will determine the doctor's decision in Kununurra that night. Yes, we will move to that. We have only just got this budget and we will be very active over the next year or so. More importantly, we will monitor the trends of the work and pilot projects that other people have got under way with earlier budgets.

[10.20 am]

Mrs C.A. MARTIN: Are funds available solely for research into implementing something that works and provides a better service for remote communities in Western Australia?

Dr LLOYD: The budget is quite extensive and includes an allowance for developmental work. The developmental research that the member is talking about is the setting up of a pilot project to test it across, perhaps, our most difficult areas and the areas the member represents. Yes, there is a capacity to do that, and I believe we will be doing that within the next year or so.

Mr M.W. TRENORDEN: I refer to page 543 of the *Budget Statements*. I have not found in this budget - I am sure it is in there somewhere - the initiatives for rural and outer metropolitan doctors and nurses. As the minister is aware, an even greater crisis is looming in the next couple of years. There is no doubt that some of the international doctors in regional Western Australia do not want to work there anymore. Now that they are getting encouragement to work in the outer metropolitan area, they want to go there. They are telling me that. It is not guess work; they are actually telling me that. They want to break their contracts and move into the outer metropolitan area. That will put great pressure on regional areas. I am sure the minister is aware that many of the other captive places for our doctors are improving the financial lot of their own doctors because they are aware they have been losing them. It seems that the crisis will be particularly bad in the next couple of years with regional doctors, and also nurse practitioners and nurses. Can the minister tell me what is happening in the budget in that regard?

Mr J.A. McGINTY: One of the issues that has arisen as a result of the recruitment of more than 1 000 extra full-time salaried nurses in the system is that, to a degree, although not completely, some of the pressure has now come off the nursing area. It was an acute problem three years ago, and it is still an issue that needs to be addressed, but it is not the problem that it was. We are involved with the nurses' enterprise bargaining agreement negotiations at the moment and we are looking at some of those issues, which is as far as I can take it with nurses.

I am delighted with the success we have had in recruiting dentists to work in regional towns and cities throughout Western Australia. I have previously mentioned in Parliament the recruiting of foreign dentists -

Mr M.F. BOARD: The minister should visit Warwick.

Mr J.A. McGINTY: Warwick is not in the country, and I am answering a question from the Leader of the National Party at this stage, whose concern is outside of Warwick. We have had tremendous success in recruiting dentists and that will also be a real boon to regional Western Australia.

Mr M.W. TRENORDEN: I agree and congratulate the minister on that.

Mr J.A. McGINTY: In respect of doctors, I will ask Dr Lloyd to comment on the issue raised by the member.

Dr LLOYD: Clearly, the provisos under which the doctors have gone to work in rural towns, particularly those from overseas, and the grounds on which they may move relate to commonwealth regulations. We have been very active in meeting the Commonwealth to point out the potential discrepancy that can and will occur if coastal towns are allowed to attract the same people. It is my understanding - Chris O'Farrell may like to comment if the minister wishes - that, for the time being, people will be bound by those contracts that the Commonwealth has awarded them from an immigration status point of view. That will give government departments, mainly the commonwealth ones, time to re-evaluate their strategy on this.

Mr M.W. TRENORDEN: I agree that that is what will happen, but, as a result, it will also put pressure on the doctors involved, not being happy with that process, and cause a reduction in the numbers coming in. This is a catch-22 situation. It is a very serious matter and I wonder how we are planning to meet the deficiencies.

Mr J.A. McGINTY: The first point that should be made about this is that the provision of general practitioner services is directly a commonwealth responsibility. I do not say that by way of passing the buck, but we need to appreciate that -

Mr M.W. TRENORDEN: I understand that, but I am sure the minister is doing some work on it.

Mr J.A. McGINTY: We want to work cooperatively with the Commonwealth because often the relationship between primary and secondary care, particularly in country towns, is interwoven, and we need to have GPs who will often provide services in the country government hospitals as well. We do not walk away from that issue, and we want to work cooperatively with the Commonwealth to ensure that we provide GPs to regional areas in Western Australia. Traditionally, we have had a shortage in the number of GPs in Western Australia compared with the other States. In part, that will be addressed by the increase in medical school places, but it takes a long time for people to work their way through and for the benefit to be seen in the community. However, those are some early indications of the way in which this matter will be addressed for the future.

Mr M.W. TRENORDEN: I have not got an answer yet, minister. It is clear from the information out there that we have a crisis now, and it will be greater tomorrow than it is today; that is really the issue. I agree that in the medium and long term, an increase in graduates will ease the pressure. However, for the next five, six or 10 years we have a problem.

Mr J.A. McGINTY: I will ask Christine O'Farrell to answer that question.

Mrs O'FARRELL: At present, we are not doing too badly. We had an increase in the number of medical people in the regional areas, which included a high reliance on overseas-trained doctors. However, it is a concern that the moves to attract doctors, particularly from the overseas-trained doctor market, into the outer metropolitan areas could jeopardise our current situation and make it worse. We are doing a few things about that. One of them is that the director of the Western Australian Centre for Remote and Rural Medicine is involved with the group dealing with the outer metropolitan areas precisely to ensure that the interests of the regional sector are looked after in those areas. There might be some strategies that are complementary and do not necessarily work in competition; we want to avoid that if we can. We are also working with the Commonwealth to find ways in which we can pitch in together to get some joint solutions and some service models in the regional districts that will work better for the future. The principle is that neither party can do very well on its own, but both parties together might do a whole lot better. We are also working with the General Practice Divisions in WA to get its members in the regional areas to turn their minds to ways of working that will make medical work in these areas still an attractive proposition and keep up the numbers.

From a budgetary perspective, as an area health service we have made some significant progress in the past two years. We have invested quite a bit of additional money into filling gaps and coming to terms with some of the shake-out that has been occurring over a great number of years with the loss of specialists, the instability of services and, particularly, the loss of procedural general practitioners. We have been increasing the numbers and moving to fill some of those gaps, particularly specialist gaps, in the regional hospitals with salaried and sessional people. We have been building up the work force capability and trying to address some of the issues faced by solo practitioners, such as the burden of being on call and that sort of thing. We have made some significant inroads into that, and we will continue to do that. Overall, the performance is good and we have plans to continue to invest in some of those initiatives in the new financial year as well.

[10.30 am]

Mr M.W. TRENORDEN: Could I be provided with the budgetary figure that has just been referred to for the funds that will be allocated to this problem?

Mr J.A. McGINTY: From the federal budget?

Mr M.W. TRENORDEN: From whatever the source may be.

Mr J.A. McGINTY: I am happy to provide the information, but I will need more detail.

Mr M.W. TRENORDEN: Mrs O'Farrell referred to some funds being allocated. I want to identify the amount and source of those funds.

Mr J.A. McGINTY: Perhaps Mrs O'Farrell could provide that information now.

Mrs O'FARRELL: I will have to provide it by way of supplementary information.

Mr J.A. McGINTY: Perhaps the member could define exactly what he wants.

Mr M.W. TRENORDEN: The source of the funds and the amount of funds allocated to the particular problem.

Mr J.A. McGINTY: I will undertake to provide that.

The CHAIRMAN: Is the minister quite clear on that, because I am not?

Mr M.W. TRENORDEN: I will just make it clear. I seek information on the funds allocated to resourcing international and other doctors to regional areas.

[*Supplementary Information No A54.*]

Mr M.F. BOARD: The Leader of the National Party raised the issue of nurses, and we have a number of questions on that topic. I would like to move to a couple of those questions by way of supplementaries, because they deal with nursing numbers and staffing.

The CHAIRMAN: It had better be further to this point.

Mr M.F. BOARD: It is further to the point, because it is about nursing numbers and distribution, and a statement the minister has already made about the additional nurses.

Mr J.B. D'ORAZIO: This has nothing to do with doctors.

Mr M.F. BOARD: It has, because the minister talked about nurses. We want to explore all the issues in health, and not get bogged down on minor issues.

Mrs C.A. MARTIN: Yes, but we want a turn as well.

The CHAIRMAN: I think I might just run the show. The member for Murdoch can ask a further question, the answer will be given and we can move on.

Mr M.F. BOARD: I refer the minister to the statement about the additional nurses in Western Australia - I think he said 1 000 just now. Could the minister indicate to us the number of graduates in nursing from Western Australian universities each year? In the past three years, since the present Government was elected, how many nurses have graduated from Western Australian universities?

Mr J.A. McGINTY: The member will need to direct that question to the Minister for Education and Training. That is not something within my portfolio responsibility.

Mr M.F. BOARD: I would suggest that the number of nurses graduating from Western Australian universities in the past three years is in the order of 2 500. Could it be that the 1 000 new nurses recruited into the public hospital system is not a significant increase, considering the numbers employed each year? Is the minister embellishing, to some degree, the success of the strategy to employ nurses in the public hospital system in Western Australia? There has been an increase but it has not been rapid. It would have been expected that more nurses had been recruited into the public hospital system, given the number of graduates in nursing, which has improved over the past few years.

Mr J.A. McGINTY: I profoundly disagree with the member for Murdoch.

Mr M.F. BOARD: Tell me why. The minister may then have to talk about the number of graduates.

Mr J.A. McGINTY: Currently, approximately 9 331 full-time equivalents are employed in the government health system.

Mr M.W. TRENORDEN: That is the approximate figure, is it?

Mr M.F. BOARD: Are they registered nurses?

Mr J.A. McGINTY: Yes, I think so.

Mr M.F. BOARD: Are all the 1 000 new nurses the minister mentioned registered nurses?

Mr J.A. McGINTY: Yes, that is right. There has been no significant increase in the employment of enrolled nurses in recent times. The significant increase has been in the area of registered nurses.

Mr M.F. BOARD: I would be interested to know whether those 1 000 new nurses include enrolled nurses or just registered nurses.

Mr J.A. McGINTY: Dr Della will give a short answer to that question.

Dr DELLA: The 1 000 new nurses are actually 1 000 full-time equivalents. Currently, in teaching hospitals about 60 per cent of the nurses are full time and 40 per cent are part time. Therefore, there are many more nurses than FTEs. Since December 2000, some 3 800 nurses have been added to the nursing register. That includes both registered nurses and registered enrolled nurses in division 2 of the register, so numbers include both registered and enrolled nurses. Enrolled nurse registration has actually decreased because many of those enrolled nurses are now going on to become registered nurses, which we are supporting.

Mr M.F. BOARD: Does the increase that the minister refers to include enrolled nurses and not just registered nurses?

Mr J.A. McGINTY: The answer was that the number of enrolled nurses has decreased, but it does include both. If this is considered as a percentage increase in a nursing work force, two points need to be made. The first is that an increase of approximately 1 000 - I think the last figures I saw were just over 1 000 - to 9 300 is a very significant percentage increase. I am no good at mental arithmetic, but it is somewhere between a 10 and 15 per cent increase in the number of full-time equivalent salaried nurses. That has been offset to a small degree by the decline in the use of agency nurses, but that is a small decline, if the 2001 figures are compared with today's. The use of agency nurses ramped up a lot in 2001 and 2002, and today it is rapidly declining. The number of agency nurse FTEs has declined by 189 over that period, although the reduction in recent times and substitution by full-time salaried nurses has been far more dramatic.

Mr M.F. BOARD: Is the minister including the nurses from NurseWest when citing the reduction in agency nurses? Is NurseWest included as an agency in that sense?

Mr J.A. McGINTY: NurseWest is an agency. We are talking about full-time salaried nurses employed by the health service, and that is where the increase is. There has been a very significant increase in the number of nurses employed. That has had an immediate favourable impact on the workloads of nurses, which is a topical issue, as the member will appreciate. That figure of in excess of 1 000 extra FTE qualified nurses in the system needs to be offset by the decline of 189 in FTE agency nurses. That would leave a figure of just over 800.

Mr M.F. BOARD: Is the minister saying that he has averaged 330 new nurses over three years, resulting in 1 000 more nurses than when he came to government?

Mr J.A. McGINTY: That is it.

Mr M.F. BOARD: My question, then, is: what was the annual increase in the FTE nursing population before the election of the present Government?

Mr J.A. McGINTY: I do not know the answer to that. There was certainly a nurse shortage.

Mr M.F. BOARD: However, there was an increase in nurses. Could the minister provide, by way of supplementary information, figures on the recruitment of nurses each year?

Mr J.A. McGINTY: I will undertake to provide this information, which I think will answer the member's question. We will go back over a number of years and provide the member with the number of FTEs employed in government hospitals in Western Australia.

Mr M.F. BOARD: Could the figures go back, say, eight years?

Mr J.A. McGINTY: Yes. I undertake to provide by way of supplementary information the number of full-time equivalent salaried nurses employed in government hospitals in Western Australia.

Mr M.F. BOARD: I also want information on the nurses leaving the system. I need to know the number recruited, the number who left and the balance each year over those eight years.

Mr J.A. McGINTY: I can certainly provide the balance. I am not sure whether the pluses and minuses will be there going back eight years. I think the number will give the best indication. The real issue is workloads on nurses and the capacity within the system to implement expanded or new services. That is directly related to the number of extra nurses working in hospitals. The number of FTEs each year would give the member an answer to his question.

[10.40 am]

Mr M.F. BOARD: I hope so. There was a steady recruitment of nurses into the system prior to the Labor Party's coming to government, and we want to see how much the recruitment has increased in the way it has been positioned.

Mr J.A. McGINTY: All I know is that we had a shortage. Thanks to a dramatic increase in the number of nurses on the payroll, that shortage appears to have abated.

Mr M.F. BOARD: I hope so.

The CHAIRMAN: Is the minister willing to provide information on the number of full-time employee nurses in the past eight years?

Mr J.A. McGINTY: Yes.

[*Supplementary Information No A55*.]

Mr J.B. D'ORAZIO: My question is supplementary to that asked by the Leader of the National Party. Sitting here for the past 15 minutes, I have worked out that the Opposition has no hope of solving problems in health. If that question had any connection to the previous one, it would astound me.

The CHAIRMAN: Ask the question, member.

Mr M.F. BOARD: The member is a nasty pastie.

Mr J.B. D'ORAZIO: I refer to the allocation of doctors to country areas. Nobody has talked about prescriber numbers being allocated to the towns rather than to the doctors. If this were done, doctors could not take their prescriber numbers with them as towns would keep the numbers. It was talked about at the federal level. I refer to the minister's adviser: has that proposition been explored? It was a way of solving the problems of doctors wanting to shift to the metropolitan area and its fringes for reasons of lifestyle etc. Discussions became bogged down as doctors did not like the idea. That approach is currently adopted with pharmacists as the dispensing number belongs to the location, not the individual. Therefore, people must get approval from the federal Government to shift. Has that matter been explored further? It would go some way to solving the problem, with doctors going where they do not want to go.

Dr LLOYD: People have grappled with this problem for many years. Fortunately, it is outside the State's ambit.

Mr J.B. D'ORAZIO: I am helping the Leader of the National Party; he might get his federal colleague to push the idea.

Dr LLOYD: It is very much a commonwealth issue. Clearly, many problems are involved in addressing the matter. It is totally outside our ambit. It has been raised at the commonwealth level, particularly apropos the issue of doctors shifting to metropolitan coastal towns to the disadvantage of country areas.

The CHAIRMAN: The member for Carine had a question.

Ms K. HODSON-THOMAS: I think the member for Murdoch wants to explore some further issues regarding nurses. Rather than go to a different part of the budget papers, perhaps he might continue and I will go further down the queue again.

Mr J.B. D'ORAZIO: What a con job.

Mr M.F. BOARD: Suck eggs, guys.

Mrs C.A. MARTIN: Opposition members think our members are bad.

The CHAIRMAN: It is amazing how joviality creeps in on Friday mornings.

Mr M.F. BOARD: The Government has made a number of statements about the success of NurseWest. Page 570 of the *Budget Statements* mentions NurseWest under support services. Information has come to the Opposition's attention that hospitals do not like dealing with NurseWest. They find that insufficient staff are provided. Of the staff requested, hospitals often receive limited numbers. Hospitals would still prefer to deal with some of the independent agencies. I am not batting for independent agencies at all. Could the minister indicate the number of nurses employed by NurseWest? What are the costs to hospitals for the provision of services by NurseWest? By way of policy development, why has the State not considered a statewide tender for all agencies in the delivery of nurses, rather than competing in this way? In other words, a pre-prescribed tender list could apply with a set fee for agency nurses.

Mr J.A. McGINTY: NurseWest employs 220 nurses on a casual basis. When a hospital needs to employ an agency nurse, it goes through NurseWest. When NurseWest does not have nurses on its books, agencies provide staff. This is a cost and quality control measure that is delivering some remarkable results. The operational cost for NurseWest for 2003-04 is $1 million.

Mr M.F. BOARD: What does the minister mean by operational costs?

Mr J.A. McGINTY: That is what it costs to run NurseWest.

Mr M.F. BOARD: What does the hospital pay?

Mr J.A. McGINTY: I refer to the budget provision for NurseWest for its staff, rental property etc.

Mr M.F. BOARD: What does a hospital pay for a nurse provided by NurseWest rather than via an independent agency?

Mr J.A. McGINTY: I will get Dr Della in a minute to comment on the dollars involved. First, this is a remarkable success story. In the 2003-04 financial year, the expenditure on agency nurses was $55 million, and

the projected expenditure for the next financial year is now $35 million. In other words, a $20 million reduction has occurred in the use of agency nurses. That is tremendous. Although we had budgeted for a reduction in the use of agency nurses in the current year, projected expenditure is $9 million less than that in the 2003-04 budget for agency nurses.

Mr M.F. BOARD: Does the minister not include NurseWest in those agency figures?

Mr J.A. McGINTY: Yes, we do. In addition, NurseWest is now the largest supplier of temporary nurses to the metropolitan health system, providing 34 per cent of all nursing requirements. NurseWest operates seven days a week from 5.30 am to 10.30 pm, with four officers and an after-hours, on-call coordinator for nursing allocation. Regarding the contractual arrangement, a panel contract will be awarded shortly by the Department of Treasury and Finance that is expected to achieve a further saving of three to five per cent on agency nursing services costs. Given the success of NurseWest in the metropolitan area, it is intended to be extended to country areas as well. I think that answered most of the question. I ask Dr Della to give the dollars involved.

Dr DELLA: When we started NurseWest, the average cost paid to agencies was $50 an hour for a base-grade nurse - that was without penalties or shift allowances. By market forces, that has been reduced, and 80 per cent of those agencies now have costs ranging from $43 or $44 an hour. A NurseWest nurse is appointed at the casual rate that hospitals normally pay their casual staff; namely, around $29.77 an hour. There are no additional fees or service charges at the hospitals, which pay the casual rates paid to their normal nurses.

Mr M.F. BOARD: Has concern been raised by hospitals about the inability of NurseWest to be able to supply the number of nurses required and the nurses on time?

Dr DELLA: When we started NurseWest, there were concerns and teething problems. These have been worked out through the quality improvements involving the health services. We monitor the requests as well as the number of shifts we provide. We had a gap at the beginning, but that gap has been greatly reduced. The supply of agency nurses depends on the number of agency nurses working in the agencies. That has dramatically decreased as agency nurses have either moved to become NurseWest staff or returned to being permanent hospital staff. A shift has occurred. The system is now working much more smoothly. As was the case previously, super specialities such as intensive care units and so forth have shortages in peak care demand. In that regard, NurseWest nurses have been put through staff development to increase the competencies we require.

Sitting suspended from 10.50 to 11.10 am

Ms K. HODSON-THOMAS: I refer to the fourth dot point under waiting lists on page 548, which states -

> A further $2 million has been allocated to clear dental patients who had been on the waiting list for more than 14 months as at the end of January 2004.

I believe a number of dentists have resigned recently, particularly from the Warwick Government Dental Clinic, and that the public dental health service is finding it difficult to employ or attract dentists. How will the minister reduce this waiting time, given the loss of those dentists? The member for Kimberley is also interested in this question. Although she is not present in the Chamber, I ask the minister on her behalf whether dentists will be attracted into the public dental service in her local community.

Mr J.A. McGINTY: I will ask Dr David Neesham to respond on the Warwick issue, as I am not familiar with it. Over the Christmas period we identified a significant blow-out in waiting times. It is totally unacceptable that people should wait for treatment for such a long time. I think the worst waiting time in the State was 27 months, in Albany. We therefore targeted $2 million at people anywhere in the State who had been waiting more than 14 months. I will ask Dr Neesham to provide the most recent figures on that initiative and its success. There has been a significant reduction in the number of people on the waiting list, particularly in country areas. We have been able to recruit dentists from overseas to meet that need on an ongoing basis. I ask Dr Neesham to comment on the current figures and the situation at Warwick.

Dr NEESHAM: The $2 million waiting list initiative has been very successful. In fact, we have reduced the waiting list by about 5 000, with approximately 3 500 patients accepting offers of treatment, the majority through the private sector. There has been an issue with the dental waiting list and that initiative has been very successful. The recruitment and retention of dentists is a major national and international problem for dentistry. An initiative for a rural dentist scheme, which was approved at the health ministers conference last November, has led to our recruiting a number of dentists from South Africa this year to work in country areas. That is a short-term initiative but it is proving very successful. The retention of experienced dentists in the public sector is a problem. The health ministers conference established a committee to further look at this matter nationally, as it is not peculiar to Western Australia. Retaining experienced practitioners in public dental services is difficult.

Obviously, an increasing amount of emergency work is being done in the public dental service since the commonwealth dental program ceased, and there are issues of attraction and retention. I do not know whether that answers the question.

Mr J.A. McGINTY: No, it does not. The member needs to know how many people have been treated under the initiative, how many people are waiting, how much of the money has been spent, and what is the situation at the Warwick clinic.

Dr NEESHAM: Approximately 1 200 people have been treated under the initiative. We anticipate it will be closer to 2 500 to 3 000 by the time it finishes. It is anticipated that $1 million of the $2 million will be spent. The reason is that there was a time frame in the financial year. Because we involve the private sector, time is needed to get patients to see a private dentist and be treated. I am not sure whether we have lost dentists from the Warwick clinic. Obviously, we lose dentists from time to time and we are finding it difficult to retain experienced dentists in public dental services. I believe that if the staff numbers at the Warwick clinic were to be reduced, it would be by only one. However, there is a broader issue of dental staffing.

Ms K. HODSON-THOMAS: Could I be provided with those figures for the Warwick clinic by way of supplementary information?

Mr J.A. McGINTY: I will undertake to provide by way of supplementary information figures relating to the treatment and staffing at the Warwick dental clinic.

[*Supplementary Information No A56.*]

Mr M.F. BOARD: The additional "hit" funding used to reduce the waiting lists was needed. It is a good thing, especially since the department has used the private sector, which is something I endorse. What is the allocation for this year's funding for oral health, particularly public dentistry, on a continuing basis? What will prevent the waiting list from blowing out again once the "hit" funding has diminished? We need an ongoing program to keep the waiting list down. How does the additional funding for this year compare with last year without the additional extra funding?

Mr J.A. McGINTY: Firstly, the most significant contributor to the very long waiting list for dental treatment was the decision by the Commonwealth Government in 1996 to withdraw $10 million from the commonwealth dental scheme. We are still feeling the repercussions of that.

Mr M.F. BOARD: It was added to the Australian health care agreement.

Mr J.A. McGINTY: Nonetheless, that money has gone.

Mr M.F. BOARD: It became untied.

Mr J.A. McGINTY: There has been a recent commitment from the federal Opposition to effectively re-establish the commonwealth dental scheme and to provide funding, which will have an enormously beneficial effect for public dental patients in Western Australia should there be a change of Government. However, there may or may not be a change. I have been delighted at the success of the $2 million scheme. Accordingly, I will speak with the Premier and the Treasurer to determine whether it is possible to have another modest injection in the coming financial year to top up the dental budget. The allocation for the dental health service is approximately $45 million. An amount of $5.7 million is for the Oral Health Centre of Western Australia.

Mr M.F. BOARD: What is the percentage increase of that over last year's allocation?

Mr J.A. McGINTY: I cannot give the member that figure. I can provide it later.

Mr M.F. BOARD: It is one thing to put in additional funding - we welcome that - to reduce the waiting lists, but there is a need for a significant increase in recurrent expenditure on a continuing basis if we are to prevent the waiting lists from increasing again.

Mr J.A. McGINTY: Yes. I have indicated that we will discuss ways to inject further funds to ensure that those waiting lists come down, because waiting lists have been a priority for us.

[11.20 am]

Mr M.F. BOARD: By way of supplementary information, would the minister provide the percentage increase in funding - I assume it is an increase -

Mr J.A. McGINTY: Of course.

Mr M.F. BOARD: - in dental health, including the Oral Health Centre of Western Australia, compared with last year's allocation?

Mr J.A. McGINTY: Yes.

[*Supplementary Information No A57*.]

Mr M. McGOWAN: I refer to the third, fourth and fifth dot points on page 559 of the *Budget Statements* regarding drug and alcohol use by schoolchildren in Western Australia. I am interested in the trends, given that a lot of political noise is made about this issue by various people and a lot of untruths are told about various legislative changes. Would the minister provide some information on the trends?

Mr J.A. McGINTY: The Australian School Students Alcohol and Drug Survey - ASSAD - was first conducted in 1984 and has been repeated every three years since. "Other" drug use was added to the survey in 1996. The previous surveys were on smoking and alcohol consumption. Western Australia is the first jurisdiction to release the drug use results from the 2002 survey. A total of 3 545 Western Australian school students in years 7 to 12 in government, Catholic and independent schools in the metropolitan and non-metropolitan areas participated in the survey. It is pleasing to note that a majority of students - 51 per cent - had not used any illegal drug at any time in their life. There were no significant increases in the use of any drug by Western Australian school students aged 12 to 17 years between 1999 and 2002. There were a number of significant decreases in school students' drug use between 1999 and 2002, with the use of "many drugs" returning to 1996 levels. Between 1999 and 2002 there were significant reductions in students' reported use of the following drugs for the past 12 months: hallucinogen use decreased by 46 per cent, heroin use decreased by 41 per cent, ecstasy use decreased by 25 per cent, cannabis use decreased by 20 per cent, tranquilliser use decreased by 19 per cent, inhalant use decreased by 15 per cent, and amphetamine use decreased by 15 per cent. Overall, there were no significant changes in the use of analgesics, steroids or cocaine from 1999 to 2002. In a separate survey conducted in 2002 titled "WA Health and Wellbeing Surveillance System", the percentage of occasional use in selected drugs by participants aged between 16 and 19 years was cannabis 24.4 per cent, amphetamines 6.9 per cent and heroin 0.2 per cent. I think we can take some joy from the fact that, on the most reliable figures we have available, it appears that illicit drug use by schoolchildren is declining.

Mr M.P. WHITELY: I was pleased to hear the minister say that the level of amphetamine use has reduced by 15 per cent. I cannot remember the source of the information, but I am confident that the rates of amphetamine abuse in Western Australia are twice the national average. I am concerned that the rates of legal use of amphetamines for the treatment of attention deficit hyperactivity disorder are four times the national average. Does the minister have a comparison of the rates of drug use, particularly of amphetamine use in Western Australia, with the rest of Australia? Does the minister have any thoughts on the link between the very high rate of legal and illicit use of amphetamines?

Mr J.A. McGINTY: The ASSAD survey is a national survey and its results will be reported on a State-by-State basis. Western Australia is the first State to report the results for its schoolchildren for the year 2002, and the variation over the three years prior to that. I indicated earlier that the amphetamine use to which the member referred had decreased by 15 per cent; that is, in 1999, 12.1 per cent of school students reported the use of amphetamines in the previous 12 months. That figure had fallen in to 2002 to 10.3 per cent of all students. When this national report is released and the results of the other States' surveys are known, we will be in a position to make interstate comparisons on the same methodology and database.

Mr M.P. WHITELY: I am fairly confident that the rate of amphetamine use in Western Australia is twice the national average. I am pleased that its use has decreased. However, it is worrying that 10.3 per cent of students have used it. I suggest that its use is connected to the rate of legal prescription of dexamphetamine use for the treatment of ADHD in particular. I wonder whether the minister could provide further information about whether any studies have been conducted into the connection between the two.

Mr J.A. McGINTY: I cannot provide information on that connection. I can make available a copy of the ASSAD survey. The other interesting observation that is made on amphetamine use is that recent use of amphetamines was more common among males than females aged between 12 and 15 years but was more common among females at all other ages. Use of amphetamines in the last week of the survey peaked among 15-year-old females, while the greatest usage of amphetamines among males peaked at 16 years of age.

Mr M.F. BOARD: I refer to page 570 of the *Budget Statements*. I refer to the current enterprise bargaining arrangements for nurses. The minister knows that nurses from the south west were in Parliament recently representing other nurses, but particularly nurses from the south west.

Mr J.A. McGINTY: I hope the member did not encourage their behaviour!

Mr M.F. BOARD: Absolutely not. We do not encourage bad behaviour, as the minister knows. The nurses claim, contrary to statements the Minister for Health has made in the House, that the minister is not prepared to put workloads into the EBA.

Mr J.A. McGINTY: Who is saying that? That is outrageous!

Mr M.F. BOARD: That is what the Australia Nursing Federation has said. It has said that the minister might be prepared to mention workloads in discussions but that he has no intention, according to them, of putting workloads into the EBA.

Mr J.A. McGINTY: I would not believe them if I were you.

Mr M.F. BOARD: I want the minister to put on the record the correct position. Will the minister put workload arrangements into the current EBA?

Mr J.A. McGINTY: There are a range of issues involved with the EBA. The two major issues are salaries and working life issues. On the question of salaries, Western Australian nurses are currently the second highest paid nurses in Australia. At the reference points for various classes of nurses, their rates of pay are second only to nurses in New South Wales. Victoria was the most recent State to settle an EBA with its nurses. A very bitter, protracted, two-week industrial disputation resulted in, if my memory serves me correctly, more than 1 000 hospital beds being shut and about 1 300 elective operations cancelled. We did not want to inflict that on Western Australian patients and on the Western Australian community. That is why the Government took the unusual step of telling the nurses that they would get the same increase from the date on which the agreement expired, 1 May, as has been applied to all other health professionals. Doctors got a three per cent increase, which is not payable until October, and all other health professionals got a 3.4 per cent increase, which is payable from February. The nurses asked for a gratuitous pay rise. At that stage the Government had not even received a log of claims from the ANF. We said that from 1 May, the expiry date of the agreement, we would increase nurses' salaries administratively by 3.4 per cent. Interestingly, since then the only significant development has been that the settlement in Victoria provides Victorian nurses with a three per cent pay rise per annum over four years. Each year Victorian nurses' pay will increase by three per cent. The Government's bona fides on salaries are good. The nurses have received that pay rise in their pay packets, and they are enjoying it.

Mr M.F. BOARD: The nurses have indicated that the issue is not about wages; it is about work.

[11.30 am]

Mr J.A. McGINTY: I am pleased about that. On the second question, those issues all relate to the quality of working life. We have done a number of things to address that issue. Helen Creed is the chair of a committee within the Department of Health that includes representatives from nurses and other areas. The committee is looking at what can be done to create a more family-friendly working environment in our hospitals and the Department of Health. She has come up with a number of initiatives that we intend to implement. Glyn Palmer, the CEO of the Women's and Children's Health Service, has authorised the expenditure of a quarter of a million dollars to expand by 18 the number of places in the childcare centre at Princess Margaret Hospital for Children. That expansion will soon be under way and will hopefully be completed before the end of this year, to again provide a more family-friendly working environment for nurses. On the issue of workloads, contrary to the information that has been given to the member for Murdoch, that matter is currently on the table in the negotiations involving the Australian Nursing Federation and the Department of Health. I can say that because my chief of staff is heading up the negotiations.

Mr M.F. BOARD: The minister cannot avoid the point that will be discussed. The question is: will workloads be put into the enterprise bargaining agreement?

Mr J.A. McGINTY: That depends on the outcome of the negotiations. We have indicated our bona fides through the actions we have taken. We have indicated that we do not wish for a repeat of the industrial campaign that dogged the last days of the previous Government and the first days of our Government. We want to put patients and nurses first and make sure that these issues are resolved. If people can sit down and resolve issues in good faith, I have no doubt that appropriate provision will be made on workloads for nurses. I have indicated that publicly. One thing I do not intend to do is to attempt to conduct the negotiations for this EBA through the media, for instance. That would be counterproductive. I will illustrate that point. There was an expectation that the EBA for doctors would be very difficult for the Government this year. There has not been an angry word spoken between the Australian Medical Association, on behalf of the doctors, and the Government. We resolved the EBA in a mature and constructive fashion. Similarly with the Health Services Union of Australia, as that group is now known, we sat down, put our cards on the table and in a factual way addressed the issues of concern. If the ANF is interested in resolving all the issues associated with the EBA, it

should sit down, put its cards on the table and be realistic. If it does, we will resolve the EBA in the same way that we have resolved EBAs for every other group of health workers. I have some limited experience of dealing with the Department of Health on these matters in a former life. Sometimes people position themselves in a particular way to achieve a particular outcome. My role as health minister in these negotiations is to find the earliest possible solution. If people are genuine, we can sit down and resolve these matters in a mature, constructive and realistic way, taking into account the realities that surround us. If people are realistic, we will resolve those issues.

Mr M.F. BOARD: It seems to be exacerbated in the south west, which was indicated by the strength of opinion that has been expressed and the rally that was held. Why is the minister prepared to put a winter bed strategy into the metropolitan area? The fourth fastest growing city in Australia is Bunbury. It is increasing at a rate of 3.4 per cent. The population is expected to increase by 50 per cent in the next 10 years. However, no winter bed strategy or strategy for growth has been prepared for the south west to meet those workload demands. That was reflected in the strength of feeling expressed by the nurses who came to Perth. Why is the minister being city-centric with these strategies and not providing them to the other large growth areas in Western Australia?

Mr J.A. McGINTY: I disagree profoundly with the underlying assumptions in that question. A little later in the estimates committee hearing, the member will hear about the great things we are doing for regional Western Australia in health services.

Mr M.F. BOARD: How will we hear that? Will a dorothy dixer come from one of the minister's colleagues?

Mr J.A. McGINTY: I suspect I might get a question on some of those issues; I might be wrong, member for Murdoch.

Mr M.F. BOARD: Why not just table that stuff so that we can get on and ask some real questions?

Mr J.A. McGINTY: My general approach to these issues is that if we can get financial discipline into the health system, we can properly address the priorities. I think we now have that, given the projected balanced budget for the end of this financial year. It is the first time in a decade that that has occurred. The priorities are obviously to meet the growth in demand in areas such as Bunbury, which has a rapidly expanding population, along with the rest of the south west area, and to make sure we provide health services commensurate with that.

Mr M.F. BOARD: That is not reflected in this budget. That is the concern. They have increasing workloads but there is nothing to meet that.

Mr J.A. McGINTY: The member for Murdoch should be careful that he is not playing a game in the forthcoming EBA negotiations and doing the bidding of someone else.

Mr M.F. BOARD: No. We met as a shadow Cabinet in Bunbury a few days ago. This issue was a by-product of other issues in the region. I am not saying that it is isolated to the south west, but it happens to be on the boil in that area. Not enough is being done about that. The minister needs to be proactive, otherwise he will have a real issue on his hands.

Mr J.A. McGINTY: I take note of that.

Mr M.P. WHITELY: On page 560 the sixth dot point refers to child, community and primary health services and intervention in the early years, particularly with disadvantaged families. A pilot program running out of the Bentley Health Service is designed to intervene in families with children who have been diagnosed with ADHD and prescribed dexamphetamine for treatment. It is only a small program, but it has been incredibly successful. I believe that it has dealt with fewer than 100 families. Most of the children have been taken off the medication and most of the remaining children have had their dosage levels reduced through the appropriate use of other non-drug strategies. It mirrors the model implemented in Victoria, where child and adolescent mental health services are involved in the diagnosis and treatment of ADHD. Rates of prescription in Victoria are about a sixth of those in Western Australia per head of population. Are any plans afoot to extend the small program offered at Bentley Health Service to make it more generally available? It is doing tremendous work. I would love to see that model, which is similar to the Victorian model, replicated throughout Western Australia.

Mr J.A. McGINTY: I do not know about the model to which the member is referring, so I have no plans to extend it.

Mr M.F. BOARD: I refer to the issue of indemnity insurance, particular as it relates to GPs. I will refer to the total budget allocation, as this matter deals with a policy issue. I have been disappointed that our State has been very slow to implement tort law reform to support commonwealth initiatives to try to cap and deal with the huge issue of indemnity insurance. That was reflected to some degree at the AMA function last night, at which this issue was mentioned. As both Attorney General and Minister for Health, the minister is in an ideal position to

push that legislation through in Western Australia. That has not occurred. Will the minister explain why not, and when some tort law reform might be introduced to assist with indemnity insurance?

Mr J.B. D'ORAZIO: I thought this was the health division.

Mr M.F. BOARD: It is about health. It is one of the biggest issues. It is why we do not have any obstetricians in the bloody country. GPs are leaving in droves.

Mr J.A. McGINTY: The Government in Western Australia has in many senses been leading the nation in response to the tort law or negligence crisis that has occurred throughout Australia. So far we have introduced three Bills to deal with this issue. Two of those Bills have been passed. They have been handled by the Parliamentary Secretary to the Premier. One is currently in the middle of being debated in this House. I do not think its passage through the House has been completed.

Mr M. McGOWAN: It has not yet secured passage. The second reading stage has been completed.

Mr J.A. McGINTY: That Bill deals specifically with medical negligence and introduces the Bolam test into state law for medical negligence; that is, whether the peers of the medical practitioner approve of his or her conduct. That is the test that will apply to medical negligence, and was sought by the AMA. The debate on that Bill is currently before this House. We have also been progressing significant reforms to the Limitation Act.

Mr M.F. BOARD: That is the key.

[11.40 am]

Mr J.A. McGINTY: We have been talking with the Australian Medical Association about this. The drafting is proceeding slowly because of the complexity in these matters. I hope that it may be possible to have introduced into the Parliament a complete reform of limitations law in Western Australia, which is a profoundly important thing.

Mr M.F. BOARD: The minister knows he has the Opposition's support when it comes to the statute of limitations.

Mr J.A. McGINTY: This outbreak of bipartisan support is worrying.

Mr M.F. BOARD: No, it is something we should have moved on with. The problem with the delay is solely one of drafting, not of getting support.

Mr J.A. McGINTY: This issue was very much brought on by the problem with obstetricians who face the prospect of legal action in respect of births they attended 24 years after they retire. If a person continues work as an obstetrician until the age of 65, he could face legal action as he approaches his ninetieth birthday, which is totally unacceptable. We have figured out a formula that we have been discussing with all the interest groups. The complexities of the limitations law are great, and we want to make sure that we get the drafting right. However, it is not too far away and I hope that it will be introduced and put through the Parliament this year. People might argue about this, but I think it will position Western Australia with the best limitation laws in the country because it will allow a measure of flexibility for circumstances of latent injury and disease, which is not currently there. At present it is set at a rigid six years, and if a case does not fit within that six years, with the exception of mesothelioma cases, there is no possibility of taking legal action. In many cases of latent injury, people do not discover that they have the disease until after the six years has expired. That is a nonsense; it is totally unacceptable and it is causing grave injustices to people. We are working through all those difficult areas. The limitation period has now come down to three years everywhere else in Western Australia. This State has a basic period of six years. Everywhere else there is the capacity to extend, which we do not have. We are dealing particularly with the obstetricians and the limitation period for children taking action. We are also dealing with the mentally incapable and a whole host of other relatively privileged positions that the Government, for instance, occupies in respect of defending legal actions, which we want to wipe away. All of these are very complex matters that we want to make sure we get right. I assure the member for Murdoch that if that legislation is not introduced by the end of June when the Parliament rises for the winter recess, it will be ready when we resume in August. Coupled with all the tort law reforms that have flowed from the national position, the Ipp report and the like - we will have implemented all of them - is the Limitation Act, and I think the member will find that medical practitioners in this State will say that this is the model for the rest of the Australia.

Mr M.F. BOARD: We look forward to that.

Mr J.B. D'ORAZIO: I refer to the first dot point on page 543 of the *Budget Statements*, and my question is in two parts. First, and this is an area I have an interest in being a pharmacist, what action will be taken on

pneumococcal immunisation for children and getting the federal Government to come on board? The expense for people is just astronomical. Second, can the minister advise me on the effect of the $10 million of funding that we introduced in this term of Government to address waiting lists and waiting times? I get two bites of the cherry in one; it is called preventive questioning.

Mr J.A. McGINTY: All members would be aware that pneumococcal infection causes septicaemia, meningitis, pneumonia and otitis media. The latter is an ear infection in children and it is the most common cause of glue ear and deafness in younger children and is responsible for high rates of antibiotic treatment and hospitalisation in children under the age of five years. Prevenar is the licensed pneumococcal vaccine for use in the under-five age group. In August 2001, the Australian Government funded free pneumococcal vaccine for children in high-risk groups for pneumococcal disease; that is, Aboriginal children and children with predisposing medical conditions. In Western Australia in 2002 there were 66 cases of severe pneumococcal disease, including two deaths in children less than five years of age. Up to 74 per cent of these cases, including one death, could have been prevented by the prevenar vaccination. This is an under-representation of the true impact of pneumococcal disease in Western Australia. In September 2003, the National Health and Medical Research Council recommended the prevenar vaccination for all Australian children at two, four and six months of age. However, the Australian Government decided not to fund prevenar through the national immunisation program. The cost of prevenar is currently up to $150 per dose, so the minimum cost of the recommended schedule of three doses is $450 per child; thus, prevenar vaccination is prohibitively expensive for most families. As a post-budget announcement, the Commonwealth Government stated that it is re-examining subsidising funding for prevenar vaccine for all Australian children. The suggested subsidy system is unclear at present, and it would be better to fully fund the vaccine to ensure maximum coverage and impact on disease outcomes. The federal Opposition has made a commitment to fully fund a prevenar vaccine program if elected to power, and as the federal election is imminent and the cost of the program is high - it is $11 million for a single year age cohort in Western Australia - the State Government will await further announcements regarding commonwealth funding. It is expected that an expanded pneumococcal immunisation program will be in place in some form by early 2005. I will certainly be raising this matter at the Australian Health Ministers' Conference and be putting every pressure I can on my good friend Tony Abbott to come through with the goods to make sure that this very necessary vaccine is funded.

Mr J.B. D'ORAZIO: The second part of my question was about the waiting lists and the $10 million that we have allocated to alleviate that problem. Can the minister explain the results of that program?

Mr J.A. McGINTY: I will give the House the current figures on the attack that we have had on the waiting lists. As the member has rightly commented, we have committed $10 million to cut elective surgery waiting lists and to offer all patients who have waited for more than 500 days the option to have their operation before July 2004. The blitz was announced to ensure that treatment was given within clinically desirable time limits, with a special priority to long-wait children. At 30 November 2003, 3 250 patients fell into this category statewide. It was always anticipated that a significant number of long-wait patients would not accept an offer of treatment. As of today, 1 728 patients have elected to not proceed with surgery, 651 have been treated and 250 are scheduled for treatment shortly. I am confident that the remaining patients will all either receive treatment or be shown not to require surgery in the remaining six weeks of the program unless they are clinically deferred. We have a commitment to reduce the wait list. The fact that many patients have proved not to require surgery has allowed us to extend this program to include patients classed as semi-urgent category 2, who have been waiting for longer than clinically desirable times. Of these, 482 have had their surgery completed and a further 121 have their surgery scheduled. If we combine the long-wait cases, those at whom the program was originally targeted and who have been waiting for more than 500 days, with what are referred to as the over-boundary cases, those who have been waiting for longer than clinically desirable, this $10 million has also been used for, as of today and under this program, a total of 1 133 patients who have had their surgery and another 371 patients who have dates booked for surgery. We have also made sure that children have received priority, and all of those children who had been waiting longer than the 500 days at 30 November have, I believe, now been treated or have been deferred for clinical reasons, so they have had the option of the surgery.

I think this is an excellent result and we have been successful in ensuring that the number of people on the waiting list for elective surgery has declined. The number of people on the waiting list at tertiary hospitals is the lowest for a decade, the number of patients waiting longer than 500 days is the lowest it has ever been and the median waiting time for patients is declining steadily with a fall from 5.06 months in February 2001 to 4.57 months in March this year. We will continue to work on these figures. They are not satisfactory. I want to see a further dramatic improvement in the number of people on the waiting list and the waiting times. The response to this $10 million program has been very encouraging indeed.

[11.50 am]

Mr M. McGOWAN: My question relates to the capital works program detailed on page 581. I am very interested in the Rockingham-Kwinana District Hospital redevelopment program launched earlier this year as part of the Reid review. As the minister will be aware, he and the Premier jointly opened the $10 million emergency department that has been constructed at Rockingham, and I presume he will shortly be opening a new restorative day care therapy unit and the general practitioner clinic. I understand from the budget papers that a $95 million redevelopment of the hospital is planned over the next 10 years or so, with a majority of that being spent in the near future. Without trying to pre-empt what the minister intends to say, I am interested in what is being planned for the Rockingham-Kwinana District Hospital, particularly in orthopaedic surgery and renal dialysis services for this growing and vibrant community in the southern suburbs of our great city.

Mr J.A. McGINTY: The Reid review, *A Healthy Future for Western Australians*, was released in March this year, and puts forward a comprehensive 10-year vision and blueprint for the reform of the state health system, involving 86 separate recommendations, of which 85 have been endorsed by the Government. A key recommendation, in fact the first recommendation to be accepted and implemented, is to reconfigure all metropolitan hospitals including that in the electorate of the member - the Rockingham-Kwinana District Hospital. As part of the capital works plan, $95.3 million has been allocated to redevelop the Rockingham-Kwinana District Hospital. Stage 1, over three years, will involve the expenditure of $53.7 million, and the remainder will be expended in stage 2. In 2004-05, $1.052 million is allocated for the planning of stage 1. Completion of stage 1 is scheduled for June 2006. This includes building an additional 150 beds on the campus to take its capacity to 217 beds. The project will commence in June with the engagement of consultants who, along with key staff, will undertake the detailed service planning necessary to identify and develop the building infrastructure. Development of this hospital will improve access to hospital care in a high-growth metropolitan area, and reduce demand on the tertiary hospitals for general care. Services to be provided on the campus will include emergency medicine, general medicine, general surgery, orthopaedics, paediatrics, obstetrics, gynaecology, mental health and satellite renal dialysis. I will ask Dr Kelly to further elaborate on the nature of the proposal in answer to the specific question of the member for Rockingham. The redevelopment will complement the recent $10.3 million development at the Rockingham-Kwinana District Hospital, which included installation of a computerised axial tomography scanner, the creation of a day therapy building, and a major redevelopment of the emergency department, which is due for completion in July this year. Dr Kelly will provide more information on the specific services to be provided.

Dr KELLY: The minister has answered the question on satellite dialysis. Part of the development of stage 1 will be the introduction of a satellite dialysis service in the Rockingham-Kwinana District Hospital. It is intended that orthopaedic services be expanded to undertake a range of procedures that can be done in a general hospital.

Mr M. McGOWAN: I am a bit unsure as to exactly what satellite renal dialysis is; although I know what renal dialysis is. Perhaps by way of supplementary information I could receive a more detailed package on the service improvements.

Mr J.A. McGINTY: Dr Kelly can provide that information now.

Dr KELLY: Satellite dialysis is for those patients who are well enough to be treated in a secondary facility, rather than a tertiary hospital. The ratio of nursing care required is less than is required in what is referred to as an in-centre dialysis unit. It is full dialysis capacity, but it is really just a definition of how unwell the patients are at the time.

Mr M. McGOWAN: As the minister is aware, as part of the redevelopment a general practitioner clinic is being opened. I am not sure whether the minister answered this earlier or not, but I am interested in details about when that will be taking place. I heard the minister touch on it earlier, but I left the Chamber for a period. I am interested in when the GP clinic will open at Rockingham, what services will be provided and when it is proposed to open other GP services around the city.

Mr J.A. McGINTY: In the upgrading of the emergency department at the Rockingham hospital, an area was set aside and developed expressly for the purpose of providing a GP clinic within the emergency department. Although the new emergency department is operational, this facility is in a part that does not have easy access at the moment because of ongoing construction work. When the whole redevelopment becomes operational in July, we will be in a position to open the GP clinic in the emergency department. The problem of GP availability after hours is particularly acute in outer metropolitan areas, such as the Rockingham electorate, and this development will make an excellent contribution. It will need to be worked through constructively with the GPs from that area.

The Government is in the process of finalising all the arrangements for the other GP clinics. Approximately 50 per cent of all attendances at emergency departments are triage category 4; that is, they are semi-urgent. A further seven per cent are non-urgent category 5. The decline in bulk-billing and access to after-hours GP services has contributed to the pressure on emergency departments. It has become a key issue and that is why the Government has responded by looking at the emergency department general practitioner clinics. The agreement that has been entered into with the federal Government is that the services provided by the general practitioners in these centres will be bulk-billed to Medicare, by agreement with the Commonwealth Minister for Health. The Department of Health has entered into a service agreement with the Western Australian Divisions of General Practice covering the period 1 April 2004 to 30 June 2006. This contract is valued at $4.6 million recurrent, with a further capital commitment of $1.3 million allocated to develop the centres. The Western Australian Divisions of General Practice will employ the doctors, nurses and other staff and provide management support, and the State will provide premises, services, consumables and security at those places. Hopefully, by the end of this month a number of these centres will be up and running and will be in a position to take some pressure off the low acuity patients who present at emergency departments.

Mr M.F. BOARD: This is an issue the Opposition wanted to draw out in this estimates debate because the issue of these clinics is not clear-cut. They have not met with the acceptance of general practitioners generally in the metropolitan area. Personally, I think the department has erred by co-locating the clinics with emergency departments. Why has the Government co-located the clinics when they could have been community-based, which probably would have met with the expectations of GPs? Are the agreements or contracts for the provision of general practitioners in those clinics already signed? Is that likely to proceed in the future? My understanding is that there is much dissatisfaction about the co-location model. They should have been community-based services, keeping people away from hospitals, rather than attracting them to hospitals. I do not see the sense of that, unless the Government feels it must utilise hospital equipment through the GP clinics. It seems to me that GPs in the metropolitan area could have been brought onside through more general discussions prior to that announcement, which would have been to the satisfaction of all concerned, rather than just one or two of the heads of the Divisions of General Practice, who seem to have acted against the wishes of GPs in this instance.

[12 noon]

Mr J.A. McGINTY: It is true that some general practitioners in some GP organisations are not happy about the agreement reached with the Divisions of General Practice and the State and federal Governments to implement this service. I have given this figure before: however, I paid a visit to the Joondalup Health Campus recently, and I was disappointed to hear that 4 000 people who presented at the emergency department at that hospital last year walked out without being treated. Many of those people, although not all, would have been low acuity patients who were sick and tired of waiting and could have been seen by a general practitioner. The area has a shortage of GPs. The GP clinic on the grounds of Joondalup hospital charges a co-payment, which for low-income families is often a difficult proposition to meet. That gives an example of the nature of the problem.

A campaign has been run - we are all aware of it - by some people opposed to the proposition. In part, that campaign has lacked honesty. I give an example of an article that appeared in *The West Australian* only last week that referred to the GP clinic at Royal Perth Hospital. It referred to a $3 000 hot water system to make cups of coffee. Some doctors scoffed at this facility. The hot water boiling unit installed at a cost of approximately $3 000 was not for making cups of coffee, as reported by *The West Australian*; this system prevents the spread of legionella bacteria. This hot water system services the entire clinic, including treatment and consulting rooms, not only the kitchen. It was installed for clinical safety reasons.

Mr M.F. BOARD: I did not raise that issue with the minister, but I know he wants to get it in!

Mr J.A. McGINTY: That is an example of a willingness on some people's part to run with misinformation on these matters. I give another example from the same article.

Mr M.F. BOARD: The point is that the minister could have made the clinic bulk-billing and community based without its being co-located at the hospital. This would have had the support of GPs. It could all have been achieved.

Mr J.A. McGINTY: The answer to the member's question is that the Government negotiated with the Divisions of General Practice representing GPs. What is being put in place reflects that agreement and the contract signed to give effect to that agreement. If groups other than the Divisions of General Practice wish to complain about it, or some members within the divisions are not happy with what their representatives have done, that is an internal matter for doctors to determine. I return to the article in *The West Australian*.

Mr M.F. BOARD: Why?

Mr J.A. McGINTY: We need to ensure that debate proceeds on this matter on the basis of proper information, not misinformation. I refer to a laminar fan flow system installed at the hospital, according to the article in *The West Australian*. This information was maliciously fed to *The West Australian*, I believe. All toilets, cleaners' closets and kitchens need extractor fans to prevents any foul smells being recirculated into the main airconditioning system, and hence spreading the smells throughout the building. There is no laminar fan flow system. The extractor fan referred to in *The West Australian* is a simple domestic extractor fan that cost approximately $300.

Mr M.F. BOARD: Is this one less question the backbench has to ask now?

Mr J.A. McGINTY: A reference was also made to a statue. The implication in the article in *The West Australian*, again it was misleading, was that something luxurious had been done. I find it unusual that doctors would complain about a good quality working environment. This was a plastic stone imitation statue purchased from Bunnings for $149, less 10 per cent GST; therefore, the cost to the hospital was $135.46. The statue was bought by a hospital employee who thought the place would look a bit better with a nice, cheap little statue. The doctors who oppose the proposition sought to make a great deal out of this matter. It was similar to the doctor who sought to make the point to the media that she will close her surgery in Wembley on Sunday mornings in response to the opening of the hospital GP clinics. The clinics have not yet opened. The doctor shut her surgery before the announcement was made, yet she sought to paint it as a response to the clinics. That sort of a thing annoys me because I like to ensure that the facts are out in the community. I do not mind having a good argument about whether something is justified on its merits, but I do not appreciate people putting about misinformation and the media picking it up and running with it.

Mr M.W. TRENORDEN: That has never happened before!

Mr M.F. BOARD: Why are the clinics co-located? What advantage does the minister see in attracting people to hospitals who should rightly be primary health care category 4 and 5 patients? Why attract them to the hospital in the first place? Why not make the clinics community based, and only attract people to hospital who need to go to hospital? Why create the illusion that people must go to the hospital first, and then end up at the clinics? It seems the opposite to what we are trying to achieve. If the clinics were community based, they could bulk-bill. People would know about them, and not go to the hospital in the first place.

Mr J.A. McGINTY: This is partly a philosophical argument about bulk-billing. Part of the objection from some doctors is that the clinics will bulk-bill. I am philosophically very much in favour of bulk-billing. Some doctors who oppose the scheme are not. That needs to be understood as background. As a result of the decline in after-hours GP availability, and the decline in bulk-billing, people have gone to emergency departments for primary medical care, and they have had to wait a long time for that care. I am dealing with the realities of people congesting the waiting rooms. They add nothing to bed blockages because these patients will not be admitted to hospital. However, they congest the waiting rooms as many more people need treatment in the emergency department. We seek to establish a link to general practice in the community. Therefore, people who have had their emergency treatment can be referred back to their GP. It is an integrated system. Two models are considered. First, the Divisions of General Practice said they saw this as a significant boost, in having interaction between general practice in the suburbs and emergency medicine as practised in emergency departments. They looked at it from the view of benefit to the general practitioner. I looked at it from the view of benefit to the emergency departments by taking low acuity patients from the emergency departments and having them treated in a GP setting. The Commonwealth agreed to make a contribution. In fact, Tony Abbott also threw in $200 000 to help get the GP clinics up and running. That is a cog in the wheel of what is necessary for the efficient operation of the emergency departments and having people treated where they should be treated - namely, in a primary care setting. The Government has opted to do it this way. I think it is good. The federal Government thinks it is good. The Divisions of General Practice, at least previously, thought it was good. The Government stands by its commitment to the clinics.

Mr M.F. BOARD: Sure, it will alleviate pressure on emergency departments now, but that is a short-term vision. In the long term, the Government should educate people not to go to hospital when seeking the services of a GP in primary health care. That service could be community based. Hospital attendance should be left for hospital attention. That would have been a better long-term solution that would have satisfied the GPs as well.

Mr J.A. McGINTY: A trial of a very similar model has been conducted over the past few years in the Hunter region of New South Wales, and it has been a tremendous success. We need to build on the positive outcomes achieved in that trial. Also, we must ensure we link up other people in Western Australia, particularly those in general practice, to upgrade the standard of after-hours GP care, which is not provided at a satisfactory level at the moment. A good model is found in New South Wales. We seek to build on that model. It has worked.

Obviously, we do not want to attract people to emergency departments, but insufficient was being done to establish after-hours services in the broader community. The Government has taken the initiative. The member should give us a pat on the back for taking the initiative to expand the range of after-hours services.

Mr M.F. BOARD: The clinics are great, but the minister is cementing an unnecessary long-term attraction to hospitals.

The CHAIRMAN: The member for Murdoch needs to seek the call or speak through the Chair. I need to allocate questions. Other members seek to ask questions.

[12.10 pm]

Mr M.P. WHITELY: The first dot point under environmental health on page 561 refers to a major initiative for 2004-05. I applaud that initiative. It refers to the implementation of a scheme for monitoring the prescription of stimulant medication, particularly to people with attention deficit hyperactivity disorder. Will the minister give some detail on the information that will be collected? I appreciate that it may be necessary to do this by supplementary information. I am interested particularly in what information will be collected, how regularly it will be collected and whether it will be made publicly available. The scheme will collect information on patient demographics, but will it also collect information on the prescription pattern of doctors involved in prescribing stimulant medication and the geographical pattern of prescription across Western Australia?

Mr J.A. McGINTY: We will provide that information by way of supplementary information.

[*Supplementary Information No A58.*]

The CHAIRMAN (Mr A.P. O'Gorman): With the indulgence of members, I have a question. I refer to capital works for the Joondalup Health Campus on page 547. An allocation of $24 million comprises $2 million in 2005-06, $15 million in 2006-07 and $7 million in 2007-08. What will that money provide by way of capital infrastructure?

Mr J.A. McGINTY: The cash flow for the Joondalup Health Campus commences in the 2005-06 budget, which will expand general hospital beds from 225 to 300 in line with the Reid report recommendations. Although further development to improve services in the Joondalup area is a priority, Rockingham-Kwinana District Hospital is a higher priority general hospital. Its current bed number is about 87, which needs to be expanded to 300 beds in two phases. There are, therefore, strong commitments to Rockingham and Joondalup in the very early phase of implementing the Reid recommendations. Nothing in regard to private contractual arrangements has influenced the timing of the proposed capital works for Joondalup. The Joondalup Health Campus has submitted a proposal for redevelopment of its facility, which includes the emergency department and an increase in theatres and bed capacity. That is perfectly consistent with the Department of Health's direction, although the final configuration will be determined by the proposed metropolitan clinical services plan. Having spent some time with you, Mr Chairman, at the Joondalup Health Campus, I can say that redevelopment of the emergency department is a priority. It is now the second busiest emergency department in the metropolitan area and we must ensure that it is able to cope with the continuing dramatic expansion of population in the region. Similarly, the increase in the number of beds and other facilities that have been referred to will ensure that we are able to meet those needs into the future. A total of $9 million of the $24 million is for a complete remodel of the emergency department and associated services to ensure that the facility remains state-of-the-art and is able to cope with an increasing demand for services, not only in the next few years but also the next 15 years. The remaining $15 million of the $24 million is to expand the general hospital from 225 beds to 300 beds and for further theatre development. The key areas of focus, therefore, in the immediate expenditure commencing in the 2005-06 financial year will be beds, emergency departments and theatres.

Mr J.B. D'ORAZIO: I refer to the third dot point on page 558. My question is again in two parts and relates to capital works.

Mr M.W. TRENORDEN: There have been three questions from the Government and none from the Opposition.

Mr M. McGOWAN: You get nine-tenths of the questions anyway.

The CHAIRMAN: Order, members!

Mr J.B. D'ORAZIO: Will the minister provide a bit of background, first, on what capital works in the budget will be provided for the Kimberley, especially to rebuild ageing hospitals and health agencies; and, secondly, on the promised Telstra centre for burns reconstruction at Royal Perth Hospital?

Mr J.A. McGINTY: Again, a remarkable but unsung element of this budget and the provisions that have been made is the commitment to rebuild hospitals and health services in the Kimberley region. The 2004-05 health

budget increases the previous $41.7 million capital investment in Kimberley health facilities and staff accommodation by an extra $33.9 million to a total of $75.6 million over the next five years. In other words, $75.6 million will be spent in the next five years on all hospital and health services in the Kimberley. The member for Kimberley will be delighted to know that that will consist of $10.9 million for new inpatient facilities at the Derby Regional Hospital; 34 overnight beds and eight day beds, for which design planning has commenced; a $600 000 refurbishment of the former maternity ward for a new dental facility once new ward areas are operational; and a new $4.79 million, 26-bed Numbala Nunga nursing home. Planning has commenced for the latter high priority project, which must be completed no later than 2008 to ensure continued commonwealth funding. That is a big commitment to Derby.

Broome District Hospital will receive $1.7 million for a new computer tomography facility - CT scanner - that is aimed for completion at the end of 2004; recurrent funds for operations provided by the WA Country Health Service in the 2004-05 business plan; $25 million in new capital works funds over the next three to five years for a staged redevelopment of the hospital to upgrade it to regional resource centre capacity; new and remodelled works for a specialist centre; more acute beds; a coronary care unit; a level 2 neonatal nursery; an additional operating theatre; and a sterilising function in key functional support areas.

Mr M.F. BOARD: How many press releases does the minister have?

Mr J.A. McGINTY: An outline brief has been completed to assist the Department of Housing and Works appoint project consultants. A functional brief is being developed by the Country Health Service planning consultants for completion before the end of July. A non-government provider is developing the long-awaited residential aged-care facility in Broome with a one-off contribution of capital from the Kimberley investment fund of $2.435 million and with $75 million still to be paid. Construction is pending resolution of land issues in the area.

We are aiming for a major redevelopment of the Fitzroy Crossing District Hospital on the existing site and a co-location partnership with the local cultural health service. Planning funds have been allocated in the 2004-05 health budget for capital works. The concept master plan has been prepared and negotiations for resolving the issue of local residential aged care will be under way next month.

We have allocated $8.75 million to Halls Creek for a new acute bed facility comprising four step-up and step-down care beds. Tenders have closed and contracts have been signed for construction. The builders are on schedule to commence in June. A new six-bed residential care facility, owned and operated by the Halls Creek Peoples Church Frail Aged Hostel, has now been completed with assistance from the Kimberley investment fund of a grant of $750 000 and $570 000 for new staff accommodation.

A new $2 million, 10-bed residential high-care facility is planned in Kununurra, with an expected completion date of September 2005. The purchase of two four-bedroom houses for $550 000 for support staff accommodation at the new facility has been completed. An additional $370 000 will be provided to construct two two-bedroom apartments for staff. Site issues for that project are being worked through with the shire. Part of the $8.5 million committed for upgrading facilities in Kununurra and Wyndham will go to expanding the laundry workshop stores, additional acute care beds and expanding primary health care at the Kununurra District Hospital campus. An amount of $400 000 is budgeted for a new dental clinic.

Mr M.F. BOARD: Just put it in an e-mail!

Mr J.A. McGINTY: But there is more! In Wyndham - which pretty much completes this swing through the massive rebuilding of all health care facilities in the Kimberley - I am sure the people in the Kimberley will be delighted to hear that part of the new $8.5 million budget commitment for Kununurra and Wyndham will upgrade Wyndham's health facilities. Planning for this new project has not yet commenced, but about $4.5 million will be provided to upgrade those health facilities. I am sure everyone in the Kimberley will be delighted to hear that.

[12.20 pm]

Mr J.B. D'ORAZIO: The minister forgot to answer the second part of my question, which was the about the progress of the Telstra burns and reconstruction centre at Royal Perth Hospital.

Several members interjected.

Mr J.A. McGINTY: I will answer if I can, Mr Chairman. The State Government will provide $2 million -

Several members interjected.

The CHAIRMAN: Order, members! The minister's answer cannot be heard. Please allow the minister the opportunity to respond.

Mr J.A. McGINTY: The State Government has allocated $2 million for the construction of the facility, and I must say that it is particularly appropriate that we talk about this matter today in the light of the arrival of four burns patients from the Port Hedland gas explosion and their treatment at the Royal Perth Hospital facility. A further $1 million, additional to the $2 million allocated by the State, is being provided by Telstra. The new facility will provide world-class outpatient care and surgical intervention for reconstruction. Clinical research will also be undertaken in this facility. It will be the best in Australia; in fact, it will be unique in Australia. It is a tribute to Dr Fiona Wood and the great work that she does at the burns unit at Royal Perth Hospital. Functional and operational briefs were completed in February 2004 and architects were appointed. Preliminary brick and electrical demolition work has been completed. Major demolition work was due to commence on 19 May. It is expected that major construction will commence at the end of June 2004. The project is due for completion in February 2005 and is currently on target. It is six months ahead of the original estimation. Again, a remarkable achievement.

Mr M.F. BOARD: The minister talked a lot about the Kimberley but he did not mention the Royal Flying Doctor Service in his delivery. The minister had his cuddle with Tony Abbott. There was a sense of glasnost! I could see the minister gritting his teeth.

Mr J.A. McGINTY: I believe "détente" is the current term.

Mr M.F. BOARD: Is the minister able to indicate the reference to the Royal Flying Doctor Service in the budget? Is it true that the State did not match funding for the purchase of the aircraft? An amount of $1.5 million was allocated by the federal Government. It was expected to be matched by the State Government, but it was not. It was taken from the present allocation to the RFDS. Is that correct? Is the minister able to indicate what is this year's allocation to the RFDS? Such is our dependence on the RFDS, is it not time to start adding some regular capital contribution - which the Opposition would support - to the service so that it can build some sort of fund for the replacement of aircraft?

Mr J.A. McGINTY: This question has already been answered in Parliament when it was raised by the member.

Mr M.F. BOARD: Just about every second thing the minister has said today have been asked in the Parliament as well.

Mr J.A. McGINTY: No. This is all exciting new news, which I am sure the people of Western Australia will be delighted with.

The CHAIRMAN: I remind the member for Murdoch that the member for Avon is waiting eagerly to ask his question. Please allow the minister to answer.

Mr J.A. McGINTY: The answer I gave in the Parliament is that the Premier decided that the Government should make a significant capital contribution to the fundraising by the Royal Flying Doctor Service to meet its debts. That was made. In addition -

Mr M.F. BOARD: It still owes $10 million.

Mr J.A. McGINTY: That is fine.

Mr M.F. BOARD: It is not fine.

Mr J.A. McGINTY: It asked us for a donation and we gave it a donation. It was very pleased with the donation. Tony Abbott and I went out to commission the aircraft -

Mr M.F. BOARD: I was there.

Mr J.A. McGINTY: I know; the member had a dark thundercloud over his head as we were celebrating the joyous arrival of a significant improvement in health care services for the people of the Kimberley, with the new plane which is designed to improve the services to the people of that area. The Department of Health makes a regular contribution to the Royal Flying Doctor Service. My understanding was that, in addition to the increased capital grant that the Government made to its fundraising endeavours, the $500 000 a year that is generally allocated to the Department of Health was allocated towards the purchase of the aeroplane. Therefore, the cost was met. To answer the member's specific question, page 566 of the *Budget Statements* shows the amount included under the average cost per other non-government organisations not included in the outputs.

Mr M.W. TRENORDEN: It is interesting that the minister provides precise details about the Kimberley, but he cannot do the same for the south west. I think that is appalling.

Mr J.A. McGINTY: The south west or other country areas?

Mr M.W. TRENORDEN: I would like my first question of the day about country and regional services answered. The minister can do it for the Kimberley because the Government looks like losing that seat. For every other seat, the minister will not commit. I want to raise two issues but I do not see them in the budget papers. As such, I refer to the total vote. One is about the settlements for court cases. I do not see a line item. What payments were made from the health budget to individuals in the current financial year and what is the estimate for the next financial year? How many cases are related to King Edward Memorial Hospital? My second question relates to the Silver Chain Nursing Association services in the south west and Leonora. At one stage the services were facing a cut. I see no mention of them in the budget. Has the question of cutting the services been settled? In other words, are the services expected to receive their normal allocation plus an increase for inflation?

Mr J.A. McGINTY: The Leader of the National Party knows the rules. If a member cannot point to a line item, he cannot ask a question.

Mr M.W. TRENORDEN: I have.

Mr J.A. McGINTY: He has not. He prefaced his remarks by saying that he could not find a line item.

Mr M.W. TRENORDEN: I want to know what part of the figure relates to the two items. That is the line item.

Mr J.A. McGINTY: I will answer the first question posed by the Leader of the National Party when he sought details of Western Australian Country Health Service's capital works in areas other than the Kimberley.

Mr M.W. TRENORDEN: I do not want capital works, I want recurrent funding.

Mr J.A. McGINTY: The objection was raised to the capital works in the Kimberley. The member wanted to know about other country areas in Western Australia.

Chairpersons of the local district health advisory councils participated in an inaugural network meeting in May 2004. A review of the patient assisted travel scheme and other transport issues impacting on access to health services is also being conducted through the Western Australian Country Health Service. With regard to the mid west and Murchison, the total cost of the redevelopment of the Geraldton Regional Hospital is $49 million, and the estimated completion date is April 2006. There is a review of existing facilities at the Morawa District Hospital, with a view to replacing facilities. It is not on the current capital program, but community consultation has commenced. In the non-capital area, the new salaried medical service arrangements are being implemented at the Geraldton Regional Hospital. In the Pilbara-Gascoyne region, an amount of $1.55 million for redevelopment of the Carnarvon Regional Hospital has been allocated from the capital works program. The first stage of the new 54-bed high and low care aged facility in Port Hedland has been allocated $11 million in the capital works program. Provision is also made for stage 2 of the Port Hedland Regional Hospital replacement project, which will be on a new site in South Hedland, with an allocation of $65 million from the capital works program. A new service delivering health models is being implemented in Paraburdoo and Wickham.

Mr M.W. TRENORDEN: I can read all those things in the budget; I do not know what the minister is doing.

Mr J.A. McGINTY: The Moora District Hospital will be replaced with new multipurpose health facilities, at an estimated cost of $6 million allocated from the 2004-05 budget.

Mr M.W. TRENORDEN: What is the recurrent expenditure in each health district?

Mr J.A. McGINTY: The member should resist having a cheap shot. I am going to answer the question.

Mr M.W. TRENORDEN: It is not a cheap shot.

Mr J.A. McGINTY: Redevelopment is planned to enhance facilities at the Merredin District Hospital as part of the Western Australian Country Health Service's role in the delineation framework. In the non-capital area, commonwealth funding has been received to undertake a review of aged care and multipurpose services. A reconfiguration of services will be undertaken at the Dumbleyung multipurpose service. In the great southern, the upgrade of the paediatric ward at the Albany Regional Hospital has been completed at a cost of $1.1 million. A business case to undertake master planning is currently being prepared for the potential redevelopment of that hospital. In Denmark, which I visited yesterday, negotiations are continuing with the shire and the local community about the site of the new hospital and aged care facility. A reconfiguration of health services is currently under way in Gnowangerup. In the goldfields and south east coastal areas, a business case to undertake master planning is currently being prepared for the Kalgoorlie Regional Hospital. The Esperance District Hospital has been flagged for redevelopment as its role is integral to capacity building in Kalgoorlie. A business case to undertake master planning is being prepared. The replacement of the existing Warburton clinic will occur at an estimated cost of $2.8 million. A new health facility at Ravensthorpe was completed in 2003. Changes will be made to increase the capacity of the dialysis unit at the Kalgoorlie Regional Hospital. The WA

Country Health Service, in partnership with the Eastern Goldfields Medical Division of General Practice Ltd, is to link into GP practice networks to improve the access to and flow of patient information between the hospitals in Kalgoorlie, Esperance, Laverton, Leonora and Norseman. The GP and specialist practices and the Australian Government Department of Health and Ageing is funding this project. That deals with the member's first aside.

[12.30 pm]

Mr M.W. TRENORDEN: It does not. I want to know the recurrent expenditure of each of the country outlets.

Mr J.A. McGINTY: The member asked me that and we have dealt with it.

Mr M.W. TRENORDEN: I refer to page 543 of the *Budget Statements*. How much of the estimated total of $2.6 billion in 2003-04 was spent last year in payment of court and out of court settlements of cases relating to health? What percentage of that money was spent on the King Edward Memorial Hospital? How much of the estimated total of $2.8 billion for health in 2004-05 is expected to be spent on court cases and out of court settlements? How much of that is related to KEMH? The funding of the Silver Chain nurse stations -

Mr J.A. McGINTY: Can we deal with KEMH first? I undertake to provide as supplementary information past and future provisions with regard to settlements, with particular reference to the King Edward Memorial Hospital.

[*Supplementary Information No A59*.]

Mr M.W. TRENORDEN: I refer to the Silver Chain nursing services. I have looked through the budget. Of the $2.8 billion, will those 10 stations that have been concerned about their budget allocation receive their standard allocation plus inflation?

Mr J.A. McGINTY: Last year, the Government provided a 20 per cent increase in funding to Silver Chain for its remote nursing post program. Its provision for this year has not been broken down as part of the allocation to the WA Country Health Service.

Mr M.W. TRENORDEN: Has the Government requested that those services ask the community to fund the shortfalls, or has that request been dropped?

Mr J.A. McGINTY: We are not making that request.

Mr M.W. TRENORDEN: The request has been made at 10 different locations.

Mr J.A. McGINTY: I cannot answer that.

[Mrs D.J. Guise took the Chair.]

Mr M.F. BOARD: I refer to the implications of some of the structural and administrative changes under the Reid report with regard to a two-zone - north and south - health system. I refer to the *2004-05 Economic and Fiscal Outlook* under major directions to the northern and southern tertiary hospitals. What is the rationale for not including an eastern zone, and what are the ramifications of that? A great deal of costs and administrative reform came out of the Health Administrative Review Committee report, which has only just been bedded down. We are yet to see the real benefits of the administrative reforms under HARC. The Government is now proposing further administrative reforms as a result of the two-zone system. When is that due to be commenced, or is that dependent only upon the physical changes of when the Royal Perth Hospital and Sir Charles Gairdner Hospital amalgamate and so forth? Which comes first: is it the administrative or physical changes? Why has an eastern zone been omitted? That strategy will cause some conflict in the community.

Mr J.A. McGINTY: I will make two points. The first is that from 1 July the Government will reconfigure the metropolitan health regions into two regions: a northern and a southern region, as recommended by Professor Reid in his report. That is meant as a clear indication to everyone that the Government is serious about implementing the Reid recommendations. That is when the first significant step will be taken at an administrative level. Secondly, an eastern region has not been maintained because health services should relate to the public need rather than to where a building happened to be erected in the past. The current configuration of health services is artificial. That is based on where hospitals were historically built. The Royal Perth Hospital is located north of the river and yet it supposedly services areas east of Perth. The natural popular understanding of the geographic division in Perth is north and south of the Swan River. We can deliver services more efficiently by accepting what is natural and where the public live rather than where hospitals were historically built. The key recommendation of the Reid report, so far as the future of the health services in the metropolitan area is concerned, is to overcome the competition and duplication between the Royal Perth and Sir Charles Gairdner Hospitals. Much of the State's health resources are eaten up by those two hospitals, which are just a

couple of kilometres apart in the central metropolitan area. They bear no relationship to where people live. Members of the other side of politics strongly advocate disbursing hospital services to where people live.

Mr M.F. BOARD: Absolutely.

Mr J.A. McGINTY: The way to do that is by addressing the problem of the Royal Perth and Sir Charles Gairdner Hospitals. A point was made in response to a pointed question from the member for Rockingham earlier about the provision of lung transplant surgery. One of the key components of the expansion of services to lung transplant surgery is the acceptance by the physicians at Royal Perth and Sir Charles Gairdner Hospitals of the recommendation in the Reid report to integrate those services. History is the reason the current health regions have been divided into three regions. It is more sensible to divide the health regions into north and south, which is what the Reid report recommended. That is the way the Government will reconfigure the hospitals from 1 July.

Mr M.F. BOARD: In Midland, for example, the bulk of the city is south of the river.

Mr J.A. McGINTY: Technically that would be located in the northern region.

Mr M.F. BOARD: It would be. Is the river not being used as the border?

Mr J.A. McGINTY: In the upper reaches, it is a matter of which creek is counted. If a place is north of the river, it will fit into the region north of the river. We will use the Swan River substantially as the divider, not whether a place happens to be located on the left or right bank of it.

Mr J.H.D. DAY: The problem is the minister does not know much about the eastern region. The eastern region has been ignored.

Mr M.W. TRENORDEN: The minister knows that I have paid a fair bit of attention to the Reid report. I have read it and support much of it. When Professor Reid was questioned in the briefing that the Government provided, he said that the output and population-based model would deliver significant increases to country health services. Does the minister agree with that proposition? If he does, is it reflected in the budget papers?

Mr J.A. McGINTY: It is hard to see immediately where that broad understanding is reflected in these budget papers. It reflects Professor Reid's view of the way the services ought to evolve. What is reflected is that significant funds will be allocated to the major regional cities to enable people to be treated in those regions. I refer the member to "indicative timeframes for capital investment in health" on page 547 of the *Budget Statements*. The existing district or regional hospitals in each of the major regional centres of Albany, Bunbury, Kalgoorlie, Geraldton, Port Hedland and Broome will be upgraded into a major resource centre for health in those areas. The Government will provide many more health services in those areas so that people will not be required to visit Perth for treatment; they will be required to go to their regional capital.

[12.40 pm]

Mr M.W. TRENORDEN: In that same argument, the Reid report steps down with the benchmarking, so that the Northam and Kununurra hospitals have another level or benchmark beneath them. If that were extended, would it be reflected in the recurrent funding? That is what we will talk about. I concede that the capital funding and the funding for the services the minister has spoken about are in the budget papers. There are at least two or perhaps three step downs from a subregional area like my home town to a less subregional area such as Bruce Rock and down to nursing posts such as the one at Leinster.

Mr J.A. McGINTY: Some reflection of that can be seen in the major capital works on page 547.

Mr M.W. TRENORDEN: I am not talking about that; I am talking about service delivery.

Mr J.A. McGINTY: Yes. There is also reference on page 545 - the second last heading - to the outcomes from the Reid report of better accountability, resource allocation and governance.

Mr M.W. TRENORDEN: I have read that. That is why I am asking the question. It does not provide a dimension that people can follow. I agree with the view that it is benchmarked. I agree with what the minister is trying to do in the metropolitan area and in places such as Albany and Geraldton. However, it does not flow through in the paperwork to the next level. There are really three steps down from there to Leinster.

Mr J.A. McGINTY: I think that is what we will see emerge in future budgets. The Leader of the National Party should bear in mind that the Reid report was handed down at the end of March. It is now May. We do not have the capacity to pick up and immediately implement all the recommendations of the Reid report. People know that it will take some time for things to be done, which will flow on into the different communities.

Mr M.W. TRENORDEN: Or that there is a lack of interest; that is the question I am asking.

Mr J.A. McGINTY: No, far from it. The member will find a very strong commitment on our part to the Reid report and implementation of its recommendations.

Mr M.W. TRENORDEN: I am trying to support the Government on that.

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

Mr M.W. TRENORDEN: However, the minister is not making it easy at times.

Mr J.A. McGINTY: There you go. The Reid report is two months old. We need to set up the major structural changes. I indicated to the member for Murdoch the 1 July metropolitan division for the restructuring of the north-south model. That raises issues about which I will need to meet with people, such as the impact that Bentley Hospital, which is designed to be part of the southern region, will have on the provision of aged care and mental health services to people in the northern region. We will need to develop a means of phasing in new arrangements to make sure that there is no dislocation of service provision, because this should be about patients and not institutions.

Mr M.W. TRENORDEN: And benchmarking, so that people know where to go. I agree with the minister that that is the current problem. There is great confusion about where people should go. It needs to be properly constituted so that people know where to go, even if it is to the Leinster nursing post. That is the point.

Mr J.A. McGINTY: My point is that to the extent that it flows on from the Reid report, it will take some time. When we announced the first Reid initiative, which was the provision of 150 extra beds at Rockingham-Kwinana District Hospital, we were criticised for not doing it immediately. There was some expectation that we should not plan or get any approvals.

Mr M. McGOWAN: Build it and then plan it.

Mr J.A. McGINTY: Built it first and then plan it! Go to the supermarket to get some bricks and I will start to lay them immediately! People were asking why we had not done that and why we would spend a year planning it. That was the nature of the criticism.

Mr M.F. BOARD: The Reid report was about three years too late. That was the issue.

Mr J.A. McGINTY: It may well have been. Nonetheless, we must deal with the reality of what we have. We now have the Reid report. A lot of interest groups will be pushing and shoving along the way. As long as whoever is in government does not lose the focus on patients, the Reid recommendations will be implemented well. It will take some time for some of these other matters to come through.

Mr M.P. WHITELY: What plan does the Department of Health have to deal with disasters or a major incident?

Mr J.A. McGINTY: I thank the member for Roleystone for this question, unlike some of the others he has asked today!

Mr M.P. WHITELY: Am I back in the good books?

Mr M.F. BOARD: Press release No 62.

Mr J.A. McGINTY: We are organised. The question is often posed of what is our preparedness and capacity to properly deal with a disaster. The Department of Health established the Disaster Preparedness and Management Unit in October 2003 to focus and integrate the department's response to a disaster or major incident. That unit is supplemented by the revitalised State Health Disaster Management Committee, which brings together the key health stakeholders to facilitate preparedness across the system, and functions as the operational committee in a disaster. The Department of Health, through the DPMU, has taken action in a number of areas to prepare for a major incident or disaster. That is crucially necessary in the contemporary world. That has included the State Health Disaster Management Committee and its subcommittees developing external disaster site and hospital health coordinators, and a chemical, biological and radiological response. Exercise and training subcommittees are now meeting on a quarterly basis. A state health emergency operations centre has been established in the department's East Perth offices to coordinate any health response. The state health disaster plan, called Westplan-Health, has been totally revised and will be presented to the State Emergency Management Committee on 8 June for endorsement. As part of an Australian Health Ministers' Conference initiative, Western Australia and New South Wales are developing the national burns plan and the national burns standard and educational proposals. That obviously flows from the great success of Western Australia's response to the Bali attack, and the way we were able to lead the nation in dealing with burns victims. DPMU recently audited its state health disaster response capability and critical infrastructure and has developed supporting databases to monitor that capability. The department is working with the Fire and Emergency Services Authority of Western Australia to develop decontamination capabilities for all major hospitals, particularly for patients with chemical or

radiological contamination. It is anticipated that by the middle of the year the four major hospitals and two of the secondary hospitals will have some decontamination capability. We are attempting to be proactive to make sure we have the capacity to deal with something we all hope will never occur; that is, a terrorist attack or major chemical or other disaster that might beset the community. We are confident that with these initiatives, the Department of Health will be in a position to respond well. We learnt a lot from the Bali terrorist attack. The way in which Royal Perth Hospital in particular led all hospitals in Western Australia in that response was applauded internationally. We will be in a position to respond to any disasters that occur in the future as a result of having this plan in place.

Mr J.H.D. DAY: I refer to the capital works program on page 582 and in particular to the redevelopment of Kalamunda District Community Hospital. I also refer to the indicative time frames for capital investment on page 547. Where on that page is the redevelopment of Kalamunda District Community Hospital included? It is not specifically mentioned.

Mr J.A. McGINTY: Page 547 provides the longer-term capital proposals, and includes everything. It was designed to give, as best as we could in the short time since the Reid report became available, a strong indication of when we propose to implement the various Reid recommendations. I would rely on the entry on page 582, which lists the Kalamunda hospital redevelopment as having a total cost of $5.5 million, with $825 000 expended up until the end of this financial year and further amounts allocated from there.

Mr J.H.D. DAY: Given that the estimated total expenditure for 2004-05, which appears at the bottom of both columns to which I referred, is the same - namely, $162.1 million - the Kalamunda redevelopment is presumably included on page 547 but under something else. Am I correct in assuming that?

Mr J.A. McGINTY: Yes.

Mr J.H.D. DAY: The Government is making the redevelopment contingent upon the more than halving of the number of beds from 53 to 25, and the removal of obstetric and most surgical services. Those changes are making the local community in the Kalamunda district very angry. I do not believe those changes have been justified on good clinical grounds, but I will not get into a debate on that now.

The CHAIRMAN: Will we hear a question any time soon?

[12.50 pm]

Mr J.H.D. DAY: When do you propose to remove those services?

Mr J.A. McGINTY: We recently received correspondence from the General Practice Divisions of WA that said it would be inappropriate to take any action in respect of those services at Kalamunda District Community Hospital until such time as there were in place adequate provisions for obstetrics services in the other hospitals, particularly Swan District Hospital. I agree with that view and I intend to implement all the Reid recommendations in that manner; that is, nothing will be shut until there is a replacement facility, and I say that in a general sense. Obviously, there might be some minor adjustments around the edges. However, as a general proposition, we will ensure that the new facilities are in place into which existing services can transfer. I have had some discussions with Mr John Burns, Chief Executive of the East Metropolitan Health Service, about the need to significantly upgrade the obstetric services at Swan District Hospital, and I have asked him to adjust the capital works budget to accommodate that. That will obviously take some time to achieve. It is an unreasonable request to say to the people of Kalamunda that we want their obstetric services to, in future, be provided at a facility at which the physical infrastructure is not up to the standard that they have enjoyed at the Kalamunda District Community Hospital. I think that is a reasonable position.

We intend to embark upon as a matter of priority, by that I mean in this calendar year, a significant upgrading of the obstetrics facilities at Swan District Hospital. That will include things like the installation of en suite facilities and an appropriate birthing facility, which will involve a significant investment of funds into Swan District Hospital. Again, it is consistent with the implementation of the Reid report, which will be the guiding principle in the way in which we allocate these moneys.

Mr J.H.D. DAY: Can the minister clarify when he expects that to occur?

Mr J.A. McGINTY: I will ask Mr Burns to give us a date on that.

Mr BURNS: I would expect it to be in 12 to 18 months. We are just working through a capital program now, and we will not really know the time line until we get the detailed architectural plans. I suspect it will be in 12 to 18 months.

Mr J.A. McGINTY: For completion?

Mr BURNS: Yes, for Swan District Hospital.

Mr J.A. McGINTY: It will be completed in that time frame and obviously started, I would have thought, this year.

Mr J.H.D. DAY: So will no changes be made at Kalamunda prior to the completion of those works at Swan District Hospital?

Mr J.A. McGINTY: Yes, there will be, and it is good news from the member's point of view.

Mr J.H.D. DAY: I mean changes in respect of removing obstetrics services at that hospital.

Mr J.A. McGINTY: The intention is that nothing will be done until adequate replacement facilities are in place. To follow up on the next element of that question, the intention is to look at the way in which we can bring forward the allocation for the upgrading of Kalamunda District Community Hospital and get that under way. The member has made the point to me on a number of occasions that this has been going on for too long. Consistent with our view, we are keen to get in and spend that money that has been allocated in the budget for a large number of years and to commence that upgrading.

Mr J.H.D. DAY: It was originally allocated in 2000.

Mr J.A. McGINTY: It has been there for too long, and we are keen to bring that money forward. It is a matter of looking at the budget and seeing how we can do it, which is something that has been discussed between us since the budget was handed down. I anticipate some movement on bringing forward the upgrading of the Kalamunda District Community Hospital facility, but as Mr Burns has indicated, it will be 12 to 18 months before the upgrading of the obstetric services at Swan District Hospital are completed, and no action will be taken prior to that.

The other dimension to the Kalamunda issue is the interest shown by the local general practitioners in establishing a primary medical centre on the site of the hospital. I have asked Mr Burns to expedite all matters related to that, including the transfer of the land -

Mr J.H.D. DAY: The problem is that they will not do that if services, including obstetrics, are removed from the hospital.

Mr J.A. McGINTY: That is a matter we will need to discuss with them to ensure that their interest remains. I want to see this matter progressed, and we will certainly have discussions with the general practitioners in the area to see if we cannot make sure that the land is made available for them to go ahead with their capital works construction. They needed some certainty that the land would be available and what the price would be, and that is what we are going to at least finalise.

Mr J.H.D. DAY: They also need some certainty about the services provided at the hospital. I also asked about the removal of the multi-day surgical services. Can the minister comment on the timing of that?

Mr J.A. McGINTY: The provision of multi-day surgery, I thought, had been substantially resolved. I thought that had ceased to be a major issue of contention, however, there might well be some issues with that. Some multi-day surgery will continue to be performed at Kalamunda District Community Hospital.

Mr J.H.D. DAY: That is different from what had previously been publicly expressed. Mr Burns is trying to get the attention of the minister -

Mr J.A. McGINTY: He might well do.

Mr J.H.D. DAY: The minister might well ignore him, obviously. The stated intention, as the minister previously expressed, was that obstetrics and multi-day surgery services would be removed at some stage. Is the minister now saying that multi-day surgery services will not be removed?

Mr J.A. McGINTY: The local GPs and people from the hospital are aware that there have been some discussions about accommodation on the question of multi-day surgery.

Mr M.F. BOARD: I refer the minister to page 553 and the total of appropriations under output 1, prevention and promotion. I draw the minister's attention to the summary, about which I have two questions. First, it appears that the minister will underspend his budget allocation by $4 million. I assume that is because of the increased revenue from ordinary activities of $5 million over expectation. Where has the $65 million in revenue for promotion and prevention come from, and why has the revenue increased by $5 million? Second, even though there is an increase of about $11 million in the 2004-05 allocation compared with the allocation for 2003-04, where will that be spent? I do not see any particular program in here, even though we have raised this issue in the Parliament a number of times, that specifically deals with obesity, particularly young people's obesity.

According to commonwealth figures, this now affects one in four young people in Western Australia. It will be a huge problem in the future. I hope that some of those additional resources might lead to the establishment of a program to deal with that issue. Can the minister comment on that?

Mr J.A. McGINTY: I defer to Mr Michael Jackson to answer those questions.

Mr JACKSON: The question regarding child obesity is of concern to us in Western Australia and nationally. The National Obesity Task Force is addressing the issue and we have been doing work akin to that in Western Australia. We have established a major program that is looking at chronic diseases across the board and is covering the areas of prevention. Chronic diseases, such as cancer, cardiovascular disease and diabetes, affect our community. Unless we take initiatives now, particularly with young people, those chronic diseases will be a further burden on our society. We have undertaken a number of initiatives, of which the member will be aware, through health promotion programs. These are based in schools and include, for example, the Start Right - Eat Right program, which deals with nutrition, physical activity and a range of other areas.

Mr M.F. BOARD: Thank you for that, Mr Jackson. I am aware of what Mr Jackson has said but it did not answer my question. First, where has the $65 million in revenue for prevention and promotion come from? The total cost of the output, according to the *Budget Statements*, was $307 million, less revenues from ordinary activities of $65 million. The total spent was $241 million, which was $4 million less than expected; therefore, where have those revenues come from? These programs are obviously failing because obesity is rapidly on the increase in young people. I suggest to the minister that the increase of $11 million might target this area in particular. It will be a huge cost to the public health system if we do not rapidly become further involved in this area and push the public message.

[1.00 pm]

Mr J.A. McGINTY: The member's question relates to changes in funding for commonwealth programs. Mr Jackson might be able to give more particulars on that.

Mr JACKSON: The funding we receive for a number of our programs comes under the Public Health Outcome Funding Agreement. This covers many of our population health funding programs from screening for breast cancer and cervical cancer, through to women's health and into many of our prevention programs. That funding agreement has recently been renegotiated for a further five years. The arrangement is that there is a matching of funding between the Commonwealth and the State. The total funding is approximately $30 million. That is the total for that matched funding.

Mr M.F. BOARD: Is that $30 million each for Commonwealth and State?

Mr JACKSON: No, that is the total. The PHOFA funding for the next financial year is in the order of $14 million. There is immunisation funding on top of that. The Public Health Outcome Funding Agreement provides a lot of the funding we are able to divert into population health and prevention programs.

Mr M.F. BOARD: What Mr Jackson has just said does not really answer the question.

Mr J.A. McGINTY: If the member likes, I can provide the answer by way of supplementary information.

Mr M.F. BOARD: There is $65 million worth of income, and he is talking about $30 million coming in, so where does the figure of $65 million come from? Secondly, if we have underspent by $4 million in this area, notwithstanding the income, there is a surplus in the health budget, is there not?

Mr J.A. McGINTY: We started out with a projected deficit of $136 million.

Mr M.F. BOARD: The Government has underspent in this area, according to these papers.

Mr J.A. McGINTY: Can the member please particularise the question so that I can provide the answer by way of supplementary information.

Mr M.F. BOARD: I refer the minister to the total cost of outputs in 2003-04 for the prevention and promotion area listed on page 553. I would have thought it was fairly clear. It is right there for us to see. The total cost of outputs for 2003-04 is $307 million, with some extras. The total revenue is shown as $65 million, so the total output is $241 million, which is a bit over $4 million less than budgeted.

Mr J.A. McGINTY: I undertake to provide supplementary information in response to the matters raised by the member for Murdoch.

The CHAIRMAN: Will the minister reiterate, for the record, what he is agreeing to provide?

Mr J.A. McGINTY: I will provide an explanation of the net cost of outputs shown at the foot of page 553 of the *Budget Statements*.

[*Supplementary Information No A60.*]

The CHAIRMAN: For the benefit of members who are in any doubt, this session actually finishes at 2.00 pm, not 1.00 pm. The member for Ballajura has a question I believe.

Mr J.B. D'ORAZIO: I have a list of questions, and I am glad to have the opportunity to ask them.

Mr M.W. TRENORDEN: I have 30 or 40 questions.

The CHAIRMAN: I suggest that if members keep their questions to the minimum, we might actually get through them and maybe finish early.

Mr J.B. D'ORAZIO: I would love to keep my questions to the same length as those of the member for Murdoch! I refer to the first dot point on page 546. Interestingly, there has been much discussion in the media recently about security for nurses and other hospital staff. Can the minister explain what improvements have been made in protecting health workers? I am a pharmacist, and I know what it is like to be held up seven times. I can tell members that it is not much fun. Can the minister explain what improvements have been made to security for people working in the health area?

Mr J.A. McGINTY: I thank the member for Ballajura for the question.

Mr M.W. TRENORDEN: Of course you do - you wrote it for him!

Mr J.B. D'ORAZIO: Can the member not see the depth of that question? How could it possibly have been written by the minister?

The CHAIRMAN: Order, members! You will be here until 2.00 pm at this rate.

Mr J.A. McGINTY: The Swan District Hospital mental health facility has been the focus of much of the public concern about the safety of nurses, following the brutal bashing of psychiatric nurse Debbie Freeman some months ago. As I have reported to Parliament on previous occasions, the Government has dealt with WorkSafe notices and has employed a security consultant, Mike Baker, to advise on the best way to implement improved security for the nurses at that facility. We have also now engaged directly with all elected health and safety representatives at that site, who are meeting regularly with management to consider each of those reports that has been made available and to look at ways in which security satisfactory to the staff can be provided, primarily to the nursing staff at the Swan District facility. We are also aware that there is a system-wide ramification here. One of the things that has become apparent is that different levels of security are provided on a site-by-site basis, and a system-wide approach is needed. At the Armadale-Kelmscott Memorial Hospital, which in some senses is similar to Swan District Hospital, on-site security is provided. It has not been provided at Swan District.

Mr M.F. BOARD: Does that involve security guards?

Mr J.A. McGINTY: There are various forms of security, but principally it involves security guards. The Government has moved with great urgency because of the situation that presented itself with the bashing of Debbie Freeman, and recurred in the case of an acutely ill mental health patient in recent weeks. As of six o'clock this evening, on-site security will be provided through MSA Security (WA) Pty Ltd for a period of eight weeks. This is to ensure that contract security people are on-site in the emergency department and able to respond to the mental health unit at appropriate times. It will give us time to make sure that a proper training and long-term regime is implemented to protect the nurses and others at the Swan District Hospital. The hours of operation of the security service will be Monday to Friday 8.00 am to 6.00 pm; Monday to Thursday, 6.00 pm to 8.00 am; and Friday to Monday 6.00 pm to 8.00 am. Generally, there will be two guards, although during daylight hours there will sometimes be only one.

Mr M.W. TRENORDEN: Would it be better to not tell people what the hours of operation are?

Mr J.A. McGINTY: Possibly, but I am trying to provide as much information as I can, and we should do that in the House. Otherwise I agree with the member. The contract cost with MSA for the eight-week period is $58 134. As I mentioned previously, the contract will operate from 6.00 pm on Friday 21 May. That deals with the on-site security issue, which we needed to treat as a matter of some urgency. Equivalent facilities already have that security, so we wanted to get something in place as a matter of urgency.

The other issue is mobile duress alarms. The area chief executive officer John Burns has advised me that personal duress alarms will be provided as a matter of urgency, and I expect they will be available to the staff within days. Again, that is to be done on an interim basis pending proper agreement with the staff about the way in which better on-site security arrangements can be implemented, in particular personal duress alarms. In

respect of my prison portfolio, I know that civilian staff and others in prisons have carried personal duress alarms when dealing with prisoners, many of whom, especially in Casuarina Prison, are violent or potentially violent. The staff have carried personal duress alarms for a considerable period, and we should offer the same level of protection, at least, to our nurses.

Mr M.F. BOARD: The minister has answered my supplementary question, where do I stand on the list?

The CHAIRMAN: In that case you will have to wait until the member for Rockingham and the Leader of the National Party have asked their questions, and then you are on the list. I will go to the member for Rockingham.

[1.10 pm]

Mr M. McGOWAN: I have an interest in regional health services.

Mr M.W. TRENORDEN: When did the member develop that?

Mr M. McGOWAN: In an earlier answer, the minister expounded a range of improvements in regional health services, including rebuilds at a range of hospitals and additional capital works at a huge number of hospitals around the State. Page 572 of the *Budget Statements* outlines a new chemotherapy unit to be set up at Northam Regional Hospital. I am interested in the fact the Government is addressing cancer in Northam and the general Avon district. Chemotherapy services providing acute and outpatient-based services will also be provided at Narrogin. In light of the earlier discussion, it would be interesting to hear what the Government is doing in the Avon region, which is very important to the State and this Government in particular.

Mr M.W. TRENORDEN: Before the minister answers, the Northam Regional Hospital is going very well; I thank the minister. It is great to have a good, stable system at Northam. The procedures there are good, as is the case at York. I cannot say about Narrogin.

Mr J.A. McGINTY: I thank the Leader of the National Party for his comment. I ask Christine O'Farrell to comment on the provision of chemotherapy services in those two communities.

Mrs O'FARRELL: I have not come prepared for the information the member is looking for. I will have to provide it by other means.

Mr J.A. McGINTY: I am sorry that we cannot provide more information to satisfy the member's interest in regional health.

Mr M. McGOWAN: Perhaps the question answered itself in that the new chemotherapy clinic is being provided in the electorate of the member for Avon.

Mr J.B. D'ORAZIO: And he is appreciative of it.

Mr M. McGOWAN: It is good that he appreciates that improvement in services.

Mr M.W. TRENORDEN: I have said I appreciate it; that is right.

I refer to Page 547 of the *Budget Statements* and the indicative time frame for capital investment for health. Under country and south west hospitals, a line item appears for "various" health centres in a 12-year program commencing in 2005-06. The allocation is $166.7 million. Can the minister tell us what the "various" services are? Supplementary information would be fine. A range of programs is involved; I would like to know what they are.

Mr J.A. McGINTY: I can answer that question now. This is part of the Reid recommendations for the upgrade of facilities. For instance, the papers make no reference to the upgrading of Kalgoorlie Regional Hospital, and I suspect nothing appears for Bunbury Regional Hospital. Both those hospitals are intended to be upgraded to regional resource centres. The figure cited is the total allocation agreed upon to implement the Reid recommendations for health services other than the high-profile ones, or those upon which indicative time frames were given. In the short time since the Reid report was released, no time frame has been put on these facilities. The allocation is our estimate of what is required to implement the other Reid recommendations.

Mr M.W. TRENORDEN: I understand that. What are we talking about with the other facilities?

Mr J.A. McGINTY: Other that the two mentioned, I am not able to provide more information; otherwise, it would have appeared in the budget papers.

Mr M.W. TRENORDEN: When will we find out? Interestingly, a precise figure was produced, but the minister cannot not tell us what services will be provided - other than the two mentioned. When will the minister be able to tell us?

Mr J.A. McGINTY: It will be later in the year, once we get further into the implementation of the Reid report recommendations. We are considering every way to implement the Reid philosophy; for example, the amalgamation of Royal Perth Hospital and Sir Charles Gairdner Hospital to perform lung transplant surgery announced today, and a number of other matters have been mentioned. I refer to the Rockingham redevelopment and others. An expected time frame is indicated, although I expect some fluidity. As the title suggests, it is an indicative time frame. The Government intends to move fairly quickly to put the Reid implementation team in place. We have not done that yet. I expect it to be fairly soon. We can then put in a more concrete way what is meant and provide more of a time frame and provide more detail as it evolves. I cannot answer the question at this stage. It is a little premature on that aspect.

Mr M.W. TRENORDEN: Can the minister outline the logic of those forward estimates? It outlines $2.5 million, $3.5 million, $3.5 million, $15.5 million, $17.2 million and so on. It peaks in 2010-11, and then the funding drops off. There must be a logic there somewhere.

Mr J.A. McGINTY: I presume there is - but I do not know it. It is not that I am being secretive; I do not know.

Mr M.F. BOARD: My question relates to the commitment to the reconfiguration of hospitals under the Reid report. I refer first to Fremantle Hospital. Some confusion has arisen about the long-term role, if any, at Fremantle with the advent of a tertiary hospital on the Murdoch site, it is assumed, and what will happen to Fremantle, particularly in the interim. Although this facility should have been provided sooner, I notice a budget allocation for the magnetic resonance imaging machine for Fremantle for the next budget year. I presume it will proceed. What capital implications are there for Fremantle over the next 10 years while the other configurations are put in place? The same question could be asked of Royal Perth Hospital. The minister mentioned support, as well as mixed reaction among clinicians, obviously, to those proposals. What are the capital implications for Royal Perth over the next few years? How do we avoid a running down of services until such time as a new hospital or a super-hospital is reconfigured?

Mr J.A. McGINTY: I will answer, and then defer to Dr Shane Kelly to give more particulars about Fremantle Hospital. The general approach is that we do not want services to run down; we want them to expand and to be enhanced.

Mr M.F. BOARD: They will need budget allocations.

Mr J.A. McGINTY: It will be as though they will continue to be provided at that site. For example, the MRI machine at Fremantle will be installed and will be operational in the not-too-distant future. It is necessary to enable Fremantle to operate until the new southern tertiary campus is provided. Similarly, capital money will be spent on ward upgrades so patients will not be required to utilise run-down conditions. As announced today, lung transplant surgery will be undertaken at Royal Perth Hospital. That will continue. The burns reconstruction unit through the burns unit at Royal Perth Hospital is under way. We will continue to maintain and upgrade the facilities until such time as replacement facilities are built. The member for Murdoch will see a number of manifestations of this approach. It is not our intention to do nothing at Royal Perth Hospital and Fremantle, for instance, or at Sir Charles Gairdner, depending on the site of the northern tertiary hospital.

Mr M.F. BOARD: In his heart, does the minister really believe that Royal Perth and Sir Charles Gairdner will amalgamate to one specialised tertiary hospital?

Mr J.A. McGINTY: Absolutely, and without qualification.

Mr M.F. BOARD: Does the minister not see that as an illusion to create a bigger picture of movement in the health system?

Mr J.A. McGINTY: No.

Mr M.F. BOARD: The minister is committed to that proposition.

Mr J.A. McGINTY: As the question is philosophical about how we see matter evolving -

Mr M.F. BOARD: It is very important as it is the key to all the other changes to be made.

Mr J.A. McGINTY: The Australian Medical Association indicated strong support for the idea of the merger of Royal Perth and Sir Charles Gairdner. It left open the question of which site. The clinicians at both institutions, as indicated in feedback to Professor Reid and reflected in his report, support the in-principle merger. I expect from here that people involved in the system will be very concerned about the interim arrangements. However, when confronted with the choice of whether people want to continue to work in the current facilities or whether they want something world class, they will say that, provided the transitional arrangement are in place, they would prefer to work in a larger, world-class facility for their specialty area. I suspect that some difficulties will

arise in determining the site. Difficulties will arise with individuals. That has been an issue whenever the duplication at and competition between Royal Perth and Sir Charles Gairdner has been sought to be overcome. We intend to drive forward with a clear statement about where we stand. As the member noticed at the retiring president's address at the AMA function last night, the call for no dramatic changes in policy direction consequent upon a change of Government is something that has the broad endorsement of the Western Australian community, including the medical community. The medical community wants to see a clear plan and it wants to stick to it and implement it. I expect that we will need to work through those difficulties. I expect that the Liberal Party will announce opposition to the merger of Royal Perth Hospital and Sir Charles Gairdner Hospital; however, that is all part of political posturing that we foresee coming along.

[1.20 pm]

Mr J.H.D. DAY: Like you did before the last election?

Mr J.A. McGINTY: We are steadfast in our resolve to implement the Reid recommendations, other than in respect of Princess Margaret Hospital for Children. The step that we announced today about the two health regions in the metropolitan area - one north and one south - from 1 July is an indication of our bona fides. Members will hear of significant announcements in the weeks and months ahead on the implementation of that plan. The reaction of all the key players is anticipated. We understand where they are coming from, but we do not intend to be detracted from the plan.

Mr M.F. BOARD: But the major budgetary allocations, from what the minister said, in a capital works sense do not really kick in until about 2009.

Mr J.A. McGINTY: I will ask Dr Kelly to explain how the strategy for Fremantle Hospital and the southern tertiary hospital will work. I think that will answer the question on areas generally.

Dr KELLY: As the minister indicated, there are no plans to reduce services or run down facilities in Fremantle Hospital. We need to continue to maintain those services and continue to enhance the existing facilities as required until those tertiary services that are intended to be transferred to the southern tertiary hospital can be transferred. We anticipate that will be some years out. However, obviously, some funding is needed to get on with planning the southern tertiary hospital in the forthcoming financial year and a funding flow from there to develop that facility in the near future at the preferred location of Murdoch. To reinforce what the minister said, those existing services at Fremantle Hospital will continue until the tertiary services that are intended to be transferred are transferred. I confirm, for example, that $4.1 million has been allocated and we have accepted a tender for the purchase and installation of a magnetic resonance imaging scanner. We anticipate that it will be up and running by October this year. We have just completed a major redevelopment of one of the general wards at Fremantle Hospital at a cost of $1.1 million. Another $2.6 million has been allocated for future renovations in the next couple of years, focusing on some areas that need attention. I am really just reinforcing that it is business as usual and there will be a continued development of services until those services that will be transferred - that is, the tertiary services - are able to be transferred when the southern tertiary hospital is built. Obviously, we must continue to maintain the facility at Fremantle even post the development of the southern tertiary hospital, as the Reid reforms state that it is a major player in the provision of aged care, rehabilitation and mental health services and others.

Mr J.A. McGINTY: I add something specific to that answer from Dr Kelly. There are two line items on page 547 of the budget papers that relate specifically to this matter. The first is equipment replacement. Over the years ahead, as part of the Reid implementation, there is provision for $260 million to continue equipment replacement. That will be done in situ. That is one item. Another arguably more important item is "Minor Works - Buildings and Services" for building maintenance - a few lines from the bottom of that page - which has an allocation of another $260 million. Therefore, altogether we are talking about more than half a billion dollars allocated to maintaining buildings and equipment in existing hospitals over the years in the implementation of the Reid review. As Dr Kelly has described it, it is business as usual, with continual upgrades to facilities to ensure we meet the needs of patients until the last day before they are transferred to the southern tertiary hospital.

Mr M.F. BOARD: I have a supplementary question. Dr Kelly mentioned Murdoch as a site for the southern tertiary hospital, which would be good if it is a co-location model. I was disappointed that the Reid report virtually ignored the services and integration in that sense provided by the private sector. It appears that the advantage of the Murdoch site is that it would be a co-location model. Will the Government proceed with co-location models under its reconfiguration of hospitals; and, if so, has the Government considered the Joondalup site as a co-location model?

Mr J.A. McGINTY: Although Reid recommended the southern tertiary campus be at Murdoch, we have received a submission from the Cockburn City Council requesting that consideration be given to Thomsons Lake, which will be the next stop south beyond Murdoch on the railway. The advantage of Murdoch is its proximity to road and rail public transport, Murdoch University and St John of God Health Care facilities. There are other advantages at Thomsons Lake, particularly that in 20 years it will be closer to the heart of where people south of the river live. That is the balance that needs to be considered there. The Department of Health will conduct an internal evaluation of the two sites and I hope that within a few months we will have a firm commitment to a site for a facility south of the river facility. It is a lot easier than developing a north of the river facility for the simple reason that we are talking about a greenfield site.

Mr M.F. BOARD: That is the point I make. Is the Government happy to pursue co-location models?

Mr J.A. McGINTY: Yes. I foresee considerable synergies being developed between the public and private sectors.

Mr M.F. BOARD: We have seen one in the development of the cancer centre; that is an excellent example.

Mr J.A. McGINTY: Yes.

Mr M.F. BOARD: There are huge opportunities in other areas that we have not pursued. Reid did not go down this line. I do not know whether it was in his terms of reference - it should have been - to look at some of those synergies and a better use of public money for getting an outcome. Even tendering arrangements across the sector can be achieved in those senses if the minister pursued them. I will not be attending another estimates committee, therefore I make the point that it is an area in Western Australia that has huge potential. We have not integrated public-private cooperation for the benefit of the public purse - not necessarily for the benefit of the private sector - by moving some of those services closer together.

Mr J.A. McGINTY: In light of the level of détente that is now being experienced in respect of health policy, it is a pity the member for Murdoch will not be around to see it all through. However, Professor Reid said to me that Western Australia has the best private health system in Australia, particularly because of the involvement of St John of God Health Care. I am sure the member for Murdoch would agree with that.

Mr M.F. BOARD: Absolutely!

Mr J.A. McGINTY: The promotion of public hospitals and public health as government responsibilities, which is something I hold very close to my heart philosophically, is something we will continue to do. However, we will continue to seek to gain benefits by the overlap, integration and cooperation between the public and private sectors. The member for Murdoch mentioned the cancer centre, which is a marvellous model. There is a range of things we can do cooperatively, provided that one group of people are borne in mind as the beneficiaries; that is, patients. That is the only question really. That is why I am pleased to see so many of the traditional areas of dispute in health policy cut and falling off.

Mr M.F. BOARD: However, the outcome should be the public dollar going further as a result of that cooperation.

Mr J.A. McGINTY: Absolutely! I come now to the question the member for Murdoch asked about Joondalup. A range of options present themselves at Joondalup and there is a range of limitations caused by the current site. The intention is to develop towards the end of the Reid period - looking at the next 12 to 13 years in that way - a northern tertiary campus, apart from the Royal Perth-Sir Charles Gairdner one, in the far northern suburbs. It may be that the existing Joondalup Health Campus site is the best site to do that on. It may well be that the existing Joondalup site will become a general hospital and there will be the necessity for a new tertiary hospital to be developed in Perth's northern suburbs. That is something for the long term. We are now looking at the more immediate implementation questions. It raises some significant issues of the extent to which private and public can work together and what configuration the Joondalup Health Campus might ultimately take. That manifests itself a little bit in the short term in the split between private and public beds in Joondalup. Given that we intend to expand that facility, we need to determine how that can best be done. I do not have the answer to that at the moment. It is not a question that is exercising our minds at present.

[1.30 pm]

The CHAIRMAN: As the member for Wanneroo, I would like to ask the minister a question. Will it be in the next 10 to 12 years that discussions will occur about the expansion of the Joondalup facility with the hospital moving north to service the urban growth?

Mr J.A. McGINTY: I have just found a reference to that.

The CHAIRMAN: I would appreciate some clarification.

Mr J.A. McGINTY: Provision is made at page 547 of the *Budget Statements* for $24 million to be spent on the Joondalup Health Campus in the years 2005-06, 2006-07 and 2007-08 to upgrade theatres, the emergency department and increase the number of beds to 300. Further down on that page, under the heading of state tertiary hospitals, there is a provision of $181.95 million to construct the new far northern tertiary hospital. We do not have a date as yet. The options that present themselves include the Joondalup Private Hospital moving to another site or that we could develop the Joondalup Health Campus site. A series of possibilities present themselves. It will be when we move to a far north, central and southern model for the provision of health services. In the short term it will be northern and southern.

The CHAIRMAN: Given the growth and development in my electorate, I suggest that the Department of Health look closely at the allocation of land as the developers start to sell their lots. The department might need to grab some land early on.

I think I have abused my position in the Chair enough. I will have a conversation with the minister another time.

Mr J.A. McGINTY: The Reid report has given a real focus within health to the way in which we want to deliver health services in the future. Things like allocating a site for a far northern tertiary hospital in the distant future will become a reality as a result of that report. We will see a number of other consequences flow directly from that.

The CHAIRMAN: I thank members for their forbearance.

Mr J.B. D'ORAZIO: I refer to page 544. Is the minister able to advise what impact is being made on agency nurses in government hospitals in Western Australia?

Mr J.A. McGINTY: I thought the member was going to ask a question about renal dialysis!

Mr J.B. D'ORAZIO: It was asked before!

The CHAIRMAN: Nice try, member. We might come back to him later.

Mr J.B. D'ORAZIO: The minister was asked.

The CHAIRMAN: Was it asked? I have not been keeping up with that.

Mr M.W. TRENORDEN: I refer to the support services listed at page 570. A review of transport services for country patients has been instigated. The minister is aware that most of my electorate is closer to Perth than Mandurah but people in my electorate are not eligible for the patient assisted travel scheme. Outside politics, that is a serious concern. Access to the metropolitan area is by either Brookton Highway or Great Eastern Highway. It means that people have to drive a fair distance. There is a considerable number of people who live less than 100 kilometres from Perth but further than 70 kilometres, which is the distance from Perth to Mandurah. However, I do not want to have a go at Mandurah because people there are entitled to whatever services they can get. It is a big concern in my electorate because people can see others are getting a benefit that they are not receiving. The minister referred to a program a few minutes ago that was not within his portfolio. Improving the *AvonLink* and *Prospector* train services would give the opportunity to link services to Quairading, Wyalkatchem and other towns. I am talking about health services. Those things are not being done. Public transport to get people from country areas to the services they require is quite scarce. People from Quairading who have to travel to Perth are up for a two-day stay in the metropolitan area unless they drive themselves. I would like to know what is happening because it is causing a bit of pain.

Mr J.A. McGINTY: In a moment I will ask Mrs O'Farrell, who is responsible for PATS, to comment on that. First of all, there is a significant growth in expenditure on PATS, which is causing problems for us.

Mr M.W. TRENORDEN: Inquiries to my office reflect that. The number is rising quite considerably from people who want to access PATS.

Mrs O'FARRELL: PATS was reviewed in this term of government and some improvements have been made. It became clear as we looked at the country service system and designed the regional network concept that there needed to be a broader look at transport as part of the solution in delivering health services in the regions and not just schemes like PATS. The transport review will cover all aspects of patient transport, not just PATS. We will endeavour to engage in the process with the Department of Local Government and Regional Development and the Department for Planning and Infrastructure to see what connections might be required to give people access in networked regional systems, both within the regions and for access to services that need to be obtained outside a region or to bring services to people in a region. The review will continue to the end of this calendar year. We hope to emerge from that with some interest from other areas in terms of what might be done.

Mr M.W. TRENORDEN: Some time ago the member for Murdoch and I were in Canada. By the proper use of what was termed in those days as "telehealth" - a term that is now dead - transport costs were reduced by 50 per cent. That is why I was keen to ask the minister the questions much earlier today. If the Department of Health followed through on the things it was looking at eight years ago when it used to have a telehealth section - which seems to have vanished - it might have saved some money. We need to look at whether we will start delivering services like the rest of the Western world seems to be able to do through the better use of technology instead of putting people in cars, buses or trains. As I said, costs were cut by 50 per cent in Canada. The service was improved by giving nurse practitioners and doctors real backup. Even the Mayo Clinic was used in Canada, believe it or not.

Mr J.A. McGINTY: A terrible film came out recently called *The Barbarian Invasions*, which described the Canadian health system. By comparison, I think we have a world-class system. I agree with the member on the appropriate use of technology. The implementation of the Reid recommendations on the building up of health services in health resource centres in the major regional centres will enable a lot more people to stay in the regions for their health treatments. I will quote some statistics to indicate the nature of the pressure on PATS. In the 12 months to June 2003, growth and expenditure on PATS was $1.1 million or about 10 per cent. Projected expenditure based on data to December 2003 suggests additional expenditure of approximately $1 million is likely in the 2003-04 financial year. The budget for 2003-04 for PATS is $12.8 million. It is likely that the actual expenditure will be $14 million. That is the nature of the growth with which we are dealing. Interestingly, the main cost driver is airfares, which have increased by 66 per cent over the past three years. While that obviously does not relate to the member's electorate, it does to the more outlying parts of the State. Air travel accounts for only 16 per cent of all PATS trips but it accounts for approximately 60 per cent of all expenditure. The member can really relate this to the Pilbara, the Kimberley and perhaps the goldfields area for the real cost pressures. The cost pressures are not coming from the member's constituents; they are more outlying, and associated with the use of aeroplanes.

[1.40 pm]

Mr M.W. TRENORDEN: They are still coming from my electorate, but I understand that the dollar implications are not as high. The minister spoke last year about reviewing the PATS process. The difficulty with PATS is that a lot of people have to travel to their local doctor to make application, then go back home and either receive the money or not, which is duplicating the process for the client. Is there a process in place to make it more streamlined for individuals to submit applications for PATS, considering some people live 100 kilometres from that service?

Mr J.A. McGINTY: Nothing that I can add in addition to what Mrs O'Farrell said in answer to the question initially.

Mr M.F. BOARD: I do this every year and I want to do it again this year. I refer to the costs of running HealthDirect. It is anticipated that there will be 235 000 calls this year. Page 554 indicates that the number of calls received by the health call centre is expected to be 235 000. The Government is predicting a cost reduction from $33 a call to $26 a call, and I want to know how that has come about. Under bulk-billing, people can see a general practitioner for $25. It concerns me that that does not show a health outcome; it is a health direction. People who call HealthDirect are generally advised to go to a hospital, clinic or GP and incur another cost. That cost can be nearly doubled to get the outcome. I ask the minister - probably by way of policy direction: with the advent of the after-hour clinics, would he expect that with advertising and promotion he might be able to reduce the cost of Health Direct by people directly accessing GPs rather than making phone calls and then being directed to GPs?

Mr J.A. McGINTY: Possibly, but whether -

Mr M.F. BOARD: I am not sure how the minister justifies the reduction, but $33 is an extraordinary amount to pay for a phone call.

Mr J.A. McGINTY: HealthDirect is about to receive its one-millionth call. The service has been much patronised.

Mr M.F. BOARD: That is because there are not many after-hours services. That is the point I raise.

Mr J.A. McGINTY: To a degree, there might be a marginal change as a result of the after-hours GP emergency department clinics. The other change that I expect will add to the patronage of HealthDirect is the part of the new configuration of the contract with St John Ambulance that will mean a diversion of low urgency or non-acute cases to HealthDirect for advice rather than an ambulance going out to deal with them, which is what

currently happens. I would expect to see a decrease in demand from low acuity patients for the use of ambulance services, an increase in the use of HealthDirect as a result of that initiative, and more people using HealthDirect as part of some of the winter strategies affecting emergency departments; however, it is hard to see how that would reflect in the cost per call, because I expect they would be marginal changes only.

Mr M.F. BOARD: My understanding is that, because of liability issues, HealthDirect is unable to give direct health advice. It actually gives advice about where to attend or where to go in given circumstances. From my advice, that is what it has become, rather than a provider of a direct outcome, because of possible litigation issues. Can the minister clarify that?

Mr J.A. McGINTY: Over the past nine or 10 months the Government has endeavoured to cast a critical eye over every area of health expenditure, and this is a significant area of health expenditure. When the federal Minister for Health and Ageing, Tony Abbot, was in town, he visited the call centre. He has spoken about it at health ministers' meetings as being an important part of the arrangements. One of the successes of the call centre in the Hunter region in New South Wales was the triaging of people over the telephone to stop very low priority patients going to hospitals or general practitioner clinics. People were given advice over the phone to wait overnight or things of that nature, which assisted the GP after-hours clinics and associated emergency departments. The call centre has an important role to play. On current projections we are looking at delivering a balanced health budget this year. A reason for that is the scrutiny we have given to every area of health expenditure, and this is one area for which we would like to get value for money.

Mr M.F. BOARD: The former Government started it. It is a terrific health service. However, it is extraordinary that the cost of calls to it is dearer than the Medicare rebate levy to a GP.

Mr J.A. McGINTY: I agree. That is why we must look at it.

Mr J.B. D'ORAZIO: I found the question that had alluded me earlier. I refer to the first dot point on page 41 of the *Budget Statements*. Will the minister advise the committee of the steps being taken to expand renal dialysis services in regional Western Australia?

Mr J.A. McGINTY: I thank the member for Ballajura for the question.

Mr J.B. D'ORAZIO: I am sure that the Leader of the National Party will be interested in the answer.

Mr J.A. McGINTY: I am sure he will. Currently, 52 funded renal dialysis places are available within the WA Country Health Service, excluding the south west. The Department of Health funds another 39 places at the Broome Regional Aboriginal Medical Service. Currently, 21 patients are being treated in Perth and are waiting to return to their regional centre. The Government proposes to increase the renal dialysis services at Port Hedland and Kalgoorlie by increasing the number of available places at the sites by 14. I am sure that the members for Eyre and Kalgoorlie will be particularly interested to learn that the Kalgoorlie Regional Hospital is funded for 16 dialysis places. Currently, 18 high-acuity patients are being dialysed and six patients are on the waiting list in Kalgoorlie. There is a growing need for dialysis services in the goldfields. The Government will allocate $30 000 in May 2004 to purchase an additional dialysis machine. Funding is to be allocated in 2004-05 to treat up to 24 patients in Kalgoorlie. That will do much to relieve the pressures that families in Kalgoorlie feel when their loved ones need to be transferred to Perth to receive treatment that can be made readily available locally.

Mr M.W. TRENORDEN: That is good news, but the minister should be aware of the residential problems in Broome. The Aboriginal housing problems in Broome are serious. That is part of the reason why the service is not working as well as it should in Broome.

Mr J.A. McGINTY: Unfortunately, these issues are never straightforward. The problem in Kalgoorlie related to the ability to have appropriately trained staff. There was concern that the Government was running the service at peak capacity with staff who were not trained to deal with some of the complexities that can arise. The Government is very keen to inject money into the training and recruitment of nursing staff who will be competent to deal with any emergencies or high-acuity issues that arise from the treatment of patients. I will look into the accommodation in Broome that the member mentioned. Often it is not a matter of giving more dollars for staffing issues.

Mr M.W. TRENORDEN: It is more about administration.

Mr J.A. McGINTY: Yes.

Mr M.W. TRENORDEN: I refer to home care dental services on page 581 of the *Budget Statements*. The budget states -

WA Country Health Service will complete a Multi Purpose Service (MPS) Leading Practice project to assess the potential to expand the MPS concept to the establishment of integrated district health centres.

I have a great interest in this because I was the inventor of MPSs.

Mr J.A. McGINTY: Were you?

Mr M.W. TRENORDEN: Yes.

Mr J.A. McGINTY: Congratulations. They are a great concept.

[1.50 pm]

Mr M.W. TRENORDEN: Things have moved on a bit. The previous Government discussed this matter with Senator Graham Richardson, who was the responsible minister at the time, and we got that process going. I support moving on to a new process, because the federal-state funding arrangements have changed. It is important to talk to a number of those communities throughout the State, particularly in the wheatbelt, about what system they can adopt. That is part of the reason people are concerned and are approaching me and the minister about the future. They cannot see a defined future. The old MPS system has broken down due to changes in funding methods. We need to get to this position quickly. What is the position?

Mrs O'FARRELL: There are 28 MPSs. I do not think they have broken down; nothing has changed. The funding mechanism remains the same. We continue to receive and allocate commonwealth and state funds in a pooled way, as we have done before. Commonwealth funding continues to grow. We have a very vibrant and growing program in our MPS sites. We are very pleased to have received funding from the Commonwealth for the review. We have completed stage 1. We kept that review very wheatbelt focused, because that is predominantly the focus of our MPS sites. The second stage is finalisation of negotiations for the money for that. We are very keen to look at how we can build on a foundation that has been created and at where we can take MPSs, particularly in the wheatbelt districts in future.

Mr M.W. TRENORDEN: Aged care is a very important part of the integrated services. I sat close to the federal Treasurer the other day and privately asked how we could make those services viable. The fact is that we cannot talk about 40-bed institutions or even 20-bed institutions in most of these towns. Integrated health care services must be delivered that include meals on wheels and a doctor. Is any particular work being done in this process that brings aged care into the equation? If so, is there a model for using a number of beds or is there - I hope there is - a move towards a more common use of beds?

Mr J.A. McGINTY: These issues were brought home in very sharp focus to me yesterday when I travelled with Mrs O'Farrell to Denmark.

Mr M.W. TRENORDEN: I wish you had gone to Pingelly, because they are up in arms.

Mr J.A. McGINTY: Are they? They were in Denmark also but about a different issue; namely, determining the site for the new hospital, which, primarily, will offer aged care. We spent the entire day discussing nothing but the interaction of community provision of aged-care packages to keep people in their homes and in the community as long as possible before having to accept either low or high care. We discussed also where the high-care facilities would be provided in future. I am acutely aware of those issues. Increasingly in country towns, particularly smaller towns, the issue is about provision of appropriate aged-care services.

Mr M.W. TRENORDEN: What about ANS?

Mr J.A. McGINTY: To a lesser degree.

Mr M.W. TRENORDEN: Not to a lesser degree.

Mr J.A. McGINTY: Lower level accident and emergency services was the issue in Denmark yesterday, and from what I have seen it is also an issue in other towns. I do not know about the Pingelly matter the member referred to. The issue is complicated given the nature of the funding arrangements. Regardless of whether we put the funding available from the Commonwealth into beds or community packages when we cater for our own demographic, increasingly, people in those country towns are getting older and need those services.

Mr M.W. TRENORDEN: Fewer people want to retire in Mandurah. One of the great things about regional WA is that people there are not retiring to the coast as they used to and they are not moving those aged beds to Mandurah. They are staying in the wheatbelt.

Mr J.A. McGINTY: We must do much more to support those communities so that aged people stay in their communities, as that keeps the balance in the communities.

Mr M. McGOWAN: The minister mentioned plans for a lung transplant unit here in Western Australia, which is fantastic - and unexpected, obviously, from my question. Reference is made on page 538 to organ tissue donation. It strikes me that, although it is good to have the service, the acquisition of the organs post mortem and liaising with the families is the stumbling block in some respects. Having the service is a massive improvement, but obtaining organs is the other part of the equation. Are any new initiatives being pursued or is anything else being undertaken to achieve a greater rate of organ donation?

Mr J.A. McGINTY: I agree with the sentiments expressed. I have been guided very much by the member for Southern River and his personal experience as a recipient of a kidney donation. Western Australia has traditionally had one of the lowest rates of organ and tissue donation in the country. People are dying and people's lives are being severely inconvenienced as a result of the low level of organ donation. We have introduced three initiatives. Firstly, we have moved to amend the Coroners Act to give the coroner the power to refer to DonateWest more deaths that might result in tissue donation than is currently the case. That Bill is currently before the House. I hope it will have an expeditious passage and that it will enjoy, in the spirit of today's discussions, bipartisan support. I am sure that it will. Secondly, we have appointed Dr Harry Moody to be the organ donation coordinator at Sir Charles Gairdner Hospital. I am told that he has had some early success in securing donations that otherwise might not have been made. We can look forward to the success of that initiative, which is built on the Spanish model of having active physicians in hospitals to talk with families in order to identify and secure donations from people who die in the hospital environment. The third initiative arose from the recent meeting of the Australian Health Ministers' Conference at which Tony Abbott, the South Australian minister and I put together a recommendation, which was agreed to by all other ministers, to review our organ and tissue donation legislation to give greater effect to the wishes of donors. If a person expresses during his life a desire to donate his organs, that should not be subject to a veto by his surviving family. That is obviously a difficult issue, because doctors will not take organs when a family vehemently objects to that. Our legislation is satisfactory. However, there is a need to change the protocols to ensure that families are advised of the wishes of the deceased and what the doctors intend to do, rather than there be a presumption that the family of the deceased person should have a right of veto. Those three initiatives should immediately complement the lung transplant surgery initiative that we announced today, so that we can put into effect the increased number of donated organs that should result from those three earlier initiatives. That will enable us to treat people here, quicker and with less disruption to their lives.

Mr M.F. BOARD: Page 547 outlines an allocation of a stack of money to King Edward Memorial Hospital - $153 million - most of which is for the never-never; it will be spent after 2013. My question is not on the relocation of the hospital but on the Douglas inquiry, about which there has been much publicity. My question relates to the unresolved issues. Pages of the report were withheld from the public, primarily because natural justice was not being provided to certain clinicians -

Mr J.A. McGINTY: And patient confidentiality.

Mr M.F. BOARD: And for reasons of patient confidentiality. I would have thought that there would have been ample time in the years since the Douglas inquiry announced its findings to deal with those issues so that we could put the inquiry to bed once and for all. That has not happened. Will there ever be closure of this issue? Will those pages eventually be published, or will the minister say now that they will be completely removed from the community and that we will never have a resolution of at least those aspects of the inquiry?

Mr J.A. McGINTY: That decision was made before I became health minister. I have been flat out on a thousand and one things, many of which we have spoken about today. I have not turned my mind to revisiting the decision that was made. I accepted the advice that patient confidentiality would be jeopardised by the disclosure of those pages. I have not done anything about it.

Mr M.F. BOARD: I think the minister will find that the patients would be happy for those issues to be resolved.

The appropriation was recommended.

On motion by the Chairman (Mrs D.J. Guise), resolved -

That the clauses, schedules and titles of the Bills be agreed to.

The CHAIRMAN: That completes consideration of the estimates by the committee. I take this opportunity as Chair of the estimates committees to say that I appreciate that the advisers have been here for quite some time today. On behalf of all members of this Parliament I thank all the advisers for their attendance.

Mr J.A. McGINTY: I echo that sentiment and thank all those who have contributed to what we have been able to talk about today in a constructive way, and for all the efforts made to present the information to Parliament.

Mr M.W. TRENORDEN: Minister, you have been far better than most. We actually got some questions answered. Some of the estimates committees have been a waste of time.

Mr M.F. BOARD: On behalf of the Opposition I also thank all the advisers. It is unfortunate that there are so many of you. We would have liked to explore further health issues, if we had had more time. We appreciate the fact that you have been here and have assisted us today.

Mr J.B. D'ORAZIO: On behalf of the Government I thank the minister and all his advisers for doing a fantastic job in health. The minister is going from strength to strength and the community will obviously appreciate his efforts.

Committee adjourned at 2.01 pm