Division 66: Health, $2 652 835 000 -

Mrs D.J. Guise, Chairman.

Mr R.C. Kucera, Minister for Health.

Mr M. Daube, Director General.

Mr A.M. Chuk, Deputy Director General, Corporate and Finance.

Dr. B.L. Lloyd, Deputy Director General, HealthCare.

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

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

Mrs C. O'Farrell, Executive Director, Country Services.

Dr D. McCotter, Executive Director, Drug and Alcohol Office.

Associate Professor D. Arya, Acting Director, Office of Mental Health.

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

Dr P. Della, Chief Nursing Officer.

Ms E. Rohwedder, Acting Director, Funding and Reporting.

Mr P. Aylward, Acting Group Director, Finance and Information.

Ms P. Ford, Group Director, Planning and Workforce.

Ms S. McKechnie, Director, Resource Management.

Mr M. Higgs, Acting Director, Asset Management.

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. 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 in preface to their question. For example, members are free to pursue performance indicators that are included in the *Budget Statements* while there remains a clear link between the questions and the estimates.

It is the intention of the Chairman to ensure that as many questions as possible are asked and answered, and that both questions and answers are short and to the point.

The minister may agree to provide supplementary information to the committee, rather than 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 6 June 2003, so that members may read it before the report and third reading stages. If the supplementary information cannot be provided within that time, written advice is required of the day by which the information will be made available.

Details in relation to supplementary information have been provided to both members and advisers and, accordingly, I ask the minister to cooperate with those requirements. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question with the Clerk's office. Only supplementary information that the minister agrees to provide will be sought by 6 June 2003.

Mr R.C. KUCERA: At the outset, I point out that many of these individuals have budgets that are bigger than those of many government departments; hence the number of advisers present today.

Mr M.F. BOARD: I refer to page 1075 and the appropriation and forward estimates. The grand total of the 2003-04 estimated expenditure is $2.652 billion. I have a few questions associated with that figure. As I asked in the Parliament the other day, can the minister indicate the total commonwealth appropriation that is embedded in that figure of $2.652 billion?

Mr R.C. KUCERA: Through the Chair, I will ask Mr Chuk to answer that question so that members have a clear picture of the construct of the overall budget.

Mr CHUK: If I have understood the question correctly, the member is seeking the amount within the appropriation that comes through commonwealth health care agreement funds.

Mr M.F. BOARD: I have a couple of questions associated with that. First, what amount has been incorporated in the budget from the Australian health care agreement? Secondly, are you aware of any other commonwealth contributions, outside the Australian health care agreement, that is embedded in that budget?

Mr CHUK: The appropriation for the 2003-04 budget includes a sum of $734 million that will be directed from the Commonwealth to the State by way of the health care agreement. I understand that an additional $230 million will be provided to the State through other commonwealth programs.

Mr M.F. BOARD: If I understand the answer correctly, the total is $964 million.

Mr CHUK: When those two figures are added together, yes.

Mr M.F. BOARD: As a follow-up question, the information that has been provided to me by the federal minister indicates that of the three line amounts offered in the Australian health care agreement, that figure of $734 million is the optimum amount, if Western Australia signs the Australian health care agreement and matches growth funds. Am I correct in assuming that the Government has factored in the larger amount?

[9.10 am]

Mr R.C. KUCERA: It is partially correct but there are some difficulties associated with it. Our detailed analysis of the Australian health care agreement has revealed an even worse deal for us than we first thought. It is easy to play semantics and politics with this division between the States and the federal Government.

Mr J.H.D. DAY: That is exactly what this Government has been doing.

The CHAIRMAN: Member!

Mr R.C. KUCERA: If the member for Darling Range will allow me to explain, I will tell members why it is worse. The federal Government has marketed its offer as providing an extra $10 billion nationally. However, Western Australia will receive about $100 million less than it would have had it simply continued with the current agreement. We have put in an additional 27 per cent over the life of the current agreement, which includes what the previous Government did. The federal Government has put in an extra 22 per cent over the life of the current agreement - that is 22 per cent of the federal Government's allocation, not 22 per cent of the total budget as somebody has tried to paint it. I insist on giving the committee the figures. The figures over the forward estimates that have been given to us by Senator Patterson show a marked decrease for the States of almost $1 billion over the life of the new agreement. I would suggest that it is very unlikely at this stage that this State would sign the agreement. It would be a sheer nonsense and insanity to accept $1 billion less. Regardless of whether members opposite think that is a good thing, I do not. We struggle to fund health in this State as it is. I have a page from the health and ageing 2003-04 federal budget, which is supplied by Senator Patterson and is a public document, which shows quite clearly how the federal Government is ripping money out of the public hospital system, for whatever reason. One can quite clearly see where it is going; it is propping up the rest of the Medicare system.

The CHAIRMAN: With the concurrence of the minister and the committee, I will have the document photocopied and then the minister may give it to members present.

Mr R.C. KUCERA: It is not a terribly good copy, but thank you for that, Madam Chairman.

Mr M.F. BOARD: I understand what the minister is saying. The minister has not signed the Australian health care agreement and he is saying that he will not sign it.

Mr R.C. KUCERA: I will not sign it until I have an opportunity to negotiate and point out clearly to Senator Patterson, and indeed the Prime Minister on this occasion, that this State suffers unique disadvantages. Last year we went through a reform process which virtually every sector of the health industry in this country applauded. Even the federal minister applauded it. I would be remiss in my duties as the Minister for Health of this State if I walked away and accepted a second-rate deal.

Mr M.F. BOARD: Three amounts were offered under the Australian health care agreement. A lower amount was offered if the minister did not sign the agreement, but the minister has factored in the highest amount as if he had signed the agreement and has matched funds.

Mr R.C. KUCERA: As the member may be well aware, our budget papers were constructed before the federal Government made this somewhat disturbing offer. We based our budget purely and simply on last year's figures and the increasing contribution that had been given by the federal Government over the last five years of the

previous agreement. Unfortunately, it turns out that we will be worse off because there is a reduction of almost $1 billion to the States. That being the case, it puts our budget under even more pressure.

I must point out two other factors. The first is that as well as doing that, the federal Government has placed on the budget some very stringent conditions of acceptance of the agreement. The net effect is that the flexibility we have to use the federal budget will be curtailed even more than it has been until now. I will give a very clear example. Last week while the Prime Minister was in the State he went to Ngala Family Resource Centre and announced a multi-million dollar program for child care. I do not have a problem with that, but the first that the people of this State heard of that was when they read about it in *The West Australian*. That is no way to do business with health dollars. Quite frankly, I think that all of us in this Chamber, regardless of our political allegiance, need to look carefully at what Senator Patterson is proposing and what the Prime Minister has done in winding back some of the good programs that the Commonwealth has put together and starting to undermine the very construct of the state budget.

Mr M.F. BOARD: Notwithstanding whether we agree or disagree on that issue, the point is that the minister has utilised the top amount of the offer to boost the state budget. The reality is that the State will not get that money unless the minister signs the Australian health care agreement or there is a change to it.

Mr R.C. KUCERA: When I wore a previous hat, I had a name for that - I used to call it blackmail. It is as simply as that.

Mr CHUK: The changes to the funding arrangements that the Commonwealth proposes under the health care agreement over the next five years mainly impact on the out years. It is a coincidence that what we would have received next year under the old agreement is the same amount of $734 million as the maximum of 100 per cent that the member is referring to under the new agreement. That is the case only for next year. The $734 million came into the budget construct, not because it was the new offer, but because it was the best we had at hand, based on the previous projection which, in turn, was based on the Commonwealth's previous budget papers. Therefore, the figure of $734 million is the same under the new arrangement of 100 per cent as the old projection under the previous commonwealth government papers.

Mr M.F. BOARD: Will any of the money allocated for 2003-04 have been spent prior to the new budget period?

Mr CHUK: No.

[9.20 am]

Mr R.C. KUCERA: This point is of great concern, and should be to all people in Australia. The fundamental underpinning of the reform program, which we discussed at length last year with the federal Government - not just me but every state and territory minister -was that the money that we were allocated in the first instance, particularly under the Medicare agreement, would not all come to the State. The member for Avon raised a very good question late last year with regard to Merredin. Under the federal Government's system, X amount of dollars is allocated to Merredin - not Merredin specifically, but for the doctors who work in Merredin - for Medicare. The federal Government estimates that each person visits a doctor six times a year. If no doctors in that town bulk bill or if there is no doctor, the $25 that would go to the State or to that doctor through the Medicare arrangement would not come to the State. The great difficulty with that is that we have to top up that funding through the state budget process. I am often accused of arguing and fighting with the federal Government over that matter and simply squabbling with it. The reality is that this State misses out on an enormous amount of money it should receive because of that arrangement. The fundamental argument I put to Hon Kay Patterson is that I am not asking for any extra money from the federal Government; I am asking for proper indexation. I am asking for the federal health minister to give me the bucket of Medicare money as a state health minister because of the unique problems this State faces supplying the medical work force generally. I want to use that money in different ways. At the presentation of the federal offer, Hon Kay Patterson read a letter from a patient who said he had been asked to go over the road and use a bulk-billing doctor as opposed to using an emergency department. She hammered on the table and said that was the kind of thing she was talking about with regard to cost shifting. That seems a very sensible arrangement. Everyone in this Chamber has paid their taxes and all our families have paid their taxes. They expect a fair return from the Medicare arrangement. I am asking the federal Government to give me a fair return.

Mr J.H.D. DAY: Would the minister like all the Medicare funding to be made available to the State?

Mr R.C. KUCERA: Absolutely. There should be a single, seamless health system in this State. I have no problem with the federal Government collecting taxation and allotting it to the States on a fair and equitable basis. Indeed, because the federal Government collects tax, I demand that it set the benchmarks and the standards. However, I expect it to allow us to get on and deliver health services on an equitable basis.

Mr J.H.D. DAY: Does the minister think the federal Labor Party would go along with that?

Mr R.C. KUCERA: I have no doubt it would.

Mr J.H.D. DAY: Does the minister seriously believe the federal Labor Party would hand over all the Medicare funding to the States?

Mr R.C. KUCERA: I am putting a proposal. As the State Minister for Health, I have seen the inequities in the system. I could ask the member the same question about his federal colleagues.

Mr J.H.D. DAY: From the State's point of view, there is a lot of merit in that. However, I would not expect it to happen easily. Surely it would happen less easily under a federal Labor Government.

Mr R.C. KUCERA: Of course. It may have been a very different question had there been a different outcome last year. Who knows? The member is asking me a question and I am giving him my clear and unequivocal view as the Western Australian Minister for Health that a single health system in this country is the way to go. I doubt whether that will ever be achieved.

Mr J.H.D. DAY: That would mean going the other way and giving it all to the Commonwealth. Hon Kay Patterson could argue that.

Mr R.C. KUCERA: I do not have a problem with that.

The CHAIRMAN: Order! Members are straying from the budget papers.

Mr M.F. BOARD: We absolutely agree with many of the things the minister has said. Indeed, we have fought for them for many years. The point is that this budget shows the top offer from the Commonwealth, which is $734 million, knowing that the minister has not signed the agreement and knowing that he may not match those growth funds.

Mr R.C. KUCERA: I am sorry, but I must correct the member. It is a complicated issue. I will answer that first part of the question before it gets too complicated. The member said we put in the top offer from the Commonwealth.

Mr CHUK: The provision for the health care agreement funds that are built into this budget do not relate to the recent offer; they relate to the understanding the State had at the time the budget was developed.

Mr M.F. BOARD: That is even worse, because that is based on an incorrect figure.

Mr R.C. KUCERA: If that is the case -

Mr M.F. BOARD: It puts a hole in the budget.

Mr R.C. KUCERA: That is not correct. We based the construct of the budget on what the federal Government was going to give us before the new agreement was settled on. It turns out that the very top offer it gave us is exactly what we would have gotten anyway. That is a cut in anybody's language. The member may laugh at that.

Mr M.F. BOARD: I am not laughing at it.

Mr R.C. KUCERA: People make much of the fact that they say, "This is what we want, this is what we get and anything in between is a cut."

Mr M.F. BOARD: The fact remains that the state budget has been embellished because of a figure that the State may not receive.

Mr R.C. KUCERA: I will refer this matter to Mr Chuk.

Mr CHUK: I am not making myself clear. The State Government puts its budget together during March and April. At the time, the State had not received the offer from the federal Government. At that time, the best information available to us was the information published in the commonwealth budget papers in the previous year. That is the information that was used.

Mr M.F. BOARD: The budget is in jeopardy based on the agreement on the table now, unless the minister signs the agreement and gets the growth funds.

Mr CHUK: With regard to the appropriation that health receives - that is, the appropriations that are budgeted for and provided for in the forward estimates - a single appropriation comes from Treasury to health that includes the health care agreement money plus state moneys. On that basis, I do not believe that the health budget is in jeopardy for the coming year or beyond.

Mr M.W. TRENORDEN: It is important we understand each other. It is clear that before we go any further we must understand what this budget is predicated on. We have six hours of questioning to go. We must know whether this budget is based on the new or the old format, otherwise today's proceedings will be a farce.

Mr R.C. KUCERA: Treasury received the money from the federal Government as part of the fixed grants. Together with the Health Department, Treasury estimated that the federal Government would provide the State with $734 million in the first year and an estimated increase in the out years. Treasury predicated the amount of money that is allocated to the state health budget on those figures.

Mr M.W. TRENORDEN: On the old system.

Mr R.C. KUCERA: On the system that was in existence. The money will come to us in any case. The only thing in jeopardy is Treasury's figures; that is, the overall money that comes to this State from the federal Government. Our figures are locked in from Treasury. If there is a shortfall from the federal Government, obviously the entire construct of the state budget will come under consideration. That is the very point that every state and territory minister raised with Hon Kay Patterson in Canberra some three or four weeks ago. The federal Government is doing this to all the States and Territories; it is not just the Labor States versus the Liberal-National Party coalition. What the federal Government is doing to the health budget undermines the basic fundamental construct of all state and territory budgets. The federal Government knows how important health budgets are. The way it has been done may be just a coincidence, but I do not think it is, frankly. The federal Government is engaging in base politics. It is not a consideration for the people of this State. Neither is it a consideration for the individual Australian that deserves decent health care. That is the problem. To put members' minds at rest, my understanding - I will take advice on this - is that our money is locked in from Treasury. Treasury will have the problem if the federal Government backs away from us.

Mr J.H.D. DAY: If the State continues to increase funding to its health system at the same rate that has occurred over the past seven or eight years or so, there would be no difficulty matching the Commonwealth's rate of increase. I do not know what the argument is about.

Mr R.C. KUCERA: We do not have an argument over matching. I asked Hon Kay Patterson to match our funding. There is a 9.7 per cent increase in the State's health budget this year.

Mr J.H.D. DAY: Therefore, from what the minister has said, the State would have no difficulty matching the federal Government's rate of increase. I do not know what the argument is about.

Mr R.C. KUCERA: I will qualify that. We do not have a problem matching it provided the conditions that are attached to that matching are not thought up by bureaucrats in Canberra who think that a medical service in the suburbs around Duntroon can be run in the same way as a medical service in Merredin, Bencubbin or Fitzroy Crossing is run. That is the great difficulty I have with much of this talk about matching funding. The guidelines are very specific and inflexible.

[9.30 am]

Mr J.H.D. DAY: Of course there must be a recognition of the differences. As I said, if the rate of increase of recent years continues, there would not be any difficulty in matching the funding. I am not an apologist for the Commonwealth.

Mr R.C. KUCERA: I am well aware of that.

Mr J.H.D. DAY: We have had and will continue to have plenty of arguments with the Commonwealth. It wants to make sure that what occurred with New South Wales does not occur again. I understand some health funding was diverted to the construction of the Olympic Games facilities. It was ultimately put back into health at the direction of Bob Carr, the New South Wales Premier. The Commonwealth is trying make sure that the States are not rorting the system, which I do not think has occurred in Western Australia. If it has, we have a major problem.

The CHAIRMAN: Member, you are testing my patience.

Mr J.H.D. DAY: Can the minister inform us what funding the State will receive from the Commonwealth if it signs the agreement and at least matches the Commonwealth's rate of funding over the next five years? In other words, what is the maximum amount we will get from the Commonwealth?

Mr R.C. KUCERA: That is on the basis that we agree with the federal Government's offer as it is now.

Mr CHUK: I have that information by year but not in total.

Mr J.H.D. DAY: That is what I want.

Mr CHUK: It is my understanding that through the health care agreement arrangements proposed by the Commonwealth, we would receive $730 million in 2003-04, $779 million in 2004-05, $823 million in 2005-06, $871 million in 2006-07 and $922 million in 2007-08. That represents a six per cent annual increase.

Mr J.H.D. DAY: Therefore, how can the minister say that Western Australia will receive less from the Commonwealth? There is clearly an increase each year. The minister is trying to give the impression that Western Australia will receive less. Those figures clearly demonstrate that that is not the case. There is a sustained increase.

Mr R.C. KUCERA: Andrew Chuk will discuss the technicalities, and then I will make a comment.

Mr J.H.D. DAY: Those numbers increase - $734 million, $779 million, etc

The CHAIRMAN: I think the member has asked the question. Let us get an answer.

Mr CHUK: The "less than" reference relates to figures which I do not have before me but which are available; that is, the Commonwealth's assumptions as published in last year's commonwealth budget papers. We recently heard that we will receive $734 million next year, which is pretty much the same as forecast in those budget papers. However, the amount we will receive over the five years is a reduction on what the Commonwealth had previously forecast.

Mr J.H.D. DAY: It is a reduction compared with its earlier forward estimates. However, it is not the case that Western Australia will receive a reduction in funding, which is what the minister has been trying to lead people to believe.

Mr R.C. KUCERA: Does the member agree that we should receive only a 17 per cent rather than a 22 per cent increase over that five years?

Mr J.H.D. DAY: A 17 per cent real increase is not bad.

Mr R.C. KUCERA: It is not bad. The member is saying -

Mr J.H.D. DAY: Of course we would always like more.

Mr R.C. KUCERA: We should not be arguing that; we should be shouting it from the rooftops.

Mr J.H.D. DAY: We are getting a 17 per cent real increase.

Mr R.C. KUCERA: These figures are a scandal. The member is defending -

Mr J.H.D. DAY: The minister has been trying to lead people to believe that Western Australia will receive less from the Commonwealth. That is not the case, as Mr Chuk's figures demonstrate.

Mr R.C. KUCERA: The member is kissing away - giving back - a billion dollars of funding to the States for public hospital systems.

Mr J.H.D. DAY: To the States as a whole.

Mr R.C. KUCERA: The highest proportion of in-patient care in this State is delivered to public patients in public hospitals. Every week the member's colleague comes into this place and talks about the pressures on public hospitals. Yet, the member for Darling Range is prepared to accept a $1 billion reduction in funding. He should tell the people at Swan District Hospital -

Mr J.H.D. DAY: That is a political comment. Yes, there is a reduction in funding compared with the forward estimates. I agree with that. However, there is not a reduction in real funding. As the minister said, there is a 17 per cent real increase. Of course we would like more, and if the minister can get more, good luck to him.

Mr R.C. KUCERA: This State had to put $232 million additional money into health this year because of the niggardly way the Howard Government is treating the States with its health funding.

Mr J.H.D. DAY: We will come to that. That is because the Government does not have control over the system.

The CHAIRMAN: I call the member for Darling Range to order for the first time.

Mr R.C. KUCERA: It distresses me that the money we had agreed to receive from the federal Government is now not good enough for it. The Opposition is saying that we should accept what is essentially a five per cent lower offer than what we currently get.

Mr J.H.D. DAY: If the minister can get more, good luck to him. However, he needs to be clear in what he tells the people of Western Australia. There is a sustained increase.

Mr R.C. KUCERA: The member needs to be clear about his allegiances and loyalties. He is a state member of Parliament -

Mr J.H.D. DAY: Absolutely, and if the minister wants me to negotiate with the Commonwealth to get more, I will do it. Good luck to him. He should get more if he can. However, he should not try to lead people to believe that there is a reduction.

The CHAIRMAN: Order, members! Does the member for Rockingham have a further question on this? If not, I will move on.

Mr M. McGOWAN: Not on this.

The CHAIRMAN: Excellent.

Mr M.W. TRENORDEN: I refer to page 1075, on which the grand total for appropriations is stated as being $2.652 billion. We are told that figure represents additional funding of $232 million. On page 1078 the item "gross expense increase for cost and demand pressures" shows an allocation of $196.119 million. How does that $196.119 million funding relate to the $232 million additional funding? Has that been factored in?

Mr CHUK: The table at the bottom of page 1078, major policy decisions, includes the key decisions of government over the past 12 months that impacted on health funding. It does not include some small matters, and it does not include the underlying increase that was in the forward estimates of last year. The amount specified on page 1078 is an increase on the figure in the previous forward estimates. The gross increase shown on page 1075 is the increase forecast in the previous forward estimates plus the additional funding from this year.

Mr M.W. TRENORDEN: Page 80 of the *Economic and Fiscal Outlook* refers to a range of figures. Are those figures in addition to or part of the $196 million increase?

Mr CHUK: They are included in that $196 million.

Mr A.P. O'GORMAN: The last dot point on page 1075 states -

> Demand for emergency departments' services continues to be strong, and heavy use of emergency departments by members of the community who are unable to access primary health care remains an issue. This has led to the development of a coordinated response to acute demand.

Can the minister give some more information on that coordinated response?

[9.40 am]

Mr R.C. KUCERA: To quickly set the picture for this area, the health system in this State is currently based on three sectors. The primary health care in the State is generally provided by family doctors. The health system is based on the premise that we have a good primary health care system. The middle section of health is the acute hospital system run by the State, and two-thirds of which is funded by the State. The final part of the health system, which is not included in the State's health responsibilities nowadays - it is a great shame - is aged care. Increasingly, the role of my portfolio is dealing with aged care issues, which are funded by the federal Government. As a breakdown has occurred in the GP system with a dramatic decrease in bulk-billing and patient access to family doctors across the State, enormous pressure is being placed on our emergency departments, most of which are running at 98 per cent capacity almost continually. Also, the ageing population - unfortunately, we are all in that boat - is putting pressure on our emergency departments. People who should be properly treated in aged care or nursing homes are forced to seek treatment in emergency departments. Nobody argues with that well-known fact.

In January of this year, the Government put together a task force to deal with the 10 issues. I throw to the director general to show how we are dealing with these pressures.

Mr DAUBE: After I speak, I will ask Mr John Burns to speak on some of the work being done in this area. It is a problem we face, as the minister said, in common with every other State and pretty well every other developed country. A vast amount of national and international literature is available on this subject. The problems and pressures we face are no different from those faced elsewhere. The pressures are an ageing population, declining access to general practitioner services and a hospital system designed to deal with the pressures of the 1970s rather than those of this decade. We also face the reality that many people regard our emergency departments as places to go if free care is needed, rather than places to go if they wrap a car around a lamppost or are involved in some other similar emergency. The reality is that emergency departments are a long way from the model seen on television. They are often full of very old people.

We are fortunate to have an allied health system. Obviously, we are trying to cope with the pressures. A range of activities have been developed. Two areas are important to address. First, some time ago we responded to the concerns expressed to us by people working in emergency departments. They said that they were expressing their concerns, but nobody had listened to them for some time. We needed to alleviate some pressures, some of which were occupational health and safety issues as much as anything else. Dr Lloyd looked at the needs of the emergency departments. It may be appropriate to ask him to comment, and then ask Mr Burns, who is coordinating our state emergency response, to speak to some of the measures to deal with emergency pressures in the coming year and beyond.

Dr LLOYD: The review of emergency services by an expert group clearly showed the number of areas in which improvements could be made. As defined by that group, these included issues relating to demand management and out-of-hospital care and coordination. It also related to the capacity of emergency departments in physical and staffing structures and staffing and patient flow, through to bed occupancy rates and bed management practices. Subsequently, out-of-hospital care needed to be improved to stop people attending hospitals when they could otherwise be treated in the community. That range of initiatives has been defined. A large percentage of those issues delineated by that group have been commenced or put in place.

The current work led by John Burns deals with some of the more cutting edge parts of that issue. He will review that work for members.

Mr BURNS: An issue explained before was the growth in demand on emergency departments. In the past couple of years, demand on emergency departments has grown at about five per cent a year. Clearly, this could not be sustained in the health system. We have looked at better coordination, which is the essence of the exercise. We found many people were doing a lot of good work, but it was not coordinated. That work is being redirected. We are talking to St John Ambulance and establishing protocols: when patients are picked up, we are defining which hospitals they should attend. We are putting in weekly, daily and monthly monitoring systems to ensure we have a handle on the area. We are talking to nursing homes. For example, a pilot study is taking place using HealthDirect, by which nursing homes can ring in before sending patients to emergency departments.

As mentioned before, two new emergency departments are to be constructed. That will take a while. Computerised axial tomography - CAT - scan machines have been put into Swan District and Rockingham-Kwinana District Hospitals. The Rockingham exercise has seen a 22 per cent reduction in emergency patient transfers from Rockingham to Fremantle. We are working on these matters and are making progress. It is not an easy task. We are addressing those issues at both ends. We are working with GP divisions, with nursing homes and with St John Ambulance. This gets coordination going in that area to see improvements in the system.

Mr R.C. KUCERA: Something that cannot be changed in the public health and public hospital system is the demand placed upon it. When every other part of the system is full or under pressure, the public hospital system still stays open. Never was that more clearly seen than in the highly publicised case last year. Despite the breakdown of the federal veterans systems, which did not work, at the end of the day the patient received very good care in the public hospital system. The Government is putting enormous capital contributions into the area. The CAT scanner provision, for instance, is extended. We have provision for such machines in all major places we can possibly put them. As budgets become available, we will extend that provision. The Rockingham experience is a 22 per cent reduction in patient transfer. Providing these facilities in Swan District will pay dividends.

Three weeks ago, the Premier and I opened a new observation ward at Swan District Hospital to allow us to hold people there. This will be a direct benefit for people in the electorate of the member for Avon as they come down from the wheatbelt. As we develop Moora District Hospital and the like, the program will be extended. An enormous amount of work is taking place. That does not mean that we will not have a difficult time when the peaks and troughs arise. We will battle to overcome these difficulties.

Mr M.F. BOARD: The Liberal Opposition agrees, of course, with the emergency department study, inquiry and coordination. Some argue that the difficulty is the shortage of beds in the system to assist with the emergency department situation. Is there a plan this year for additional beds? If so, where will those beds be placed?

Mr R.C. KUCERA: There will be. I pass the question to the director general.

[9.50 am]

Mr DAUBE: I will first make a broad observation, which is that in this, as in so much else, we need to take a comprehensive approach. There is no single remedy to the problems that we and the other States face. Therefore, the approach has to include not only dealing with the people who are there but also prevention; for example, stepping up the influenza campaign to ensure that people are better prepared for winter, and working

with general practitioners and so on. It is crucial that we recognise that there are no magic wands here; if there were, somebody around the country or around the world would have found them. There is clearly pressure on beds, and I will ask Mr Burns to talk about the beds that will be made available for the winter period.

Mr BURNS: Every year we open beds during the winter months and close them during the summer months to match demand. The metropolitan area has been broken up into three health areas - south, north and east. The additional beds that will be coming on stream will be 32 in the north, 30 in the south and 60 in the east, a total of 122. We will also have the capacity, if the demand forces us to do so, to increase the number of beds further, but we believe at the moment that that is about the right number that we should be planning for.

Mr M.W. TRENORDEN: If an extra 122 beds will be opened over the winter months, how many beds will be shut down over the summer months?

Mr BURNS: The normal practice almost every year is that these beds are generally open from about June through to late October, when the demand starts to ease off. We then start to reopen the beds again in May or June.

Mr M.W. TRENORDEN: I would like to know the net figure. At the end of the year how many beds will be paid for out of this budget?

Mr R.C. KUCERA: As we have just explained, the number is 122. We are talking here about the emergency or winter plan. We are constantly seeking to develop the capacity of the health system generally. I cannot give a specific number of beds in that regard. We are finding at the moment that the demand level in all but the peaks is sufficient. However, we are hitting the peaks more often now because of the increased demand that is being placed on the system by those two factors that I talked about earlier: the family doctor system on the one hand, and the aged care system on the other. Those peaks are causing us concerns. The peaks and troughs are fairly well quarantined to a certain time of the year, and we deal with that. That is no different from what has happened in other years.

Mr DAUBE: There are a range of issues. Clearly bed capacity over the winter months is important to us and is something that we are trying to address. There are also other issues that need to be addressed. It is not simply a matter of making more beds available at all times. There are issues of working with the hospitals to improve bed management, and of how to address the number of aged people who are in hospitals. It is not a simple matter of opening more beds. It is also how we manage those beds within our system. Those are issues that we are also trying to work through.

Mr M.W. TRENORDEN: Our job today is to try to find out how you are spending the money, so it is a fair question.

Mr R.C. KUCERA: I think I have already answered that - 122.

Mr M.W. TRENORDEN: For six months of the year?

Mr R.C. KUCERA: Yes, to cope with the emergency demand. In addition to that, obviously more beds will become available as we change the configuration of the emergency departments. I do not know the exact number off the top of my head. Swan District Hospital is a classic example. We already have an additional eight observation beds on line at that hospital. Those beds will not be used all the time but will be used for observation as is necessary. There will be a change in capacity when the new emergency departments at Sir Charles Gairdner Hospital and Rockingham-Kwinana District Hospital come on line.

Mr M.W. TRENORDEN: Can the exact figures be provided as supplementary information?

Mr R.C. KUCERA: We can certainly provide supplementary information about what additional bed capacity there will be in the emergency departments that are currently being redeveloped.

[*Supplementary Information No A51.*]

Mr J.B. D'ORAZIO: I am interested in the emergency departments. There is obviously a breakdown of how many patients are seen by emergency departments around the State. Is that further broken down into the various triage categories? I see that everyone is nodding, so that is good. When we get to triage categories 4 and 5, is there an estimate of the individual cost of each of those visits to the health system, because that will obviously show up a figure? I remember from the Public Accounts Committee inquiry that the cost is about $163 a visit. The Medicare rebate is $25, and doctors are allowed to charge up to about $40. It should be obvious to even the most simple person that if it costs about $160 to provide a service through the Medicare Agreement but it costs only $40 to have it provided by the private sector, then we should use a system other than the emergency department of a public hospital to provide that care. I am talking only about categories 4 and 5, because categories 1, 2 and 3 need specialist care. Levels 4 and 5 are basically people who walk in because they have a

cold and want to be looked at and then go home. It is costing us far more to use the emergency department system than it is to use the Medicare system and private doctors. Why would we not all want that system to be implemented and tell the federal Government to go jump in the lake?

Mr R.C. KUCERA: That is probably the whole point of this current negotiation about the Medicare Agreement. I will give a simple example. My wife and I went to Rockingham a couple of months ago to speak with a group of doctors on a Sunday morning about the local GP clinic that they have set up. The clinic is about 40 metres from the front door of Rockingham-Kwinana District Hospital. They have put that together at their own expense. They are prepared to bulk-bill most of the time, but they cannot do that on the weekends because of the sheer cost of running the operation, so they charge an up-front fee of $35, of which the patient can get back $25 from Medicare. The problem is that for most of the people who live in that area $35 is a lot of money to have in their pocket. There was a young mother there who had to take both of her children to the doctor. She could not afford to pay $70 for the visit. She was not in the doctor's surgery. There was only one woman in the doctor's surgery while we were there. However, when my wife and I walked across the road to the hospital, there were 16 people in the waiting room at the hospital. Each of those people could quite easily have been dealt with by the GP clinic across the road. However, the Health Insurance Commission rule is that people cannot be told to go across the road to the GP clinic because it may be bulk-billing. I agree that it is absolute lunacy that we cannot change the rules in that way. It is not a cost shifting, as is constantly said by those who want to argue against it. It is simply a better use of the money that has already been allocated by the federal Government for the Rockingham hospital.

Mr J.H.D. DAY: You can do that by having a sensible arrangement with the Commonwealth. It has been done at Armadale Hospital.

Mr R.C. KUCERA: No, it has not. Armadale-Kelmscott Memorial Hospital has an up-front fee. That is exactly the same as what I am talking about.

Mr J.H.D. DAY: There is a GP clinic on the site.

Mr R.C. KUCERA: It does not bulk-bill, and the member knows that only too well.

Mr J.H.D. DAY: I am not sure about that, but the point is there is a GP clinic on the site.

Mr J.B. D'ORAZIO: I am talking to the scale of cost. The principle is something else. The point I am trying to make is that in the case of Rockingham even if there was a $35 up-front fee and even if the State were to subsidise that $35 fee and pay the whole lot, it would still be $130 better off than under the current system, so why can we not all get together and make a decent submission to the federal Government saying this is wasting a helluva lot of money out of the health system because of the inflexibility of the system? That goes for all Governments. It does not matter who is in government; they will have the same problem.

[10.00 am]

Mr R.C. KUCERA: Member for Ballajura, if I can very quickly -

The CHAIRMAN (Mrs D.J. Guise): Members!

Mr R.C. KUCERA: I apologise, Madam Chairman.

The CHAIRMAN: The minister should not apologise; conversations are unparliamentary and members know it.

Mr R.C. KUCERA: My mother taught me to have good manners.

I agree totally with the member for Ballajura. Professor Duckett, I think it was, and I think also Professor Deeble, said on a radio program the other day that if people came down from Mars and looked at the health system in Australia, they would want to ask how we got into this mess. The member for Ballajura is right. The major reform process was requested last year by all the groups that met with the federal Government, which suggested exactly what the member is suggesting: This State is given a bucket of money every year that it is unable to use and it goes back into the coffers in Canberra every year. I will get John Burns to answer that. A general practitioner clinic has been operating at Fremantle but I understand it is under attack by the Health Insurance Commission for doing exactly what the member for Ballajura suggested.

Mr BURNS: That is correct. I think that issue has been settled. It certainly was under attack.

Mr J.H.D. DAY: Did Mr Burns just confirm that it is not now a problem?

Mr BURNS: It is a separate, privately run GP clinic, located about 50 metres from the Fremantle Hospital emergency department. It is run by a group as a private clinic, and has the same relationship with the hospital as any private clinic.

It is not a simple exercise to undertake the costing. Only about 10 per cent of patients who attend the emergency department are category 4 or 5. It should be recognised that not only GP-referred patients come into the clinic classified as categories 4 and 5. About five or six per cent are admitted. Fremantle Hospital has a full emergency department staffed with consultants and junior medical staff. If categories 4 and 5 were sent elsewhere, it would not automatically mean a corresponding reduction in costs.

Mr R.C. KUCERA: I do not think that is the question the member for Ballajura was asking. I understand the bottom line would be $160 to $180 for attendance at an emergency clinic versus a cost of $35.

Mr BURNS: That would be an average cost for treating categories 1, 2, 3, 4 and 5. It would be difficult to separate the cost of categories 4 and 5.

Mr J.B. D'ORAZIO: I understand that but with a bit of ingenuity we could come up with a cost that would be far more than $35.

Mr R.C. KUCERA: Regardless of this agreement I am putting the federal Government on notice now that this Government will push the envelope as far as it can with all these issues this year. The Government will ask the health review committee, of which both the Director General of the Department of Health and the head of Treasury are members, to show why that arrangement can apply in Sydney and Melbourne but not here. Why does every man, woman and child in this State miss out on about $141 a year per head of Medicare funding? It is a scandal that it has gone on for so long and that the previous agreement did not allow this State to have that flexibility. It is a nonsense that we pay taxes, but we do not get the money back.

Mr J.H.D. DAY: The situation was exactly the same with the previous federal Labor Government.

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

Mr R.C. KUCERA: I would be just as critical of that Government. I am a state health minister and I will keep reminding members of that.

The CHAIRMAN (Mr P.W. Andrews): In front of me is a further question to one previously asked by the members for Joondalup and Murdoch and the leader of the National Party. We then go back to the member for Darling Range for a new question.

Mr A.P. O'GORMAN: In the minister's response he referred to capital works. When the Joondalup Health Campus was a public hospital called Wanneroo Hospital -

The CHAIRMAN: Is this a further question?

Mr A.P. O'GORMAN: It is a follow-on question based on part of the answer from the minister.

The CHAIRMAN: Is it a further question rather than comment on something?

Mr A.P. O'GORMAN: It is on capital expenditure. The Joondalup emergency department was built in 1996 to cater for 25 000 patients. It is currently catering for about 48 000, although I could be slightly wrong about that. What plans were put in place in 1996 to further develop the Joondalup Health Campus as the population grew?

Ms McKECHNIE: It was recognised that the demand for services in the northern corridor was likely to increase over time. The arrangements in the contract with the private operators reflect that over time there is capacity to consider additional capital development. That capital development would necessarily need to be planned within the overall capital works program that the Department of Health develops from time to time.

Mr M.F. BOARD: The minister clearly indicated that 122 additional beds are in the metropolitan area. Can the minister provide an indication of the total number of beds that will be available in the metropolitan area and the total number in the country, and whether there are plans to close country beds in the next 12 months?

Mr R.C. KUCERA: With all due respect, I am happy to provide that out of session but not off the top of my head.

Mr M.F. BOARD: Can it be provided by way of supplementary information?

The CHAIRMAN: Is the minister agreeing to provide that information by 6 June?

Mr R.C. KUCERA: Yes. I need to qualify the snapshot of information the member for Murdoch requires. At various times of the year, the bed numbers vary considerably depending on demand. People seem to perpetuate the view that beds are literally stationed in wards. I could count every single bed in every hospital in this State and provide a figure, but that would not indicate in any way whether they are being used. Their use depends on the availability of staff.

Mr M.F. BOARD: I am looking at the capacity of the system, so the relevant figure is the maximum number of beds available at any one time.

Mr R.C. KUCERA: Is that during the winter peak or the summer peak?

Mr M.F. BOARD: The minister can give us his best shot. The minister is good at embellishing, so I am sure he will provide the maximum figures.

Mr R.C. KUCERA: I am not being evasive. We will provide the best available known figure of bed capacity we can give the member. However, I need to qualify that. I do not want something made of a comparison between what is available at one given time and what is available at another given time.

Mr M.F. BOARD: The minister might be able to break down the number by hospital.

Mr DAUBE: We will provide the best breakdown we can. It is appropriate to provide that by supplementary information.

Mr BOARD: What is the situation in the country and is there a plan to close country beds over the next 12 months?

Mr R.C. KUCERA: Most of our country hospitals run at excess capacity; I understand that very few run to maximum capacity.

The CHAIRMAN: What information is the minister agreeing to provide?

Mr R.C. KUCERA: I agreed to supply the best available information on the total capacity of beds in the health system in this State.

[*Supplementary Information No A52*.]

[10.10 am]

Mr R.C. KUCERA: I will ask Mrs O'Farrell to speak very quickly about the capacity of country hospitals.

Mrs O'FARRELL: We need to think of country hospitals in the context of falling into certain categories; they are not all the same. There are a range of regional hospitals, larger district centres and very small hospitals. I do not have with me the exact number of beds in those hospitals, but the picture in the country was reasonably well documented in the country health services review. There is a significant volume of capacity that is chronically under-utilised. There are many small hospitals with a number of beds, but the number of those beds that are being utilised is very low

Mr M.F. BOARD: That is why I asked the question. Is there a plan to reduce that capacity?

Mrs O'FARRELL: No, there is no plan to close any beds. In fact, those beds have lain idle. We still maintain those facilities and run those services. As is indicated in the country health services review, the intention is to ensure that the service model is more akin to the needs in the community and to ensure that the facilities, assets and resources that are available to communities are being used in a far more flexible way to try to target some of the presenting health conditions.

Mr R.C. KUCERA: I met with Minister Kevin Andrews last year about looking at ways to try to overcome the desperate shortage of aged care beds right across the State, particularly in country areas, and the capacity to allow people to age in the towns in which they live. Again, we are stymied by the inflexibility of the federal system in utilising hospital beds for aged care and perhaps disability services. The State has offered to the federal Government a number of innovative models. The vision that Chris O'Farrell's team has for country health is one in which country hospitals are an overall health service for the area and are linked into a broad regional health service.

Returning to the point that was made by the member for Darling Range earlier, if we can start to develop in this country a single, seamless health system that allows people to go from the cradle to the grave, so to speak, in their own towns and we can pool commonwealth and state moneys for aged care and home and community care services, I suspect that instead of hospitals closing, they would go gang busters and be very well serviced.

In most small country hospitals there is a core staff who must be there, regardless of whether there is one person or 24 people in the hospital. To talk about closing beds in those hospitals is an absolute misnomer. Those beds are there and the staff are there, and often the staff are sitting around waiting for people to come into the hospitals.

The CHAIRMAN: Members, I am worried that we are not getting through enough questions. As I keep telling people, the Speaker will drop me back to chairing the Gosnells Bowling Club meeting on a Tuesday night. I

suggest that the Leader of the National Party ask his further question and then the response that the minister was about to give can be taken in conjunction with that answer.

Mr M.W. TRENORDEN: Returning to the question about emergency departments, about four years ago the Department of Health conducted a review of country areas and identified a $50 million shortfall in capital expenditure in those country hospitals. Is that part of the review?

Mr R.C. KUCERA: Part of the review of the country?

Mr M.W. TRENORDEN: No, just emergency services.

Mr R.C. KUCERA: I will ask the director general what the scope of the review was. The specific review for which I asked was of the major trauma hospitals.

Mr M.W. TRENORDEN: I understand that. However, about four years ago the review that was held into country health services identified that $50 million of capital was required for country hospital emergency departments.

Mr R.C. KUCERA: I will defer that question to the director general.

Mr DAUBE: I will ask Mrs O'Farrell to speak about that in the context of the country health services review and its consideration of emergency issues.

Mrs O'FARRELL: I do not recall that review.

Mr M.W. TRENORDEN: It was done by Jenny Sheen.

Mrs O'FARRELL: I am sorry; I do not recall that particular report. I am trying to think of the report that Jenny Sheen did. Perhaps it was a bit before my time.

The issue of capital in country health services was dealt with in the country health services review. It has been important to identify the facilities, services and service models that the regions will have. The view that was formulated was that we should progress the development of country health services using the concept of a regional network model, so that rather than operating services in a fragmented system, in which they operate in silos, separate from and competing against each other, we link them and operate a single, dynamic system of care. Underpinning that is the role delineation framework as was outlined in the review. The role delineation framework better informs us of how we should progress with the detailed capital infrastructure development plans for each of the health services. For example, we will build on the current raft of achievements of the really innovative remodelling in some of the small country hospitals. They have been reinvented as more multipurpose-type services, with more integration of service providers who, in the past, have been out in the community. Now those service providers can come in under the main roof. That is the case particularly with community health, allied health and mental health service providers. Those care teams can now work in a much more integrated fashion. The role delineation framework gives a very sound basis on which to start modelling health service facilities so that we can make the best possible use of the services, and that is underpinned by principles of integration and the like. The review has been completed and we have had a comprehensive re-look at all our services and facilities throughout the region. We have taken that information and we are progressing with a fairly detailed capital works assessment of what facility upgrades are needed. We have a view on which regional centres need to be upgraded; for example, the small hospitals and services in the district centres that have not benefited from some sort of modernisation in the past. There are some priority areas in particularly emergency departments that have jumped forward in the review. Katanning Hospital is a good example of a district hospital with an emergency department that has become a little out of kilter with need. That is one hospital that will feature in our priority plan. There are a number of such hospitals. This process has been very valuable in enabling us to get a more comprehensive and longer term view of what sort of investment is needed in capital infrastructure in the country in the future. We are now in possession of a much more comprehensive understanding of what those needs are, so that will benefit our capital planning process. Putting forward submissions and business cases for financing some of those capital works projects is, at last, being underpinned by some fairly decent strategic planning, so that submissions from small places are not considered in an ad hoc fashion.

Mr M.W. TRENORDEN: The point is that somebody else might have that benefit, but I do not. Where do I get that information?

Mr R.C. KUCERA: The information for what - individual hospitals?

Mr M.W. TRENORDEN: No. Further to the Health Administrative Review Committee report, the information that has just been provided indicates that there has been a program to identify hospitals. I do not know where that report is and I would like to read it.

[10.20 am]

Mr R.C. KUCERA: The program has not been to identify hospitals but to review all country services, as has been pointed out. As Mrs O'Farrell said, the important issue is to get health services working together as a group not on an individual hospital basis. I am more than happy to offer the member for Avon a briefing with the country services division. I do not have a problem with that because there is nothing to hide. One of the problems with individual country hospitals working on their own is that people tend to base the efficiency of health services in those hospitals on the amount of money they are given as opposed to the services they provide. That has been a failing of the system in the past.

Mr J.H.D. DAY: When the Labor Party was in opposition that was the only thing it talked about.

Mr R.C. KUCERA: Maybe it is something that has surfaced. Now there is one single unified system we may not have that problem in the future - who knows? If we keep doing things the same way, that is insanity. The member for Darling Range knows that.

Mr J.H.D. DAY: Absolutely; that is the problem.

Mr R.C. KUCERA: I look at the way the member for Darling Range changed the system when he started the process which we have picked up on.

Mr J.H.D. DAY: It was started before my time.

Mr M. McGOWAN: The member for Ballajura asked about emergency departments. The minister spoke in some detail about Rockingham-Kwinana District Hospital. He referred to the number of patients in emergency departments and the level of ailments for which they need treatment. The answer may be provided by way of supplementary information, but I would like to know the number of people who have attended the emergency department at that hospital each year for the past few years, the level of their ailments and whether they could be serviced by general practitioners, and the total cost of the upgrade for both capital and equipment that is being undertaken at the emergency department.

Mr R.C. KUCERA: The breakdown I have is for the whole of the emergency system. I do not have the upgraded figures in front of me, but for 2001-02 almost 302 000 people went through the emergency departments of the major teaching hospitals. I am not sure if the advisers have a breakdown of the figures for the Rockingham-Kwinana District Hospital. If not, I will provide supplementary information on that.

Mr M. McGOWAN: That would be fine. I am looking for the number of patients who went through the emergency department in each of the past couple of years, their level of ailments and whether they could be treated by GPs, and the total cost of the upgrade of the emergency department and equipment at the hospital.

Mr R.C. KUCERA: We can do that for the Rockingham-Kwinana District Hospital. As for categories 4 and 5 GP attendances, for example, somebody may get something in his eye and that could be adequately dealt with by the emergency department. However, if a doctor's surgery were open across the road, the same thing could be done there. We can give the member the breakdown for which he asks.

Dr LLOYD: Unfortunately, we always need to put a caveat on the number of patients who could be treated by a general practitioner. It is not an easy estimation to make in the triage scoring that we use across Australia for emergency departments. Triage scoring is designed to tell us how soon somebody should be attended to in the department; it is not to tell us the complexity of that person's problem or where he or she could alternatively be treated. It is probably a problem that has been thrown up in the past year or so. It is a piece of information we would like to have now, but it is not something that our triage people in emergency departments can provide. We make estimations, and we could make estimations based on categories 4 and 5, but they would be estimations only. We can give the member those numbers for Rockingham-Kwinana District Hospital in particular, as well as for the rest of the system.

Mr R.C. KUCERA: This point needs to be made. The Prime Minister said in a recent speech -

> We are absolutely committed to maintaining and strengthening the public health system, especially through the maintenance of Medicare. We will continue to provide resources for the three main elements of the public health system - access to free treatment as a public patient in a public hospital, payment of a Medicare rebate at 85 per cent of the scheduled fee for a visit to a GP, and maintenance of the Pharmaceutical Benefits Scheme.

I must say that I have seen no evidence of that in the budget that has been put before us by Senator Patterson. The statements made by the Prime Minister over the past few weeks have clearly undermined those principles. There is no doubt about that. That will place increasing pressure on costs and attendances at our hospitals. There is no way that speech can be reconciled with what has been done to our health system over the past few weeks.

Mr HIGGS: We will happily provide the patient numbers for the Rockingham-Kwinana District Hospital emergency department in a briefing for the member.

Mr M. McGOWAN: I would not mind it as supplementary information rather than a briefing.

Mr R.C. KUCERA: I am happy to provide that by way of supplementary information. We will provide as supplementary information the patient attendance numbers at the Rockingham-Kwinana District Hospital emergency department, the category of the patients having triage treatment and the total cost of the hospital redevelopment and equipment.

[Supplementary Information No A53.]

Mr HIGGS: The estimated total construction cost for Rockingham-Kwinana District Hospital is $9.8 million. We will confirm that it includes the computerised tomography scanner.

The CHAIRMAN: Is that the supplementary information that the member for Rockingham required?

Mr M. McGOWAN: I asked for a full breakdown of the upgrades to the hospital, including all equipment upgrades, that have been undertaken in the past year and are currently progressing. I am happy to have it now, but I would like them broken down in printed format.

Mr R.C. KUCERA: I am happy to provide that as supplementary information.

Mr J.B. D'ORAZIO: May I point out that last year it took three hours before I was able to ask a question. I have been here an hour and a half and I still have not been allocated a question even though under the previous chairman I was next in line.

The CHAIRMAN: I can only go by the notes that have been left behind. I will see members behind the Chair at a quarter to 11. I take the member's point, and I will try to move on as quickly as possible.

[10.30 am]

Mr M.F. BOARD: If we keep our questions and answers short, sharp and shiny, we will get through a lot of questions. I refer to waiting lists. Will the minister indicate the number of people that were on the public waiting list who left the public waiting list over the past 12 months?

Mr R.C. KUCERA: Will the member for Murdoch refer me to a page number.

Mr M.F. BOARD: I refer to waiting lists on page 1076 of the *Budget Statements*. According to statements made by the Minister for Health, the number of people on waiting lists in Western Australia is the lowest in the country. How many people on the waiting list in the public health system left the waiting list without having had surgery?

Dr LLOYD: Over the past 12 months, there was a two per cent decrease in the number of patients on the waiting list and an 8.6 per cent decrease in the median wait time. I do not have the exact breakdown of those figures with me. We usually present those as part of the Australian Institute of Health and Welfare figures that are presented each year. I recall that in the preceding year some 200-odd patients dropped out of the waiting list. I do not have those figures. If the minister, members and chairman agree, we can provide that as supplementary information.

Mr R.C. KUCERA: What is the member asking us to supply?

Mr M.F. BOARD: The number of people on the public waiting list who are no longer on the public waiting list, assuming their surgery has been done privately through the Medicare 30 per cent rebate. I want to know the decrease in the number of people on the public waiting list as a result of those who left the waiting list rather than those who have had surgery.

Mr R.C. KUCERA: We can provide both figures. Did the member indicate that he wanted figures of the number of people who went to the private system?

Mr M.F. BOARD: I want the figures for those who left the public waiting list. It is a simple question. I want to know the number of people who left the public system without receiving surgery.

Mr R.C. KUCERA: We can provide that. I draw the member's attention to the waiting list weighted hospital separations item on page 1096 of the *Budget Statements*. We exceeded our estimated target this year of the numbers of people dealt with through the waiting list process. We can provide the member with that information. We can work through that figure and let the member know how it was arrived at.

[*Supplementary Information No. A54.*]

Mr J.B. D'ORAZIO: I refer to the first dot point under significant issues and trends on page 1075 of the *Budget Statements*. In his introduction, the Minister for Health said that there are three key elements of the cost problem with regard to pharmaceutical benefits. The Victorian Government has piloted a program of allowing pharmaceutical benefit scheme prescriptions to be used for emergency departments, which is obviously cost shifting, but the pilot program has been approved by the federal Government. Does Western Australia have an agreement to do that? I understand the savings are about $22 million a year.

Mr R.C. KUCERA: That is one of the issues I discussed with Hon Kay Patterson. All the state health ministers discussed that reform process, which, unfortunately, seems to have disappeared in the halls of Canberra. I understand that we are looking at that process.

Mr CHUK: The current health care agreement, which expires shortly, provides for a pharmaceuticals collaborative arrangement between the Commonwealth and the States. Late last year, Western Australia came to an agreement with the federal Government to pursue the benefits offered under that arrangement. As a consequence, it has been trialled in six secondary hospitals in the metropolitan area. Subject to those trials being successful and implemented, it will spread to hospitals across the metropolitan area.

Mr J.B. D'ORAZIO: Including the major hospitals?

Mr CHUK: That is the intention, but only when it operates smoothly in the secondary hospitals.

Mr J.B. D'ORAZIO: It is not too difficult to write prescriptions. What is the issue regarding smoothness? It is either done or it is not done.

Mr CHUK: A number of issues regarding its implementation must be worked through. We are required to put in place a new information technology system to keep track of the processes. That is currently being developed and put in place. I believe we will use a system that was used by another State. This arrangement will provide some modest benefits next year. The total revenue benefit next year will be about $2.8 million. Netting off the cost will probably provide a saving next year of about $1.2 million. I am not certain what other information the member requires.

Mr J.B. D'ORAZIO: When it is fully implemented, will it save about $22 million across the State?

Mr CHUK: That is correct. The trial is being conducted in only six of the secondary hospitals in the metropolitan area.

Mr R.C. KUCERA: A difficulty we have with these types of matched programs is the fairly stringent conditions that have been put on them - understandably so - by the federal Government. Allied to those difficulties is the infrastructure that must be put in place, which often must be supplied by the State rather than the federal Government. A lot of other linked conditions are attached to these programs. This year there was an absolute flurry before the federal budget period when money was thrown on the table and was expected to be spent by the end of June under very stringent conditions. The federal Government knew full well that we could not meet some of those conditions. That is an example of the State Government trying to work with the federal Government. Given the amount of research that was done last year, and the clear indications from every sector of the health industry that reform was desperately needed in the way in which the bucket of money was to be spent on the public health system, it is very sad that the issue seems to have been sacrificed on the altar of Canberra again. The PBS is a classic example. The States must bear the brunt of some of these issues.

Mr J.H.D. DAY: I refer to the forward estimates on page 1075 of the *Budget Statements*. By my calculation, in 2003-04 there is a $212 million increase in expenditure compared with the estimated actual expenditure for the current financial year. That is an 8.7 per cent actual increase. In 2004-05 there will be a $214 million increase, which is 8.1 per cent in actual terms. The increase for 2005-06 is significantly less at just $112 million, or 3.9 per cent in actual terms. The increase in 2006-07 is again small, just $140 million, or 4.7 per cent. In the first two years of the four-year estimates, there are increases in the appropriations of around $200 million, which will decrease to around $100 million. That tells me that presumably the minister would need to put in place quite major changes in the system to sustain a much smaller increase in the last two of the next four years. That will have to occur in 2005 at the latest. Coincidentally or otherwise, that would be just after the next election. It can be inferred from comments made by other ministers - for example, the Minister for Planning and Infrastructure -

that the health budget has sucked a lot of money out of other portfolios. What changes is the minister considering putting in place to contain the health budget within the forward estimates?

[10.40 am]

Mr R.C. KUCERA: I first refer to the member's comment about the health budget sucking money out of other areas. There is no doubt that health is a key issue. The State Government is certainly treating and funding it as such. It is a great shame that the federal Government is not treating it in the same way.

Mr J.H.D. DAY: That is not true. We can always have debates, but the member should recognise the truth.

Mr R.C. KUCERA: The member for Darling Range really is becoming an apologist for his federal colleagues. That is a great shame. This is the one thing we could go forward on together. An increase of $232 million in this year alone is not a small contribution from this State.

Mr J.H.D. DAY: I agree it is not small.

Mr R.C. KUCERA: It has put my colleagues under pressure. No-one is more aware of that than I. I am also aware of the pressure that the federal attitude to health is placing upon the construct of the overall state budget. I will not get into this issue. I am more than happy for the director general to address this issue, and I understand he wishes Andrew Chuk to talk in the first instance.

Mr CHUK: The member referred to the grand total on page 1075. The percentages cited by the member are correct for that line. However, there are some complications in using that line. The capital contribution line shows the portion of the appropriation that is provided to fund the capital program. It has some distortions according to the amount that is required to fund the capital program, and that influences the percentage increases cited by the member. For instance, in the current year, 2002-03, $38 million of the appropriation will fund the capital program. That goes down to $18 million in 2003-04 and up to $69 million in the following year. If the member is trying to get a view of the general operations of the department, the grand total figure may not be the best to use. I suggest that the figures for "total appropriations provided to deliver outputs" is more reflective of the operating environment of the department. According to that, the appropriation for 2003-04 is $2.634 billion, as opposed to $2.402 billion in the current year. That is a 9.7 per cent increase. In 2004-05, that appropriation will be $2.797 billion, a 6.2 per cent increase; and the increases for the following two years are in the order of 4.5 per cent.

Mr J.H.D. DAY: It sounds like the general trend I outlined is the same.

Mr CHUK: The expenses line in the operating statement is most reflective of the operating position of the department. Again, members will see the same trend. The appropriations line is affected by the balance between commonwealth, state and own-source revenues. If the member wants to compare the operating position of the department over the forward estimates, he will find that the expenses line on the operating statement is the most reflective of the total position of the department. That shows a 6.3 per cent increase in operating expenditure next year and, off the top of my head, an increase of close to six per cent for 2004-05.

Mr J.H.D. DAY: Will there be a 6.3 per cent increase in operating expenditure next year?

Mr CHUK: That is correct.

Mr J.H.D. DAY: Would it not be more relevant to talk about that rather than a nine per cent odd increase?

Mr R.C. KUCERA: Why?

Mr J.H.D. DAY: We are talking about operating and recurrent expenditure; that is, what is available for the operations of hospitals, community health centres and services and the mental health system.

Mr R.C. KUCERA: Health is an overall system.

Mr CHUK: The Government has endeavoured to represent both figures. The first dot point on page 6 of the *Budget Overview* catches this relatively well. It states -

> The Government has allocated $2.6 billion in 2003-04 for the Department of Health, an increase of $232 million or 9.7%. This will underpin total expected expenditure on health of $3.02 billion, an increase of 6.3% or $178.3 million.

Mr R.C. KUCERA: There has been no attempt to not be transparent. It seems that we get slapped if we give all the figures and we get slapped if we do not. For the first time, this is a construct of a health budget that is realistic, sensible and balanced. As the member said, it put my parliamentary colleagues under pressure. However, this is a Government that recognises that health is a key issue. I go back to my original statement that this is the problem with the federal attitude. It is not the construct of the health budget we are concerned about in

negotiating the AHCA agreement; it is the construct of the overall state budget that is under pressure. I do not think there is any coincidence at all. Frankly, I think it is simply base politics.

Mr J.H.D. DAY: We can debate that for hours.

Mr R.C. KUCERA: I do not think we can. I have a view of it. I am fiercely parochial when it comes to this State.

Mr J.H.D. DAY: As we all are. However, we must look at the reality and facts of the situation. I have not asked my main question, but I first want to clarify something. This is obviously an accounting issue, but I would like it on the record so that we all understand it. How does the minister reconcile the amount of $18.512 million that is shown on page 1115 as the capital contribution for the coming financial year with the estimated expenditure in the capital works budget of $105.131 million?

Mr R.C. KUCERA: I have equal difficulty with the intricacies of this.

Mr CHUK: I will work through the items contained in the capital contribution table on page 1115. It indicates that for the 2003-04 year, the total capital works program, as described in the preceding information, will be $105 million. Beyond the $105 million that the Government will spend on physical works on buildings, systems and equipment, there will be loan repayments of $9.4 million, which is also treated as capital. The untitled line in the table represents the total capital outlay from the capital account of the department, which will be $114.5 million. The department will have available to it $15.4 million of asset sales to fund those capital works. A figure of $80 million is reported against the holding account. A portion of the $2.652 billion appropriation will not be given directly to the department but will go into a holding account. That is the amount that is deemed as the accrual component. It covers depreciation, leave accruals and some other small items. From that account Treasury has determined that $80 million should be withdrawn to fund our capital program. A small amount of $645 000 relates to funding transactions relating to the Gordon inquiry outcomes. I cannot quite explain those. The $18.5 million at the bottom of the table is the portion of the capital program, taking into account expenditure and the known flows into the capital programs that I have just described, that is required from government as an equity injection to balance the capital account.

[10.50 am]

Mr J.H.D. DAY: Can the minister tell us how the $15.4 million will be raised by asset sales? Which assets will be sold?

Mr R.C. KUCERA: I direct the question to Prudence Ford.

Ms FORD: The $15.4 million is made up of four significant asset sales. First is the old Bunbury Hospital site. Bunbury Regional Hospital was rebuilt three or four years ago, and we are now in a position to dispose of the old site. Second is some vacant land at Murdoch. Third is the sale of the hospital linen and laundry buildings and asset, as per a contract negotiated some years ago. Fourth is the disposal of Heathcote Hospital at Duncraig Road.

Mr M.W. TRENORDEN: Good luck.

Mr R.C. KUCERA: Whatever you do, do not mention the war!

Mr J.H.D. DAY: Is it possible, without jeopardising what the State might receive through a tendering process, to provide the breakdown of what it is expected to receive? I do not want that put on the record if it would jeopardise what the State might receive.

Mr R.C. KUCERA: Obviously, estimates are involved.

Mr J.H.D. DAY: If it is not commercially sensible, do not provide it.

Mr R.C. KUCERA: I thank the member for the concession. The member is aware of the sensitivities of the site, and the Government is attempting to deal with all sensitivities. The disposal has been handed over to the Department of Housing and Works. I prefer not to give that information.

Committee suspended from 10.52 to 11.05 am

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

The CHAIRMAN: I remind the minister, advisers and members that to facilitate proceedings, they should keep questions and answers to a minimum so as many questions as possible can be asked and answered.

Mr J.H.D. DAY: The point I was pursuing before the break relates to both the budget in the out years and the first dot point on page 1075, which reads -

> Strategies are being developed to achieve a sustainable rate of expense growth, while maintaining quality and standard of care, into the future.

What sort of changes are contemplated by the minister to achieve the outcomes outlined in the budget papers, and to manage the budget with the reduced increases that will occur in the last two of the next four years?

Mr R.C. KUCERA: Before I get to change, I take a step backwards to speak briefly about the old forward estimates, if the member wants to call them that, or the previous Government's forward estimates; this Government built on the way those were done. Page 6 of the 2003-04 *Budget Overview* reads -

- Over the next four years the total additional funding to be provided to Health is $1.084 billion. Since coming to office, the Government has injected $2.45 billion to increase health services for the community.

Before I refer to changes, it is worth pointing out the following two dot points -

- It is estimated that approximately 78 000 operations will be performed across the public hospital system in 2003-04, up from around 70 700 operations in 2002-03.
- In addition, a total of $105.1 million has been allocated for capital works in the health sector -

Mr J.H.D. DAY: That is very interesting, but we can read that for ourselves.

[11.10 am]

Mr R.C. KUCERA: If that is the case, why has the member asked the question? I will ask the director general to talk about the changes, but I must say I am concerned about the difficulties we have had in working with the previous Government's forward estimates.

Mr DAUBE: It is important to put where we are in context, both nationally and internationally. The range of problems that we face are very little different from those that are faced by other States and countries. The problem with the growth in health costs is shared by all Governments.

Mr J.H.D. DAY: That may be the case. I am not arguing about that. I am asking what concepts does the minister have in mind to bring about the changes that he has said will occur.

Mr R.C. KUCERA: Again I will ask the director general -

Mr J.H.D. DAY: The minister must have some ideas about this himself.

Mr R.C. KUCERA: I have ideas, but I would like the director general to talk about that, because the issues that he is talking about underpin the vision that we have for health.

Mr DAUBE: It was precisely with that concern in mind that the Government has established a health review committee. That committee does not have the role of just saying how can we save something tomorrow. It is looking at the longer-term issues for the health system over the coming years and then over the longer term to identify ways in which, whether they be working with clinicians or others, we can reduce what is perceived as a drain on government. That committee is just about to report to the minister on the planning for its program of work. As the member will be aware, the committee is chaired by Michael Reid, and the Under Treasurer and I and a few other people are members of that committee. There is a substantial program of work that in my view is vital to be done in a context in which it is not all being done by people who are also involved in day-to-day activity around the department, because all of the additional pressures mean that it is then often very difficult to do the much more serious longer-term planning. The committee has been tasked by the Government to report back within 12 months of its establishment. A program of work is under way -

Mr J.H.D. DAY: We know all that.

Mr R.C. KUCERA: What point is the member making?

Mr J.H.D. DAY: I am asking what sorts of changes are being contemplated, not in the sense of setting up a committee or a review, but how will the minister bring about changes in the system? Is the minister looking at changes in teaching hospitals, secondary hospitals, country hospitals, primary health services or whatever?

Mr R.C. KUCERA: We will not be doing what the former Government contemplated in its last set of estimates, and that is close King Edward Memorial Hospital for Women. That is one thing we will not be doing.

Mr J.H.D. DAY: That is absolute rubbish. The minister was one of the Labor Party goons standing out the front of King Edward claiming -

Mr R.C. KUCERA: Point of order.

Mr J.H.D. DAY: I withdraw that word. The minister was one of the Labor Party apparatchiki standing outside the front of that hospital trying to politicise the issue when that was never the case at all.

Mr R.C. KUCERA: What we are not doing - that is the reason I used that example - is contemplating closing hospitals.

Mr J.H.D. DAY: I am not suggesting that you are.

Mr R.C. KUCERA: The member may not be suggesting that, but I get this constant barrage from both the Liberal Party and the National Party about closing hospitals. We are not contemplating closing hospitals.

Mr J.H.D. DAY: I am not asking about what the Government is not doing. I am asking about what it is contemplating. Can we hear from the director general?

Mr R.C. KUCERA: I am happy for the director general to address that matter.

Mr DAUBE: The sorts of issues that have to be looked at by the health review committee are issues that have been around for quite some time. I will take one example. Something that Governments of all persuasions have struggled with for many years is role differentiation in teaching hospitals. That cannot be dealt with overnight. It needs to be looked at very carefully. Other issues that we can look at are different approaches to models of care, whether we have optimal service configuration in the system, and whether we can better realise the benefits of area health services now that we have developed those services. I do not want to extend that too long. I just want to make the point that there are some significant system-wide issues that we will be looking at over the coming year. To take the issue of role differentiation among the major teaching hospitals as one issue alone, that is an area in which we should be able to gain substantial benefits in terms of both future planning and the services that we can provide to the community.

Mr J.H.D. DAY: When will those changes start to be put into effect?

Mr R.C. KUCERA: We have already started to see some benefits from the first two or three meetings of that group, and that will be ongoing. I will ask the director general to comment on the longer-term issues.

Mr DAUBE: Some recommendations will be coming through to government during the course of the next 12 months, mainly towards the end of that period. It is not for us to say now when those recommendations should be implemented. If what we get is what we anticipate, which is a major change in developing our program, it will be a staged implementation. There will be some aspects that we can look at in the short term, and there will be other areas where we will have to take a much longer-term view. We need to start looking at the future of the system - not at what we want to see this year or next year but how we want the system to look in 10, 20 and 25 years as the population of the State develops.

Mr M.W. TRENORDEN: I refer to item 114 on page 1075 in which there is a variation, as the minister is well aware, of $232 million. What proportion of that $232 million is to meet services as opposed to meeting increased costs; for example, the costs of insurance, superannuation and wages?

Mr CHUK: If I understand the question correctly, the question is testing the extent to which that $232 million is to provide new or expanded services as opposed to meeting costs. I think it is fair to say that the construction and preparation of the budget and the way in which it was built up and delivered to government by the department was very much based on ensuring that we can first guarantee that we can deliver current services before we recommend to government that we do new and additional things. Many people are well aware of the burden of expenses growth in health and the fact that the inflation cost of inputs such as labour, pharmaceuticals and the like is nationally running a good one per cent above the consumer price index, due largely to pressures in the national labour market. Beyond that, we have the demands on the health system due to demographic impacts such as the growth in the population, which will mean that a greater number of people will attend hospitals, and the ageing of the population, which will mean that a greater number will attend hospitals with acute conditions.

Mr M.W. TRENORDEN: What I want to know is the difference between those expenses that you have outlined - and you must know what they are, because you must have listed them in making your budget application - and what is left for new services.

Mr CHUK: The service plans for the next financial year are currently in preparation, so the global health budget is now in the process of being devolved to the health services and we are working out how much we can deliver to the health services within the budget construct. The basic premise underlying that from the department's perspective is guaranteeing to government that we can deliver current services.

[11.20 am]

Mr M.W. TRENORDEN: We are wasting time. Will the minister list the total cost of the growth expected in insurance, wages superannuation etc?

Mr R.C. KUCERA: We may be able to simplify the information on the amount of money that is spent on wages. That would give a fair indication of what is left for additional services. The increase in wages has been pretty much the same for a number of years. The percentage of money that goes to labour costs is quite high - I think in excess of 80 per cent.

Mr CHUK: Around 70 per cent of hospital costs are labour costs. The aim of the budget is to guarantee that the Health Department can deliver current services. The task now before the department is to take that bundle of money to the health services and work out how best we can deliver services in the coming year. That might mean some service changes and reconfiguration of services or that some services that are in decline continue to decline. It might mean that new services are added. The point I am trying to make is that specific service plans for health services have not been finalised at this stage. It is not possible to say that a certain service will increase.

Mr M.W. TRENORDEN: On page 1118 the budget shows that wages increase by $70 million-odd. However, by some miracle, superannuation contributions increase by about $400 000. I am not sure how that has happened. I would like some detail on the costings.

Mr R.C. KUCERA: Will the member refer to the line item?

Mr M.W. TRENORDEN: Employee costs on page 1118 are shown as $1.4 billion. However, superannuation barely increases to $430 000. I do not understand that.

Mr CHUK: I am not able to explain why superannuation will increase by $400 000 pro rata compared to the employee costs in total.

Mr M.W. TRENORDEN: I would like an answer to that.

Mr CHUK: I would be happy to answer that.

Mr R.C. KUCERA: One explanation that springs to mind immediately is that employee costs involve agencies and they do not get paid superannuation.

Mr M.W. TRENORDEN: It would be good to know that.

Mr R.C. KUCERA: I will provide that as supplementary information.

Mr J.B. D'ORAZIO: Visiting medical practitioners do not receive superannuation.

Mr R.C. KUCERA: The member was asking why there is a small increase in the level of superannuation. I will provide supplementary information on the increase in the cost of superannuation in the 2003-04 period.

[*Supplementary Information No A55.*]

Mr M.W. TRENORDEN: I want information on the increased cost. Salaries and superannuation costs are shown, but not the rest of the costs. Mr Chuk seemed to indicate that it will be available some time later. Is that the case?

Mr CHUK: It might be a process issue. The first step in the process is the allocation of the budget to health and the allocation of the amounts that we are discussing today. The next step is to devolve the budget across nine key budget areas within the Department of Health. Each of those areas will advise what their service plan is based on, say, $400 million for the next financial year. I am not trying to avoid the question but I cannot say today that services next year will not increase because they will. However, at the same time, I have said that the fundamental structure of the budget is to ensure that what we do this year will continue next year. The department will meet the enterprise bargaining agreement cost, the cost of drugs etc.

Mr M. McGOWAN: The third major initiative for 2003-04 listed on page 1103, refers to work at Peel Health Campus, particularly on renal dialysis services. When will the Government be in a position to provide renal dialysis services at Rockingham-Kwinana Health Service to meet the needs of a community of 110 000 people? What proportion of renal dialysis services are provided to private patients? What contract prices are being paid for renal dialysis services from private providers in WA and how much do these exceed the benefits payable by HBF?

Mr R.C. KUCERA: I understand that the future of the Rockingham dialysis unit is part of the overall state provision of dialysis services.

Ms McKECHNIE: The Department of Health has been engaged in a review of renal dialysis services across the State. In February, a review document that listed a series of priorities was announced by the Minister for Health. One of the service development priorities within that plan related to the need for further renal dialysis services in the south metropolitan area. The greatest priority for service development is in the northern metropolitan area, as documented in the review plan, which has been released. In the southern metropolitan area, the work at the Peel Health Campus, in the first instance, has been designed to create an efficient operation for that service. The work group that undertook the review considered that efficiency to be a greater priority than a second, small and inefficient service. The priority for the service at Rockingham is considered to be the third to fifth year of the service development plan as it is being outlined at the moment. The service developments in renal services, however, need to be prioritised among other service needs across the State and built into the overall capital works program.

[11.30 am]

Mr R.C. KUCERA: At the moment the footprint for the south west area is serviced by Fremantle, Melville and Peel. It is felt that the 25 to 30 minutes people must drive either way represents adequate coverage. However, as I said to the people of Rockingham, as their needs develop, we will be aware of their needs and we will consider the situation during further development of the campus.

This issue highlights a scandal in this State; namely, the availability of private health insurance cover for dialysis. I understand that the biggest provider of health insurance in this State, HBF, provides virtually no cover for people who require dialysis in this State. This issue has gone on for about three years. Just after I came to office I received a copy of a letter in which HBF was asked why it was not providing cover. The response to the letter of Dr A. Irish from the Department of Nephrology at Royal Perth Hospital, who had been constantly asking HBF to support those people with private insurance cover, states -

> From our observation, the public hospital system in Western Australia provides an excellent dialysis service. I do not believe the private sector could improve on that service sufficiently to justify the impact this benefit would have on contribution rates.

Effectively, that means that if people go on holiday in Queensland or pop up to Darwin, HBF will cover them for dialysis, but if those people want to visit their grandkids in Mandurah, bad luck; HBF does not provide cover for that. The sum total of that is that Western Australia is the only State in which private industry does not provide full cover for dialysis. We have a great system of dialysis in this State, but it is putting enormous pressure on us. We have an impending disaster in diabetes right across Australia. Kidney failure is one of the biggest causes of hospitalisation in this State and it is growing at exponential levels, particularly among Aboriginal people. Yet the 25 per cent of people with private insurance cover in this State who are seeking dialysis cannot get cover by HBF. It is an absolute scandal.

The CHAIRMAN: I would like the minister to conclude his remarks promptly. A number of members have sought the call.

Mr R.C. KUCERA: I conclude on this note: we are carrying the cost for renal dialysis right across the State to the tune of some $7 million. That is absolutely outrageous.

Several members interjected.

The CHAIRMAN: Order, members! I am chairing this Estimates Committee hearing, and shortly I will ask the minister to conclude his comments and we will move to the next speaker.

Mr R.C. KUCERA: I conclude by saying this: the State is desperately trying to put in place a statewide program of dialysis. Last year a $2.2 billion contribution was made to private insurance in this country, none of which went towards the provision of renal dialysis through local hospital services. I will stand corrected on that, but I know that was the case.

The point I am making is that over one-quarter of the patients in Rockingham would currently pay hospital benefits and I cannot see why HBF cannot support those people in this State. If we were able to get refunds from HBF for renal dialysis, I suspect we could very quickly put those kinds of things in place. It is an absolute scandal that people are being denied that cover. It is yet another example of how Western Australia is treated as the cinderella State.

Mr M. McGOWAN: What is the position with the other health funds?

Mr R.C. KUCERA: This is a real issue. The previous Government raised this issue with Wooldridge. A percentage is paid by some of the other health funds, but I also understand that that contribution is lower than that in other States of Australia. The consequence of that is that there is virtually no private dialysis in this State.

If some people are prepared to pay through the nose for it, that is fine. If we were able to recoup the cost of dialysis, we could start to move towards supporting those services in small country hospitals. All members in this Chamber should take up this issue.

Mr M.W. TRENORDEN: There is a very great need out there.

Mr R.C. KUCERA: Of course there is; there is an absolute need. Diabetes is now reaching epidemic proportions and will impact on virtually every man, woman and child in this State. Not only must people have dialysis, but also their jobs suffer and when their jobs suffer, their families suffer - everybody suffers. I think it is a scandal, and it has only just come to light because of the issues that have arisen in the past few days.

Mr M.F. BOARD: I refer to page 1076 and the NurseWest initiative. Can the minister indicate the total number of nurses in the public hospital system, the total number who have been recruited this year and, of the number who have been recruited this year, how many were recruited directly from universities, and how many nurses left the public hospital system this year?

Mr R.C. KUCERA: I will refer that to the chief nursing officer. For the first time in the Parliament, I congratulate Dr Phillip Della, the very first chief nursing officer appointed in this State. I notified him of his appointment last week.

Dr DELLA: We have those figures, but I do not have all those breakdowns at the moment. We recruited 428 nurses and full-time equivalents between February 2001 and February 2003. I can break down those figures as we do get monthly figures. We look at seasonal variations, because more nurses are employed in winter than in summer. The nurses coming out of the universities are recruited in both the public and private sectors through the nursing consortium in the State, and we can break those numbers down for the member. However, I do not have the actual number of recruits with me. The nurses register, which is a reflection of nurses registering, has increased dramatically. In 2001, there were 26 678 nurses on the register and the provisional figures that were handed to me yesterday by the Nurses Board of Western Australia indicates that there are now 28 945 nurses on the register. The employment of nurses is monitored on a monthly basis, and I can provide that information to the member. As at February 2003, 6 158 FTEs had been employed in the metropolitan area. In that month we used 356 agency nurses. That is a decrease on the previous month, but those numbers are monitored on a monthly basis. I do not have with me the figures that the member has requested but I can provide them.

The CHAIRMAN: Is that an indication that the minister will provide that information by way of supplementary information?

Mr R.C. KUCERA: Am I being asked for the information?

Mr M.F. BOARD: I would like the minister to provide by way of supplementary information the total number of nurses in the public system, the total number who were recruited this year and, of the number who were recruited, the total number who came directly from universities - that will give me the number of nurses who were recruited from subsequent training - and the total number of nurses who left the public hospital system this year.

Mr R.C. KUCERA: I know I have answered a number of parliamentary questions on this issue in recent weeks, so that information should not be difficult to provide.

The CHAIRMAN: I confirm that the minister will provide that information by way of supplementary information.

[*Supplementary Information No A56.*]

Mr R.C. KUCERA: Nursing has been a good news story for this State. It was interesting to note that federal Minister Kemp spoke on an SBS program last night about higher education. He made the very clear indication - a similar indication to the one I have made - that an enormous number of people on the nursing register in this country are not nursing. Our efforts have largely been directed at bringing people back onto the register and back into work. To a degree that has been a success. However, I shared everybody's disappointment with the minister's comments on the program when he outlined the numbers of nursing places that he is prepared to allot over the next five years as additional higher education contribution scheme places. One of the people made the point that in New South Wales alone some 1 600 additional nurses were needed and the numbers that the Prime Minister was talking about were a little over 400 for all States for the next five years. We estimate that this State has a shortage of many hundreds more than the Prime Minister is allocating for the entire country.

[11.40 am]

Mr M.W. TRENORDEN: It is not the whole problem.

Mr R.C. KUCERA: It is not. The member for Avon makes a good point.

Mr M.W. TRENORDEN: Some people are in professions -

The CHAIRMAN: Order!

Mr M.F. BOARD: I specifically kept my question sharp and directed to numbers only so that we did not have a 50-minute discussion on nursing programs, but we are going there anyway.

The CHAIRMAN: Does the member have a follow-up question?

Mr M.F. BOARD: No, let us move on.

Mr P.W. ANDREWS: I direct the minister's attention to page 1098 and to ambulatory care. Dot points 1, 2, 4, 5, 6 and 7, particularly dot point 4, deal with haemodialysis units. I understand that in Western Australia 19 people are on home haemodialysis out of a cohort of 505 patients on haemodialysis in general. That represents approximately four per cent compared with New South Wales where about 20 per cent of people are on home haemodialysis. If my figures are correct, could the minister provide me with some budgetary information on how we can assist people to be placed on home haemodialysis?

Mr R.C. KUCERA: I do not think the member was in the Chamber when I answered a previous question on this. One of the fundamental differences, as I understand it, is the difference in private dialysis versus public dialysis in the eastern States. The hospital benefit funds there support private patients with insurance. I meant to say before when I answered the previous question that I have framed a letter to the Australian Competition and Consumer Commission asking if it would look very quickly at the situation in this State. It seems to me to be anti-competitive when we have a major hospital benefit fund that is not competing as it should in that regard and supplying the kinds of services that people expect to be provided. I anticipate that the ACCC will look into that for us. I will defer to Sue McKechnie so she may point out the differences in the way that dialysis is supplied in this State as compared with others.

Ms McKECHNIE: There are four or five different modalities of treatment in the range of the renal dialysis program. Two options are available to people in their own homes and the other options are available in either the tertiary hospital renal dialysis unit or satellite-level services. The first criterion for people to be managed in the program is their clinical condition. Not everybody on the renal dialysis program is well enough or able enough to manage haemodialysis in their home environment. It is also the case that to provide haemodialysis services in the home, the home must have a suitable environment which includes appropriate water and power supplies.

Patients clearly need to be comfortable to manage the treatment in their home and have access to other support services should they encounter any difficulties. For that reason, it is quite difficult for us to extend the home haemodialysis program very far outside the metropolitan area. Having said that, it is acknowledged that there is a great opportunity in Western Australia for us to provide a home haemodialysis program. The first priority for the moment of the renal dialysis reference group is to alter the balance of patients in the tertiary centre program to allow for more training places. There is a waiting list at the moment. One of the issues for us is the number of renal nurses who are available to train clients to be able to move from a tertiary or satellite service to a home service.

Mr R.C. KUCERA: My understanding is that the public system is virtually the only supplier of this kind of service in the State. There is no competition that would enable us to offer different services for those people who may wish to have them.

Mr P.W. ANDREWS: I put to the minister that the number of chairs being made available means that we need to look at alternative ways of delivering haemodialysis. Does the minister intend to look at some innovative approaches to this, such as the nocturnal dialysis program?

Mr R.C. KUCERA: We are certainly looking. As was said by Ms McKechnie, that is the whole purpose of the statewide process. As the member will know only too well from a personal perspective, it is very difficult for the State to fund everything, particularly when there is no backup from the private system, which is an absolute scandal. It would be much better if we were able to develop a statewide program. Because of the member's personal experience, I was hoping that he would have the opportunity to look at some of those issues we discussed earlier on. I understand that the member will be attending an overseas conference during the long break. I hope that he will take the opportunity to look at some of the innovative methods that have been spoken about.

Mr DAUBE: If I may make a brief but related comment, it is entirely appropriate that we are talking about the need to provide services for an increasing problem. We will have to turn our thoughts to innovative and general approaches to prevention, because we are very often dealing with preventable conditions. The more we can do by way of prevention, which takes time, the more opportunity we will have to find ourselves with other ways of using the funding and not having to keep feeding this continuing growth in the service. We are looking at these areas and we are working well with our commonwealth colleagues on matters arising out of the national obesity task force, which all Australian health ministers supported. It is important to keep maintaining the perspective. While we talk about the voracious demand for services, which we will keep doing, we also need to keep our eye on prevention as a longer-term end.

Mr R.C. KUCERA: As the member will be well aware, the difficulty at the moment is that the money being leached out of the system and put into the direct provision of services is impacting on the provision of those preventive programs. I understand that we need to move on, but, finally, just on that question, we are currently subsidising private health in this country to the tune of $2.3 billion -

The CHAIRMAN: I ask the minister to conclude, largely because on this last question two of his advisers spoke and he spoke twice, which is making it very difficult for both government and opposition members who are seeking the call to get any answers to questions.

[11.50 am]

Mr M.W. TRENORDEN: I refer to item number 114 on page 1075 of the *Budget Statements*. The estimated actual expenditure for 2002-03 is $2.044 billion. Will the minister tell us what the overrun of the budget is for this current financial year as at 30 April 2003 and what it is expected to be at the end of this month?

Mr R.C. KUCERA: I will refer that question to Mr Chuk.

Mr CHUK: The budget papers indicate the estimated outturn is $2.044 billion, which differs from the 2004-05 forward estimate of $2.419 billion. At the time of preparing this budget, that was the estimated difference between the budget and the estimated outturn.

Mr M.W. TRENORDEN: What will the figure be on 30 April?

Mr CHUK: That is the outturn for the Department of Health.

Mr M.W. TRENORDEN: I cannot hear a word the adviser is saying.

The CHAIRMAN: Will Mr Chuk speak closer to the microphone.

Mr CHUK: That still remains the estimate at this stage.

Mr M.W. TRENORDEN: That cannot be the case. It is a simple question. What is the deficit as at 30 April and what will the deficit be as at 30 June? It is a simple question. Mr Chuk cannot say that a figure that was prepared two months ago is the current deficit. That is not correct.

Mr CHUK: I can only repeat what I have said.

Mr M.W. TRENORDEN: Does Mr Chuk not know what the deficit of the Department of Health is?

Mr CHUK: The numbers are reconciled on a monthly basis.

Mr M.W. TRENORDEN: What were the figures at the end of last month?

Mr CHUK: It remains consistent with this position.

Mr R.C. KUCERA: Another Bali incident could occur tomorrow.

Mr M.W. TRENORDEN: That is not the issue.

Mr R.C. KUCERA: It is the issue. The estimated actual outturn for the end of the year will be as stated. There is no indication that it will be any more or any less than as stated. That is the estimated outturn. It is a simple matter to work out the estimated budget, as opposed to the estimated actual.

Mr M.W. TRENORDEN: I do not want to know what the estimated budget was; I want to know what the expenditure is to the end of each month. That is a simple question.

Mr CHUK: I do not have the April figures with me. I can provide that as supplementary information.

Mr R.C. KUCERA: We can provide those figures to the member. The figure the member should be concerned about is the $2.044 billion, which is the estimated actual. We cannot be any clearer than that.

Mr M.W. TRENORDEN: The minister can. He can provide me with the figures on how much has been spent to this day. The $238 million will be less the overspend.

Mr R.C. KUCERA: I have already indicated that we are happy to supply that information.

The CHAIRMAN: Will the minister articulate what supplementary information he will provide to the member.

Mr R.C. KUCERA: My understanding is that we will provide supplementary information on the outturn as at the end of April.

Mr M.W. TRENORDEN: The deficit.

Mr R.C. KUCERA: No, the outturn.

Mr M.W. TRENORDEN: What the hell does the outturn mean?

Mr R.C. KUCERA: The outturn is the amount of money that has been spent as at the end of April.

[*Supplementary Information No A57.*]

Mr A.P. O'GORMAN: I refer to the seventh and eighth dot points under environmental health on page 1087 of the *Budget Statements*. The seventh dot point states -

> Production of Draft Greywater Reuse Guidelines to guide household re-use of wastewater from the kitchen, bathroom and laundry (not including the toilet) to help conserve water.

I refer to those guidelines and the use of grey water. What has been the community's acceptance or interest in this as a water conservation measure?

Mr R.C. KUCERA: That is a very good question.

Mr JACKSON: Clearly, Western Australians are concerned about their water resources. Grey water reuse is an issue of concern. There has been much interest in grey water reuse over summer. In conjunction with other agencies, including local governments, the Department of Health has developed grey water reuse guidelines. Grey water is that portion of the waste stream from kitchens and bathrooms, as the member said. Therefore, it has a lesser concern from the point of view of a bacteriological load and the impact on public health. Nevertheless, the public health issues must be addressed. Grey water reuse can lead to public health concerns. Those guidelines were developed through an open community consultation process. The public and the water agencies have received the guidelines well. We are confident of progressing the guidelines. A number of other water reuse schemes have been implemented on a larger scale. They affect some golf courses and other instrumentalities. The grey water reuse guidelines that were developed in Western Australia have received substantial support from all agencies and the community and are progressing.

Mr M.F. BOARD: I refer to full-time equivalent figures listed on pages 1085 and 1097 of the *Budget Statements*. Can the minister inform us of the total number of FTEs in the Health Department? If so, is the minister able to tell us how many of those employees are involved in directly delivering clinical services and how many in the system do not deliver clinical services?

Mr R.C. KUCERA: That is somewhat problematic. The member would need to define what is meant by clinical services.

Mr M.F. BOARD: I mean employees who deal directly with patient care of some kind.

Mr R.C. KUCERA: There are many research programs etc. We will try as best as we can to answer that. I refer that question to Mr Chuk.

Mr CHUK: Is the member's interest not in FTEs but -

Mr M.F. BOARD: I want to know the total number of FTEs in the Health Department. I am aware there are visiting medical practitioners and all sorts of visiting medical services. Of the total number of FTEs - I understand that this is not a simple equation - what is the breakdown of those FTEs who are recognised as dealing directly with patients in a clinical sense and those who are not?

[12 noon]

Mr CHUK: I have some data with regard to the number of FTEs as at 30 April. No doubt the member is aware that part-time workers are included in those equations. I am advised that 23 974 FTEs were employed by the Health Departments as at 30 April. I have with me a breakdown of those figures into eight categories. In nursing services, there are 8 707 FTEs; in agency nursing, 453; in administrative/clerical, 4 822; in medical support services, which I believe includes dental nurses, 4 071; in hotel services, 3 327; in site services - that is,

engineers and maintenance staff - 509; and there are 1 850 medical salaried staff and 235 medical sessional staff. There is a balancing item of three others.

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

Mr DAUBE: The issue of a breakdown into clinical and non-clinical staff is very hard. I think it needs some further definition. I counsel against any implication that people who do not provide direct clinical services are not valued within our system. The people who provide an enormous range of non-clinical services are absolutely vital. We try to make a point of that. For example, we included them when expressing our appreciation for staff after the Bali tragedy. That has implications. We try to provide some breakdowns. There are areas in which the lines will be fuzzy. It is important to not imply - I am sure that was not the intention - that those who do not provide clinical services are not valued.

Mr M.F. BOARD: I appreciate your counsel.

Mr M. McGOWAN: The fourth dot point on page 1077 relates to the Gordon inquiry. What additional services is the Department of Health providing to Aboriginal communities as a consequence of the Gordon inquiry, and what services is it providing to the Swan Valley Nyungah Community in particular?

Mr R.C. KUCERA: Firstly, the Department of Health is a major player in the issues identified by the Gordon inquiry. Secondly, the issue of the Swan Valley camp is somewhat problematic. My director general is one of those directors general who are most concerned about the issues at that camp.

Mr DAUBE: I am indeed one of those who have serious concerns about issues relating to access to health care, confidentiality and so on. I have expressed those concerns.

Mr R.C. KUCERA: Is that in relation to the camp?

Mr DAUBE: Yes. Our response to the Gordon inquiry is broader than services. Legislation is also required, as recommendations include the mandatory reporting of sexually transmitted infections in young people. That is being developed. A further range of recommendations relates to health, and we are comprehensively implementing those. Michael Jackson will speak about the services and the work that is being done as a result of the Gordon inquiry, such as a broader look at things like the sexual assault referral centres and the child protection unit.

Mr JACKSON: Following the Gordon inquiry, we are strengthening the child protection unit at Princess Margaret Hospital for Children. That impacts on Aboriginal people. We are strengthening both the metropolitan and country sexual assault referral centres. The range of regional centres will be provided with increased funding. They are not just adult centres; they are also available to children. A number of initiatives have been developed under the sexual health program to train those front-line people associated with schools and community health to deal with sexual health and sexual abuse matters. Those workshops are being conducted in a number of regional centres, including Kununurra, Carnarvon etc. There has also been work force development in community and child health and, as the director general said, with other agencies to enable people to respond to issues of child sexual abuse. The director general mentioned the initiative requiring mandatory reporting of sexually transmitted diseases in children. Such reports will also go to the police. Those amendments to the Health Act are going forward.

It has been difficult for our workers to maintain ongoing freedom of access to the Swan Valley Nyungah Community. We have at a grassroots level endeavoured to maintain the working relationships between the camp and our Aboriginal health workers and community health staff to provide a broad range of services to that particular community. The Department of Health is implementing a number of initiatives in direct response to the recommendations of the Gordon inquiry.

Mr M.W. TRENORDEN: I refer to cash flows from operating activities listed on page 1118. I would like some clarification on the capital user charge, which is estimated to be $98.8 million. Can the minister supply a breakdown of the assets this charge is levied against? Why is the charge levied and what is the capital user charge in each instance? Is that levy paid to Treasury?

Mr CHUK: I can answer some of those questions. The capital user charge is levied against net assets. I do not have with me the entire detail of our net asset position, which I think was a part of the question. Maybe we can deal with that later. The capital user charge is an initiative promoted by the Government to ensure that the full cost of services is recognised. The Government introduced the concept of a charge several years ago.

Mr M.W. TRENORDEN: When did the department first start applying this?

[12.10 pm]

Mr CHUK: It was included in last year's budget. I need to be advised about whether it was included in the budget of the year before that. I know that it was in last year's budget. It does not affect any of the year-to-year comparisons before us. It was introduced by the Government to ensure that the price of government outputs reflects the full cost of services, particularly in comparison with the private sector provision of services. Private providers fully reflect the debt costs of their interest loan repayments in the provision of services. The Government introduced this scheme, which has been introduced pretty much nationally. Some variations have occurred across Australia in the way it was introduced. The question was in three parts. One was the detail, which I will provide later, if possible; and, second, the reasons. The third part was?

Mr M.W. TRENORDEN: Is it paid back to Treasury?

Mr CHUK: That is correct. It is a round robin; the money comes in and goes back.

Mr M.W. TRENORDEN: I do not understand the charge. I would like supplementary information on that aspect.

Mr R.C. KUCERA: I am more than happy to provide that detail. I also suggest that the Leader of the National Party seek some clarification from Treasury.

Mr M.W. TRENORDEN: I am happy to do that. The minister will provide the detail in supplementary information. I can see a little concern opposite. I seek the details, Mr Chuk, of the assets and the charge, and the relativity to the charge so I can understand it.

Mr CHUK: To respond in concept, net assets represent the active valuation of all assets. It importantly includes the valuation of cash, and largely the depreciation value of assets we hold. Hospitals purchased 10 years ago at $20 million might be depreciated by half to $10 million on the debt asset register. On the other side of the equation, if we have $10 million in the bank, that would be read against the charge. It is conceptually the value of the net assets of the organisation. Why? In part, it encourages agencies to use their capital stock.

Mr M.W. TRENORDEN: I chaired the Public Accounts and Expenditure Review Committee so I understand the background information. I would like to know the detail so I can get my head around it.

Mr R.C. KUCERA: I am happy to provide details of the assets and how the charge relates to them.

[*Supplementary Information No A58.*]

Mr R.C. KUCERA: As cash deposits are included, the answer will relate to the current time.

Mr M.W. TRENORDEN: Fine.

Mr A.P. O'GORMAN: Page 1092 of the *Budget Statements* refers to communicable diseases control. The last dot point is the hepatitis C strategy. Will these services be provided by the Department of Health or by non-government organisations, such as Phoenix.

Mr R.C. KUCERA: I will refer that to Phoenix - I mean the director general. I do not particularly want to refer anything to Phoenix at the moment! I refer the question through the director general to Michael Jackson. While I am doing that, it would be a great shame if some of the excellent work in the area is brought into disrepute by some of the nonsense we have seen lately with some funding. The Women's Health Care House in Aberdeen Street in Perth is an excellent organisation. It seems a shame that some of the great work done by those people in HIV/AIDS seem to be undermined by recent publicity about Phoenix - frankly, it is justified publicity. The bottom line with such programs is that if they are not acting appropriately, funding will be withdrawn. As indicated clearly to the parent bodies such as the Women's Health Care House, I expect them to overview such issues as well. That is slightly out to the side of the question from the member for Joondalup. His reference to Phoenix indicates how important it is that organisations and their underpinning bodies are on top of how funds are spent.

I refer the question on hepatitis C through the director general to Mr Michael Jackson.

Mr JACKSON: Hepatitis C continues to be a significant public health issue for us. In line with previous comments, the prevention strategies are high on the agenda to reduce its impact on the acute system. We have about 1 800 hepatitis C cases per year in Western Australia, so it is significant. In answer to the specific question raised, we engage two significant non-government organisations in addressing hepatitis C, particularly from a prevention point of view - namely, the Hepatitis C Council of Western Australia and the Western Australian Substance Users Association. The AIDS Council of Western Australia is also involved. These non-government organisations, through a series of contracts, provide a comprehensive range of services aimed at minimising the re-use of needles, which is the main cause of the continued number of hepatitis cases. The

needle exchange, conducted particularly through WASUA, and a range of other components of the programs, aim to address concerns about hepatitis C.

Mr J.H.D. DAY: I raise mental health, which is mentioned in a dot point on page 1106. However, I raise a general issue. I am surprised not to see a discrete section in the budget papers on mental health services. Perhaps that tells a story in itself.

Mr R.C. KUCERA: In what way?

Mr J.H.D. DAY: I am about to make the point that issues relating to the level of mental health illness in our community have been recognised over the past eight years. It needs greater attention. As the minister would be aware, the emphasis is on community-based care rather than in-patient care. That emphasis needs accompanying appropriate and informed services. I am sure the minister is aware of many of the issues given his role as a former police officer dealing with problems in the community.

Mr R.C. KUCERA: Yes.

Mr J.H.D. DAY: What is the expected allocation to mental health services in the next financial year, and what has it been for the last three years? That answer can be provided by way of supplementary information, if necessary.

Mr R.C. KUCERA: I refer to the director general.

Mr DAUBE: Before I refer to colleagues, I make it clear that mental health is an exceptionally high priority for us in the State and nationally. Dr Groves, who is overseas at present, is the acting chair of the National Mental Health Working Group established by the Australian Health Ministers Advisory Council. This was involved in convening the national Mental Health Promotion Symposium, and a national plan is being developed and presented to ministers. A range of high-level activity is being undertaken to prioritise mental health. We have separated the Office of Mental Health and the Office of the Chief Psychiatrist to ensure we maintain integrity in the system. A review of the Act is being chaired by Professor D'Arcy Holman. I make it clear that there is absolutely no lack of attention to mental health. It is true that many years ago there was a separate department of mental health - Mental Health Services. That ended in about 1983, but the priority remains.

Mr J.H.D. DAY: My point stands that the budget papers do not have a separate section. It outlines ambulatory care, admitted care etcetera. I refer to the funding allocation.

Mr DAUBE: I am not sure whether we have the numbers here. Dr Lloyd will respond. If not, we will provide them to the member.

Mr J.H.D. DAY: By supplementary information, I seek the funding for 2003-04 and the three previous financial years.

Mr R.C. KUCERA: The supplementary information requested is the funding for mental health services over the past two years.

Mr J.H.D. DAY: No. It is for 2000-01, 2001-02, 2002-03 and 2003-04.

[12.20 pm]

Mr DAUBE: It will depend on the allocations for 2003-04. The allocations are currently being prepared. I am not able to commit the department to providing that information in the normal time frame.

[*Supplementary Information No A59.*]

Mr J.H.D. DAY: In the context of providing better mental health services in the community, which are very much needed, the minister and the director general would be aware of the major review that occurred in 1995. The review had bipartisan support and brought about major changes. One of the recommendations put into effect was to establish an organisation to provide better information about how to deliver effective mental health services in the community. The Centre for Mental Health Research was subsequently established for that purpose. My understanding is that the funding it has received of $500 000 a year ceases at 30 June this year despite the fact that the centre was told in November last year that funding would continue. The decision was reversed in December. Can it be confirmed that that is the case? If so, why was the decision made? If it is the case, will the minister review the situation given the concerns about the delivery of mental health services that will emanate from such a decision?

Mr R.C. KUCERA: As the minister, the priorities I have set on mental health have been quite clear. I have a passion for the area because of my previous life, as the member rightly pointed out. I have taken the liberty of becoming a member of the visiting panel to various centres. I do that of my own volition so I know exactly what

is going on in the system. My priority is that every possible dollar goes to the delivery of services. I want to ensure that everything that can be done is done in the delivery of mental health services. Having said that, I am not aware of the underpinning of the question asked by the member. The director general and Associate Professor Arya will be able to help the member.

Mr DAUBE: I will speak briefly and ask Associate Professor Arya to speak to that. I am not aware of the commitment to continue funding to the centre.

Mr J.H.D. DAY: I am talking about the decision to discontinue funding.

Mr DAUBE: That is right. I am aware of the five-year contract. It is a matter of addressing our priorities and reviewing the work of groups to see how it fits in with our priorities. The member is absolutely right. The decision has been made to allocate funding in other areas.

Mr ARYA: I will take up what the director general has said. It is quite correct that the centre was funded for five years. As the member stated correctly, the funding was $500 000 a year for each of the five years. It is important to realise that the centre became an incorporated society and a charitable institution for the purposes of research. The Department of Health had to consider the research priorities for Western Australia. Research priorities for mental health are now focused more broadly and include work force development as well as applied mental health research. There is a strong emphasis on developing linkages with population health. In determining the priorities a decision was made to strengthen population mental health research. Some research funding will be diverted to developing a chair in population mental health.

Mr J.H.D. DAY: Given the need for the services in this area I politely and respectfully ask the minister to review the decision, bearing in mind the minister's interest in the area. I do not want to make a big issue of this.

Mr R.C. KUCERA: The review has been done. That is why the funding is being reallocated to another area.

Mr J.H.D. DAY: I understand that it was not a formal review of the effectiveness of the centre.

Mr R.C. KUCERA: It was not a formal review. I am not aware of the total underpinning of the decision but I do not intend to review it. The decision has been made on good advice. As I said, my priority for mental health is to ensure that, whenever possible, research is focused. The reality is that money must go where people are and where the difficulties are.

Mr J.H.D. DAY: This is what this is all about. It is very disappointing that the minister will not even open his mind to the issue. He has said he is not really aware of the issues behind the decision. I ask the minister to look at the issues involved.

Mr R.C. KUCERA: I take the advice of my senior people. I also take the time and trouble to find out for myself. As far as making decisions is concerned, that is the best type of research.

Mr DAUBE: There has been a deal of consideration of this issue and how funding and research funding is applied in mental health. Consideration has been given to how research funds can be most usefully used. We have considered the record of the Centre for Mental Health Research. That does not deny the good work conducted there. We have also come to the conclusion that the funds would be more appropriately allocated in other ways. That has not been done without a deal of consideration and advice. I assure the member that we are committed to ensuring that research and other funding in mental health is allocated appropriately. We believe that is what is occurring.

Mr J.H.D. DAY: The minister needs to consider the issue himself.

Mr R.C. KUCERA: I take the advice of my senior people. I respect their advice, particularly that of Dr Groves. He believes the money is better allocated to people who have mental illnesses.

Dr J.M. WOOLLARD: I refer to the first dot point at page 1088 under the heading of health promotion. It states that a major review was conducted into part IXB of the Health Act 1911 and the Health (Smoking in Enclosed Public Places) Regulations 1999. I am pleased to hear that the minister takes the advice of the senior people in his department. The minister has a cardiologist as a chief medical officer, a director general from a public health background and a chief nursing officer who also has a very keen interest in health promotion. As an aside, I congratulate the chief nursing officer on his appointment. Because of his previous role as chairman of the National Heart Foundation of Australia (WA Division), I am aware of the minister's commitment. What is happening with the review? I am concerned.

The CHAIRMAN: During the suspension, agreement was reached that questions would be kept short and to the point. The member for Carine, when Chairman, quite rightly allowed me to ask a very short question only because I was not a member of the committee.

Dr J.M. WOOLLARD: I will shorten my question. Will the minister table the review, which was due by 12 January? Will the Government listen to the community, 80 per cent of whom believe that smoking should be banned in enclosed public places? When will the Government protect the interests of patrons and staff in the hospitality industry? Is the Government waiting for litigation before it does anything? I am sure that the minister has followed recent debate in the House. The Premier and the Minister for Consumer and Employment Protection have advised me that the minister will answer these questions today.

[12.30 pm]

Mr R.C. KUCERA: The member is quite right; a major review was conducted. I have received the initial report and it is currently being considered by government. As I have already stated in the House, the Government will report in due course. The Government is not waiting for litigation. I suspect that litigation is something that the industry needs to look at very clearly in the light of the experience of the asbestos industry. The industry would be well cautioned to look at that, because the first of those class actions has already commenced in other States and in other places. We do not need to look at litigation. I will place before the House the outcome of that review when the Government has considered it.

Dr J.M. WOOLLARD: Further to that point, the results of that review were due four months ago. People are still working in that area seven and a half hours a day, 37 and a half hours a week.

The CHAIRMAN: Seriously, I had four short questions to ask, and because I was not a member of the committee, the Chairman at that time, the member for Carine, stopped me dead in my tracks. The member should ask her question.

Dr J.M. WOOLLARD: When will the Government table that review, and when will it introduce legislative changes; or will the Government support my private member's Bill and implement changes now?

Mr R.C. KUCERA: I intend to place that matter before the House as soon as I am able to do so. I anticipate that will be within the next month. The issue needs to be considered very carefully. The member asked whether the Government had listened to the community. Yes, it has. In fact, I extended the time in which people could make submissions. We received some 70-odd submissions, from recollection, which is not a large number. It is important to make sure these things are done properly. At the end of the day, this State is leading the way on this issue in this country.

Dr J.M. WOOLLARD: Not at the moment, minister.

Mr R.C. KUCERA: We are leading the way. I understand that less than 22 per cent of the population smokes. We are now at the stage of dealing with the margins, and the measures will be the most difficult to introduce. I am also mindful that if we introduce a range of measures that could label us a nanny State, it could work against us. The member is quite right. I was the chair of the Heart Foundation. As an ex-smoker, I am very mindful of the need to make sure we have proper legislation. However, I am also mindful of the fact that it must be done properly, and with government and community support. I suppose the issue is balancing those twin pillars of wisdom. I cannot take it any further than that. I have the review papers. I am dealing with the issue within government, and in due course the Government will state its position and place it on the record in this House.

Ms J.A. RADISICH: I refer to the third dot point from the bottom on page 1099. I am pleased that the health ministry considers the street doctor program and the mobile access centre bus program to be one of the major achievements for the current financial year. The minister has visited the bus, as have I, and knows the level of dedication of our local doctors to particularly the young people in the area who need it most. What commitment is the Government giving to the MAC bus, in particular, for the forward years?

Mr R.C. KUCERA: Regardless of the funding issues, it does one's heart good when one sees doctors who are still prepared to put medical issues first. It is so difficult nowadays to get people to work in the outer suburbs, and indeed in the country, that it is great to see those sorts of general practitioners. General practitioners in this country are unsung heroes as far as I am concerned, and I am happy to support them in their efforts at the moment to deal with the Medicare issue. I am concerned about some of these programs. It raises an issue that I followed up this week, and I have asked the department to follow it up; that is, a letter that was written to *The West Australian* last week by a Canadian doctor who was working in one of the outer areas - I believe in the member for Avon's area. He was deeply concerned about the Medicare issue. The Medicare moneys that he obtained during a certain period were in excess of half a million dollars, I understand - that is the advice I was given - yet he was paid a wage of $120 000 in that same period. One must wonder where on earth that money went. It may be legitimate. However, I was in Bencubbin recently, and the local council there was so desperate to attract doctors to the area that it was paying for a house, a surgery and a raft of other issues. It was supporting the doctors so that they would stay in that area.

The doctor to whom I referred, who was an overseas doctor, was getting a wage. I have asked the director general to investigate where the rest of the money goes - particularly in relation to the contents of that letter. I will be concerned if somebody is benefiting to the tune of almost $300 000 - in fact, $380 000 - out of that arrangement, and it is not being brought forward. What concerned me most was that the letter said "the authorities" were getting that money. The Department of Health is not getting it; I do not know who is. In the case raised, the indication was that the Bencubbin Shire was not getting the money. I am not saying that it is the same issue.

Mr M.W. TRENORDEN: Does it not go through the hospital?

Mr R.C. KUCERA: I understand that is not the case. I understand the shire's take out contracts with various groups whether they be corporate groups, which are involved in many of these issues, as are medical associations. I am not pointing fingers or trying to stir up trouble. It is a concern when a shire is involved. The doctors themselves established the street doctor program, and it must be commended. Having said that, I hope the Director General of Health will tell me how much funding we give them. We are concerned that the cost of supplying doctor's services outside the metropolitan area is increasing. The groups of people attending are in considerable need of this service.

Ms J.A. RADISICH: The number of doctors in the Shire of Mundaring is well below quota, and other suburbs, such as Ellenbrook, cannot attract a doctor no matter what support we provide in rented accommodation.

Mr R.C. KUCERA: I would be concerned about someone benefiting financially from the program to the detriment of the community. In some instances, people run the service to their own detriment. They could make more money if they followed some of their western suburbs counterparts.

Ms McKECHNIE: The program is funded as part of the joint state-commonwealth program for homeless youth. Funding will continue for that program in 2003-04.

Ms J.A. RADISICH: Is that the street doctor and MAC bus program?

Ms McKECHNIE: Yes.

Mr M.F. BOARD: I refer to emergency services on page 1095. I am trying to find the funding for St John Ambulance Australia this year and how it compares with the funding for the previous year.

Mr R.C. KUCERA: I understand St John's contributions, in accordance with its contractual arrangement, are under consideration. That could be why there has been a bit of noise lately in the Press about ambulance services.

Mr DAUBE: The Department of Health is having discussions with St John Ambulance. We are engaged in a review and we are looking positively towards the outcome.

Ms McKECHNIE: St John Ambulance Association has a five-year contract with the Department of Health. A progressive schedule of payments is associated with that contract. The value of the contract in 2003 was $13.5 million. The value of the contract in 2003-04 will be $13.7 million.

Mr R.C. KUCERA: I have had discussions with St John's executive and our senior executive about its method of delivery of services. We are seeking a change in configuration in an attempt to get more people treated at home. It is the federal Government's desire to provide more home and community services. I have indicated that, in future contract arrangements, it might be possible to examine how St John delivers services and how we arrange that cost. I would much prefer more people to be treated at home. If the funding arrangements for St John are driven by the number of people delivered to or transferred between hospitals and a change in the federal Government's configuration of services, that could affect us in the future. That needs to be discussed. This does not in anyway put at risk anything St John Ambulance does. It will ensure that people are serviced properly. The federal Government has indicated very clearly that it wants a change in emphasis on home services; it wishes as many people as possible to be dealt with in their homes. I can understand why. It would be very nice if we were paid for that. St John Ambulance service provides a very positive service. In discussions I have had with St John Ambulance, it is realising that the service is changing.

Mr M.F. BOARD: Notwithstanding what the minister said about people in the home, with which I agree, indications provided by St John Ambulance indicate that in categories 1 and 2 there is a blow-out of response times, which is not an issue concerning people at home; it is a question of St John's response time in emergency situations, which it says are increasing because it does not have enough response vehicles. Will the minister indicate whether an allocation has been provided for additional funding to meet that need?

Mr R.C. KUCERA: There are two issues. A decision about additional funding might be relevant if there was no change in the type of St John's services. That is why I have asked St John Ambulance to examine what services

it should provide in transferring patients as opposed to providing an emergency service. St John might have enough resources but they are being used in such a way that puts pressure on the emergency side of its service. Obviously, we are looking at additional funding issues.

Mr M.F. BOARD: Does that answer mean that the minister is considering dealing with patient transfers in a different way?

Mr R.C. KUCERA: The member is missing my point. We are moving a lot of people into the hospital system. The issue relates to what John Burns said earlier about dealing with demand. In the aged care sector - for example, the lack of nursing expertise that has arisen through under funding in the aged care sector - many people are not being treated in nursing homes and hostels. They are actually being transferred by St John Ambulance to hospitals. We have asked St John Ambulance to work with us to see whether we can change that kind of operation. It may well be that St John Ambulance picks up a role as paramedics to deal with people in their homes. If that is the case and we start to take some of the pressure off, the existing ambulance structure would cope very well. We have asked St John Ambulance to open the keyhole that it is looking at, but if it continues along the same path it is on now - that is, the traditional service that has been around for 150 years - we will simply have to keep throwing in more money, which is what the previous Government did. However, there may be a different way to do it. I know the director general is champing at the bit because we have a very positive story to tell about St John Ambulance at the moment. Some good negotiations are taking place and it is prepared to listen and talk to us about the change in configuration that I am talking about.

[12.40 pm]

Mr DAUBE: There are issues about the configuration of transportation provided by St John Ambulance. However, the important point that I must stress is that, as I said earlier, we have currently been engaged with St John Ambulance in a review of the work that we do in partnership. Clearly, that will have some impact on funding for future years. We are still considering those issues, but it is important to recognise that funding will take into account the outcomes and our views of the review. Secondly, we must have a good, close working relationship with both the management and staff of St John Ambulance. Through the work that John Burns has been doing in the emergency area, we have been at great pains to ensure that that working relationship is further developed and expanded. We need to look at the funding issue very carefully with St John Ambulance, as well as the way it works, the way we work and the working relationship. Again, through John Burns and his colleagues, that is something we are also developing further.

Mr M.F. BOARD: Is there a time frame for that review?

Mr R.C. KUCERA: We have a contract to sign. The review is obviously linked to the contract. I do not know the specific timing of that.

Mr DAUBE: The review is fairly close to winding up. We will engage in discussions with St John Ambulance in the near future.

Mr J.B. D'ORAZIO: I refer to the first dot point of the significant issues and trends on page 1075 of the *Budget Statements* and also to the capital works program for King Edward Memorial Hospital. Do those works relate to the Douglas inquiry? If so, what improvements will they generate?

Mr R.C. KUCERA: That is a good question. Some of the works do relate to the Douglas inquiry. I refer that matter to Michael Higgs.

Mr HIGGS: The major part of the work being undertaken at King Edward Memorial Hospital relates to the Douglas inquiry. It includes the upgrade of the labour ward, the redesign of the emergency centre, the establishment of obstetric and clinical day assessment units, and refurbishment of a neonatal unit.

Mr J.B. D'ORAZIO: Do those works address the specific recommendations of the Douglas inquiry?

Mr R.C. KUCERA: Yes, they do. I refer that matter to the director general.

Mr DAUBE: Dr Lloyd has chaired the committee set up to review the implementation of the recommendations of the Douglas inquiry. It is important to stress that we have undertaken a meticulous process of following through the recommendations of the Douglas inquiry. It has been a prioritised process. The high priority recommendations have been followed through. The committee includes independent participants, including a member of the Douglas inquiry, Professor Jeffrey Robinson. We are moving effectively through the Douglas inquiry's recommendations, through Dr Lloyd's chairing of the committee and the work Dr Kelly has done as Chief Executive of King Edward Memorial Hospital. Work is also being done as a result of the Gordon review in relation to the Sexual Assault Referral Centre and the child protection units.

Mr J.H.D. DAY: I was going to raise the issue of the inquiry into King Edward Memorial Hospital; I will now follow on from the question asked by the member for Ballajura. As the minister is aware, the report ultimately published and tabled in Parliament unfortunately had about 240 pages deleted from it. That issue was raised in the Estimates Committee last year. The minister arranged for a briefing from the Solicitor General. Despite the fact that the information about the clinical cases was presented in a non-identifying form, the concern was expressed that some individuals could still be identified. As the minister knows, this was a major inquiry. Some clinical people are concerned that the major benefit of the inquiry into some important issues has not been delivered because clinicians in particular do not have the benefit of reading the approximately 100 cases that were deleted from the report. A process could be followed whereby the individuals concerned could be presented with the information and asked to respond. The information could then be published in a non-identifying form, allowing all the rules of natural justice to be followed, so that clinicians could learn from the mistakes that have occurred in the past. Is the minister prepared to adopt that course of action?

[12.50 pm]

Mr R.C. KUCERA: I think we have probably gone past that point.

Mr J.H.D. DAY: I do not think we have.

Mr R.C. KUCERA: That may be the member's view, but in many ways we have gone past the point. We are approaching finalisation on other parts of that section. I will not go into those because they are being well publicised at the moment. In fact, the medical board is taking action on a number of issues that have arisen.

Mr J.H.D. DAY: The issues are much broader than that.

Mr R.C. KUCERA: I realise that. A well-formed group has been set up, which is chaired by Dr Lloyd. It includes the senior clinician who was working with Neil Douglas on that inquiry. I am very comfortable with the process that is being carried out. My advice from the department and from clinicians is that they are comfortable with the way things are progressing in that regard.

Mr J.H.D. DAY: Some people might be comfortable, but some are very uncomfortable, I can assure the minister.

Mr R.C. KUCERA: It is difficult in life to please everybody. The advice I am being given at the moment is that the process is supported. It is being independently overviewed by the people who carried out the inquiry. If the member has different information, he can bring it to me and I will be happy to act on it.

Mr J.H.D. DAY: I have just put it to the minister.

Mr R.C. KUCERA: Making a general statement is not of much use to us.

Mr J.H.D. DAY: It is not a general statement; it is a specific request that past mistakes be presented at least to the clinicians and, ideally, publicised.

Mr R.C. KUCERA: It is a specific request by the member about a generalisation.

Mr J.H.D. DAY: It is a very specific issue about clinicians learning from mistakes of the past.

Mr R.C. KUCERA: Perhaps we should let Dr Lloyd explain exactly what the learning process has been.

Dr LLOYD: The issue is clearly a very important one from our point of view, because through the implementation committee we are extremely keen to develop systems that will prevent the problems from ever occurring again. The systems that are being changed, the line accountability, the systems to look at adverse events such as deaths, are much improved. As some members would be aware, over the past six months we have moved the direction of analysis of complaints to root cause analysis, which is a system that is being used or developed around the world to look at an analysis of a problem to see why the system allowed it to occur rather than to go to an individual doctor to look at his error.

Mr J.H.D. DAY: That is not what I am suggesting. I am suggesting that information on mistakes that have occurred in the past and their clinical case histories that have been written up in a non-identifying way can be made available. As Dr Lloyd would know as a clinician, the best way in which clinicians can learn is to look in some detail at the mistakes that have occurred. Unfortunately that method is not available at the moment.

Dr LLOYD: At the moment we are doing what we believe to be a very good process to develop safety systems in King Edward Memorial Hospital which will be translatable across the system. There is a huge degree of enthusiasm about where it has gone. I am extremely optimistic about the stage we are at. Professor Geoffrey

Robinson from Adelaide, who sits with us on a regular basis, is also extremely happy with the outcome of the inquiry implementation to date.

Mr R.C. KUCERA: If I may clarify that? My understanding of the process is that it is exactly what the member for Darling Range is asking for. The new processes, protocols etc are based on case histories and the knowledge that has come out of the Douglas inquiry. I am not trying to be evasive, but the point I am making is that we have moved on past that publication.

Mr J.H.D. DAY: It is getting late. Unfortunately the Government did not take the action that would have been in the best interests of mothers and babies in this State.

Mr R.C. KUCERA: That is unfair and untrue. The member is well aware from the briefing he has that the Government did that as a result of legal advice. Consequently, there are cases before the courts at this very moment. In saying that, the member for Darling Range is misleading us. The group has been set up to deal with the Douglas inquiry, learn from the mistakes of the past, and put the proper procedures in place to protect mothers and children. It was a great shame that we had to go to Douglas in the first place.

Mr J.H.D. DAY: Of course, and not much support was provided for the inquiry by this Government after the change of government.

Mr R.C. KUCERA: That is absolutely wrong. The present Government ended up paying almost three times the amount of money the previous Government set aside for the completion of the inquiry.

Mr M.F. BOARD: I intended to raise this as a separate issue. A number of cases have been referred to the Medical Board of Western Australia, including one being heavily publicised. The minister made some statements about bringing in legislation to change the way in which the Medical Board operates. At that time he felt some frustration about the speed with which the board is able to deliver results. It is a strange situation, in that there was a very large and expensive inquiry, and a number of cases have gone to the board and been bogged down. Some are subject to legal challenges, but nothing has happened and there is no closure. There is one highly publicised case at the moment, but no-one knows when the other cases are likely to proceed. When will the minister bring the medical Bill into the Parliament? I will talk about other legislation later. I make no accusations against the Medical Board, because natural justice is necessary. However, considering what the State spends to bring matters to a conclusion on behalf of the community, the board is not operating properly. My office is receiving hundreds of letters from people with huge concerns that are not going any further. When will the medical Bill be brought to Parliament, and when will there be a system that enables people to raise issues and have some closure?

Mr R.C. KUCERA: There are four matters there. Firstly, if the member is getting hundreds of letters on that issue, he should pass them to me. I would love to see what they are about. The Government has received letters about a current case, which I will not discuss because it is before the courts. Secondly, two key issues have been holding up the amendments to the Medical Act. The first of these is corporate health. I was asked by the Australian Medical Association to consider trying to ban corporate health. My view is that that should not happen.

Mr J.H.D. DAY: Does that refer to corporate ownership of medical practices?

Mr R.C. KUCERA: Yes, but essentially it is the same thing that Australian Medical Association members currently practise themselves. What is sauce for the goose is sauce for the gander, unless you are the goose. Thirdly, the other matter holding up the medical Bill is the question of the State Administrative Tribunal. I wanted to get clear direction from the Attorney General about how he saw the medical processes fitting in under that body. I have now had instructions from him about how he wants it to sit. The Medical Board, now that I have discussed it with Professor Michael and others, is more than comfortable with that arrangement. I am still awaiting advice from the Australian Medical Association on whether it is comfortable with it. I suspect it will be, and we will move on. I intend to have that Bill drafted this year. Fourthly, what the member is talking about will very much be taken care of in some of the changes the Attorney General is intending to make to liability issues. Much of the reason doctors simply cannot come forward and talk about mistakes and deal with them relates to the current raft of liability issues right across the nation. Although I have not yet seen the detail, I was very pleased this morning to hear the federal Government announce that it has moved on two of the major liability issues that we have been desperately waiting on for the past 12 months. Once a doctor can simply say he is sorry that something went wrong, and it can be dealt with without fear of litigation, that will take care of one of the key issues. That is one of the fundamental issues we have addressed. The broader issue of liability will be addressed in the raft of changes we intend to make. They have not yet gone before Cabinet, so I will not pre-empt them. They will probably go further than the issues of the medical Bill, which I intend to introduce

before the end of this Parliament. I would be more than happy to brief the member on it as soon as we have the first draft.

[1.00 pm]

Mr M.F. BOARD: The minister said that he intended to draft it this year.

Mr R.C. KUCERA: Essentially, it is drafted, but a couple of issues must be sorted out. I will have to get more advice on those aspects. The health practitioners Bill and the medical Bill are the two major pieces of legislation I intend to introduce before the end of this Parliament.

Mr M.W. TRENORDEN: I refer to visiting medical practitioners in the statement of financial performances on page 1116 of the *Budget Statements*. The medical indemnity premiums and the retention of doctors in country areas are urgent problems for country doctors. Has the Government provided an allocation to subsidise the high premiums of medical indemnity insurance for rural general practitioners in 2003-04? If so, how much is it? Will that allowance continue in the out years?

Mr R.C. KUCERA: We have taken away the uncertainty. There was a kerfuffle recently from the Australia Medical Association -

Mr M.W. TRENORDEN: I do not know about the AMA, but there is certainly noise coming from rural doctors.

Mr R.C. KUCERA: The AMA thought the allowance would be allocated for only 12 months. I will get Mr Chuck to explain that. The issue of medical indemnity is so volatile and we are so reliant on changes being made at a federal level, which we might get, that there was no way to project what the shape of medical indemnity would be after 12 months. I gave all country doctors the assurance that we would cover them, regardless of the shape of that indemnity. The shape of the indemnity we offer could change after 12 months. I have been open and transparent about that. The message I would like the member to take back to country doctors in his electorate is that they will be covered when they practise in public hospitals.

Mr M.W. TRENORDEN: I would like to clear up that issue. I am not worried about the AMA; I am worried about the doctors who tell me that their insurers have told them not to turn up to work on 1 July.

Mr R.C. KUCERA: This morning on the radio I heard the Minister for Revenue and Assistant Treasurer, Senator Coonan, give exactly the same message I am giving to the member, and she is not exactly politically aligned to me. I refer the matter to Mr Chuk, who will explain precisely what the Government intends to do in the short term and beyond the 12 months.

Mr CHUK: The member's question referred specifically to the subsidy scheme offered to rural visiting medical practitioners. That scheme was introduced several years ago. About $1 million has been made available for that scheme in the current financial year. The recently announced approach by this Government to broaden and provide greater support to VMPs regarding all VMPs who undertake public work in public hospitals will in part duplicate that scheme. The Department of Health is currently working through just how much those two schemes overlap. It is intended that there will be no diminution in the benefit provided to the rural specialists; indeed, it will be increased under the new proposal. The rural subsidy will decrease, but it will be more than offset by the Government's support for VMPs through risk coverage to provide support to indemnify VMPs who provide public work in public hospitals.

Mr M.W. TRENORDEN: Can I therefore assume that the forward budget will include $1 million-plus?

Mr CHUK: For the rural subsidy, it almost certainly will go down, but -

Mr M.W. TRENORDEN: I want to get to the point the minister raised. In the next three weeks we must tell these doctors they do not have to worry about this year, and that they are covered against being sued in 25 years time and all the other issues relating to professional indemnity. They are not hyped up; they just want to know they are covered.

Mr R.C. KUCERA: I cannot spell it out any clearer. They will be covered. A raft of issues need to be considered. Firstly, the indemnity changes in terms of tort law will go ahead. Secondly, my understanding is that the federal Treasurer has announced his support for the changes that are to be made concerning death, disability and retirement - I have not seen the details. Thirdly, a subsidy system will be picked up by the State Government, but my understanding is that the federal Government will step in and take up part of that. We will continue to make up the rest of the subsidy. I am talking about the specialist doctors - obstetricians and others. We will cover those doctors who are working in public hospitals treating public patients. We will neither subsidise nor insure private doctors working in private arrangements.

Mr M.W. TRENORDEN: They are not asking for that.

Mr R.C. KUCERA: That is right. We must work through a couple of anomalies with some of our large privatised hospitals closer to Perth. As I understand it, that does not affect the people who work out of the member's areas. Those doctors can be assured that under their VMP contractual arrangements, they will be covered for the work they do in the public hospital system.

Mr M.W. TRENORDEN: The minister has given an indication that they will be covered in this coming budget. What figure is the minister projecting for the next financial year, 2004-05?

Mr R.C. KUCERA: I will ask Mr Chuk to speak to that aspect.

Mr CHUK: It is the department's intent that the support to rural VMPs will continue beyond the next budget year. We have recently written to all VMPs, and I think twice we have given them appropriate contacts that processes are in place to engage directly, face to face, with rural VMPs to ensure that they are aware and well informed about the changes the Government has put in place, all with the absolute intent of ensuring that our services in the country areas will continue.

Mr M.W. TRENORDEN: I will speak to the minister at a later date because there are concerns that doctors are not insurance specialists; they are just doctors.

Mr R.C. KUCERA: I am not normally critical of the Australian Medical Association, but I am on this occasion because some of the misinformation it put out was just that - misinformation. We made it clear that we would cover the doctors, and we are doing that. Running parallel, the medical defence organisations made the decision not to cover the public doctors. They have indicated right up until now that they may come back into the business.

Mr M.W. TRENORDEN: But there is a reason for that. Prudential requirements have changed dramatically.

Mr R.C. KUCERA: Of course, but when the changes to tort law reform go through it is likely to lower some of the risk factors considered by the underwriters; on the other hand, it may not lower the risk factors.

Mr M.W. TRENORDEN: That is correct.

Mr R.C. KUCERA: That being the case, we could not wait around for the medical defence organisations to make up their minds one way or the other; neither could we wait around for the AMA in this State to make up its mind. The view taken by the national office of the AMA is very different from that taken by the local people. We have put in place a system that will guarantee indemnity cover for the specific doctors about whom we are talking until the end of the next financial year; and beyond that, if there is no change to the system that the medical defence organisations are likely to apply, we will continue with a system that will support them.

Mr M.W. TRENORDEN: The minister should not hold his breath about reduced premiums.

Mr R.C. KUCERA: I could not agree more. The history of insurance in this country is littered with good intentions.

[1.10 pm]

Mr DAUBE: I am aware that simply because of the extent of media coverage and the complexity of this issue, there is a deal of uncertainty, and that uncertainty applies to many people who need not be uncertain but who are still worried for a range of reasons. Once the decision was made to handle it this way, I wrote to all the visiting medical practitioners and made it clear that "interim" did not mean "temporary" and that the scheme would continue. I will write further. We need to keep writing to those people to reassure them that their cover will continue and to make sure that they know there are continuing points of contact for them to discuss these matters.

Mr M.W. TRENORDEN: The medical defence organisations also need to write to the doctors about whether they are covered. With all due respect, the practitioners will listen to the advice of the department, the minister and other people who are not the insurer, but they will take notice only of the advice of the medical defence fund.

Mr R.C. KUCERA: I take your point. We may be talking about different issues. The member may be referring to private cover.

Mr M.W. TRENORDEN: No. I am talking about public cover.

Mr R.C. KUCERA: I do not want to waste time as I know other people have questions. I am more than happy for the member to be briefed at length. If he has constituent doctors who have concerns, I am more than happy for them to deal directly with the department.

Mr M.W. TRENORDEN: I have 100 of them.

Mr R.C. KUCERA: We encourage individual doctors to deal with us directly. This is not an issue that should be dealt with by the association. This is an issue for individual doctors contracted through the VMP and VMO arrangements.

The CHAIRMAN: I remind members that only 50 minutes remain before I put a close to estimates. If members and the minister keep the questions and answers reasonably succinct, we will get through more.

Mr M.F. BOARD: It is hard to know which way to go first as there are so many areas we want to explore. On a number of occasions the minister has spoken about a single integrated health system in Western Australia, yet we also have a private system that delivers a very large amount of health services. The minister made some announcements in this budget about the purchase of care-awaiting placement beds from the private sector. Notwithstanding the insurance issue, is the minister prepared to expand the practice of purchasing services - not just beds - from the private sector to provide a greater service to public health? Is the minister prepared to purchase beds other than care-awaiting placement beds?

Mr R.C. KUCERA: Dr Lloyd will cover the issues about the private sector. I refer to the other services the member mentioned. The member for Darling Range might be happy to hear that I recently had a very positive and constructive discussion with the head of the clinicians at the Kalamunda District Community Hospital. We talked about planning additional services in a methodical way that takes into account the needs of the community and the long-term future of programs that deal with the ageing population in Kalamunda. The topic of the redevelopment was raised, and we also talked about collocating general practitioner clinics on the Kalamunda hospital site. The great part is that the idea of developing a system of services is now being flagged by the GP divisions.

We are hoping to develop a range of services for people who are classified as care-awaiting placement. We want to keep them in either their homes or the peripheral hospitals. We can supply beds and deal with the issues at the peripheral hospitals at a much lower cost than they can be provided at other hospitals. Again, I come back to the relationship between the State and the federal Government. Some simple changes would allow us to access aged care money for those people who are sitting in our peripheral and secondary hospitals. If we had that money, we would be able to cope reasonably well. That is the first raft of services. The change in the service configuration of primary health care in Kalamunda has meant that this is one area that is progressing on the initiative of the doctors rather than the department. The member referred to the purchase of private beds. That is a very good point. We are putting an enormous amount of money into that.

Dr LLOYD: We have extended the care awaiting placement program to include transitional care, which is a new program that we are piloting with the Commonwealth. Under that program we have purchased 50 places from teaching hospitals for the community that will be serviced by private providers and we have purchased beds in nursing homes. That has extended the care-awaiting placement program quite substantially to the benefit of a lot of patients who are improving with slow-stream rehabilitation. In conjunction with the Commonwealth, we are looking at other primary health care links that will help to establish other arrangements. That is in the pilot phase. At the moment, several major pilots are under way. Presently, we do not intend to buy beds in the private system. However, the transitional care is totally run by private operators.

Mr M.F. BOARD: The question was about not only beds, but also services. Will the department be looking to purchase any services that may alleviate some of the problems with waiting lists and other problems that exist at the crisis points of the public health system?

Mr R.C. KUCERA: That is one of the recommendations that the national group made to Senator Patterson about the reform program. If I can link back to the $2.3 billion contributions made by people to private health care, we have strongly suggested that if the federal Government persists with that - it seems as though it will - there is a desperate need for us to target that. For instance, there is no reason that people should not get a 100 per cent rebate for their hips and knees through that process. However, they do not need to get a 100 per cent rebate for having the crow's-feet removed from around their eyes. Some people may think that that is necessary. If changes are made to the health care agreement and the money that remains in the system is used in a more targeted way, the States could make enormous advances and may even get rid of waiting lists altogether. As the member for Murdoch knows, only four or five specific areas continue to impact our waiting lists. A range of other stuff can be picked up through the normal system. However, that is at the national level.

Mr M.F. BOARD: My point is that some of the services provided in the public system can be provided in the private sector at no extra cost.

Mr R.C. KUCERA: From a philosophical point of view, as the Minister for Health, I will look, wherever possible, to have those services in-house as part of an overall single and unified system. If the capacity exists -

Mr M.F. BOARD: But when it goes up and down -

Mr R.C. KUCERA: Exactly. The program at Mercy Hospital, which was started under the previous Government, is a good example and it has been continued. That capacity exists. However, we also have the capacity within the public system to cope with some of those things. The great difficulty for the Government and the community is that we are picking up care-awaiting placement beds and funding them from the state health pot, and that is not really our responsibility. The beds should be available in the aged care and nursing sectors so that people can move from acute care into the proper process.

Mr M.F. BOARD: If we are going to talk about a single integrated health system, let us talk about a total integrated health system that provides for the maximum use of all available services.

Mr R.C. KUCERA: I do not see competition between the private and public health systems. They are complementary. I have never shied away from that view.

Mr J.H.D. DAY: The minister referred to discussions with clinicians at Kalamunda -

Mr R.C. KUCERA: They were very positive ones.

[1.20 pm]

Mr J.H.D. DAY: That is good to hear. Could the minister tell us what action will follow from the discussions? Is the department proposing to put into effect what was suggested?

Mr R.C. KUCERA: We are certainly looking to do that. A group of clinicians is meeting with representatives of the East Metropolitan Health Service. The group has undertaken to come up with a business case for the proper use of the hospital in that area. Things have changed dramatically over the past five years since the original plan was put in place. I swing to Dr Lloyd, who is aware of the types of discussions taking place.

Dr LLOYD: We are not directly planning to buy additional services. We are working towards better linking the private system into the department. Work that was previously assumed would come into the government system can be looked after in the private system with better support from us. For example, nurses go into homes in our Nurse-Link program, and we are now allowing GPs to access that scheme when hitherto that was not the case. That pilot is looking quite successful. Without having to buy the service, other than pay a modicum to have doctors on call, the service can be provided in the private system on a fee-for-service basis.

Dr J.M. WOOLLARD: I refer to the total budget estimate for last year and this year, as outlined on page 1075 of the *Budget Statements*. I am happy to take a response as supplementary information. I am interested in the budget allocation and budget utilised by Fremantle, Royal Perth and Sir Charles Gairdner Hospitals for stroke patients in the accident and emergency departments. I would like to know what income was generated by magnetic resonance imaging - MRI - scanners, and where the income was directed for the past year.

Mr R.C. KUCERA: I think that detail will need to be taken on notice rather than be provided as supplementary information.

Dr J.M. WOOLLARD: I am happy with that. I am concerned that the resource allocation to Fremantle Hospital in this budget has again fallen short.

Mr R.C. KUCERA: The member mentioned the MRI scanner. The money for an MRI scanner for Fremantle Hospital is in the budget. However, I have made it clear that the machine will not be purchased until the licensing issue has settled down. I am deeply concerned. When I met Senator Patterson recently in Canberra, I specifically asked her out of session why MEG - the ME Group Ltd, or the organisation that locks up licences - still has not reported, despite her assurance that it would report in April of last year. My concern is that she remarked that she had been looking at the amount of money paid to radiologists in the private system before making the decision. That indicates that if we get another licence in this State, yet again it will go to the private sector. Health dollars are stretched to the point that if it were the case, I would find it difficult to continue with the tender for an MRI scanner at Fremantle Hospital. I will continue this year to put any money I can, supported by Channel Seven, into the children's hospital, regardless of the licence issue. However, I am concerned that the needs of the south western corridor are not recognised by the federal Government. If the intention of the federal Government is to yet again allot a licence for an MRI machine in that area to the private sector, I will jump up and down - so should we all.

Mr J.H.D. DAY: A licence is not needed to operate an MRI machine.

Mr R.C. KUCERA: But the money that licence provides is needed. Nobody runs on air.

Mr J.H.D. DAY: The federal Government does not fund the machines for treating in-patients in hospitals.

Mr R.C. KUCERA: It is not only for treating in-patients but also for generating income. To raise that as an issue after the scandal that went on in this State about the issue of licences, quite frankly, amazes me.

Mr J.H.D. DAY: I am just pointing out the facts.

The CHAIRMAN: I wish to clarify that the other information needs to be put in a question on notice.

Dr J.M. WOOLLARD: The minister has agreed to that. Does that have a number, Madam Chair?

The CHAIRMAN: No, the minister has indicated that the member must put a question on notice.

Dr J.M. WOOLLARD: Can that not be provided as supplementary information?

The CHAIRMAN: The minister has indicated that he would rather the member put the question on notice.

Mr R.C. KUCERA: With the level of detail asked for I suggest that the member put the question on notice and I will undertake to answer it. I ask that she give me as much detail as possible because the question was fairly broad.

Dr J.M. WOOLLARD: I will give the minister that question on notice. I share his concerns and I believe that if money is not allocated to Fremantle Hospital for a magnetic resonance imaging scanner and a stroke unit, the hospital will be bypassed by patients.

Mr R.C. KUCERA: I am advised that the money is in the procurement budget. As I have said since day one in the ministry, many of these things in the past were done simply because there was a demand or some shroud-waving for them. We cannot do that any more. The health dollars are so precious that we must have support. It is a simple thing to ask the federal Government to stop supporting the private health industry and for once to support the public health industry in this State.

Mr J.H.D. DAY: That is just a political statement.

The CHAIRMAN: The member for Rockingham.

Mr R.C. KUCERA: It is a political issue.

The CHAIRMAN: Order! I have given the call to the member for Rockingham.

Mr M. McGOWAN: I refer to the first three dot points at page 1077 relating to the Department of Health's response to the bombings in Bali in October last year. What lessons has the health system learnt as a consequence of that awful series of events and what impact did it have on the State's health budget; in effect, how much did it cost the State to meet those costs?

Mr R.C. KUCERA: The first thing we learnt, despite the tremendous amount of criticism of Western Australia's health system, was that it proved categorically that Western Australia has a world-class system. That was recognised by me and everybody else who was involved in that incident, and we had that indication from places as far away as Germany, the United Kingdom and other places in Europe. That indication came not only from the parents of kids who were brought to WA, but also from the Governments and clinicians in those countries. The first thing I want to put on record is my absolute appreciation of the way in which our system responded. No-one responded better than the Director General of Health, who is here today, and indeed all his staff.

In answer to the question about the impact on the system and what we learnt medically, I will defer first to the director general and then to Dr Lloyd on costings. I am disappointed, despite all the rhetoric that came from the issue, that so far no funding has come from the federal Government to cover those expenses. I remind members that every one of the 39 patients was treated in the public hospital system. I put on record my absolute appreciation. I have deliberately not talked much about the Bali issue since it occurred, apart from the first couple of weeks, because I wanted people to just get on with the job. I must say that they did; every one of them responded magnificently. I now defer to the director general.

[1.30 pm]

Mr DAUBE: I will speak very briefly because Dr Lloyd chaired the group on Bali that met daily and he must be given enormous credit for the way in which our response was handled. As the minister said, we can only express enormous appreciation for the way in which the entire system responded from the time of the first call early on the Sunday morning that let us know there had been an atrocity in Bali. People throughout the system responded superbly and we learnt a number of lessons. We learnt that our system can cope well with a disaster of this magnitude, albeit putting enormous pressures on it. We estimate the continuing costs to be somewhere around $5 million and, as the minister said, we have not been able to attract that money from our commonwealth

colleagues. It is very important to learn these lessons because in debriefs we picked up on things that could have been done better in various different ways. We also learnt that while there was enormously sensitive coverage from our local Western Australian journalists, some journalists are not quite so sensitive. A German journalist tried to smuggle his way into the most secure parts of the burns ward by carrying a bunch of flowers and pretending to be a relative; therefore, we learnt to be aware of the international perspective from overseas journalists. There was a cost to the system as a whole that is still continuing. Some superb people worked really well and great credit goes to the people who rallied at the Royal Perth Hospital but also from elsewhere around the system.

Dr LLOYD: This disaster presented a significant challenge to the State's health system, as it did to any other health system. As people have alluded, the system responded well. It was initially an unquantified problem because when the group convened on that Sunday, it was uncertain of the extent of the disaster and what the system needed to provide. While 39 patients does not sound like many, the volume of work that 36 severe burn patients presents to a system is truly enormous.

The response began on that day with the convening of a group that included the area health authorities, the directors of medical services from across the system, the chief executives, nursing management, and representatives from the burns services and St John Ambulance. The advantage of having everyone together was that we could work as a unified system. We met at least daily, if not twice daily. The area-wide business continuity plan was activated and proved to be very capable. There was good across-region support, which was important in a busy time to be able to create bed capacity. All the burns patients could not be shifted into Royal Perth Hospital alone if we did not create the bed capacity across the system. Freeing up Royal Perth Hospital beds was a very important part of our business. We needed to share staff and equipment and to have a triage system at the airport to deal with patients as they came in. Indeed, that was easily attainable through this system.

A much underrated area but one that has been extremely beneficial to us was the trauma counselling program that we developed, not just for the patients and their families but the many other people who were clearly upset. Ambulance transport was important. Our dealings with the Australian Red Cross became a lesson to us in how to get in and manage plenty of blood, and the community of Western Australia was remarkably good in donating blood. Early on the Sunday we were in a position to offer teams to go to Bali or to Darwin if needed. Our goal in Perth was to take as many patients from Bali as deemed necessary.

The outcome has been that we have had many debriefings and we have learnt a number of lessons that we are now building on that relate principally to things such as communication, whether it be locally or nationally or with the airport during times of radio contact. Coordination and the lines of command have been reviewed. We have learnt how to create urgent bed capacity and how to deal with the issues around the provision of blood. We have learnt how to set up a triage at the airport and how to identify patients -

Mr R.C. KUCERA: I think we have got the message across.

Dr LLOYD: All in all it is reasonable to say that we have worked hard to learn our lessons from this exercise and we are continuing to develop those into our business plans.

Mr R.C. KUCERA: And the public hospital system has paid for it.

Mr M. McGOWAN: I want to ask one follow-up question. This is an important subject. Considering the proximity of Western Australia to Bali, what were the cost implication for our hospital system compared with those in New South Wales, Queensland and the other States to which the Bali patients went?

Dr LLOYD: We have not done a cross-jurisdictional comparison. We took more patients and more severe burns cases than any other State, so I think our costs would undoubtedly be higher, but as best I know we have not worked out the cost to that level.

Mr R.C. KUCERA: It has cost the health system about $5 million extra so far. The member has raised a good point, because if we look at the current world situation, apart from Royal Darwin Hospital, which does not have the capacity that we have, we have probably the biggest and most appropriate hospitals for anything that may occur in South East Asia. That is something the federal Government needs to recognise, particularly in terms of infrastructure costs, and it is something that I will raise as part of the individual negotiations we will have with the federal Government on the terms of Western Australia's role in the health care agreements. Senator Patterson was absolutely overflowing with praise for our health system when she came here but she was remarkably quiet when I put out my hand to try to get a couple of extra dollars.

Mr M.W. TRENORDEN: I refer to page 1075. I have written to the minister about this matter. I would like a breakdown of all the individual costs for the south west health services and the country health services. I do not expect the minister to read them out to me now, but I would appreciate that as supplementary information.

Mr R.C. KUCERA: Under the new system we now have six regions.

Mr M.W. TRENORDEN: I am not interested in the six regions. The minister is accountable for each of those services. I want the figures for each of those services.

Mr R.C. KUCERA: I am not sure what the member means by figures.

Mr M.W. TRENORDEN: I was told by Department of Health people when they briefed me some months ago that figures are available on an individual health service basis, and I want those figures.

Mr R.C. KUCERA: I am more than happy to give the member the regional breakdown of the budgets -

Mr M.W. TRENORDEN: I do not want a regional breakdown. I want a breakdown for each service, as the minister is required to do for the agencies for which he is accountable.

Mr R.C. KUCERA: As I have said, the world has changed in the past two years.

Mr M.W. TRENORDEN: I am not interested in whether the world has changed. I want to know the cost -

Mr R.C. KUCERA: I am interested.

Mr M.W. TRENORDEN: The minister should be accountable.

Mr R.C. KUCERA: I am interested and I am accountable.

Mr M.W. TRENORDEN: I want to know the cost of each of those health services

Mr R.C. KUCERA: The member should put his request in writing, and I will take it on notice.

Mr M.W. TRENORDEN: I have done that.

Mr R.C. KUCERA: Then why is the member asking for it again?

Mr M.W. TRENORDEN: I am asking the minister to table it. I gave the minister a month's notice to table it today.

Mr R.C. KUCERA: Put it on notice, and I will be more than happy -

Mr M.W. TRENORDEN: I gave the minister a month's notice.

Mr R.C. KUCERA: This is the first I have heard of it. There was no request for me to table it.

Mr M.W. TRENORDEN: It is no wonder the Auditor General has trouble with the minister.

Mr R.C. KUCERA: There has been no request, as I understand it, for me to table anything today.

Mr M.W. TRENORDEN: I wrote to the minister!

Mr R.C. KUCERA: I am more than happy to take the member's request on notice, but can I say also that the world has changed.

Mr M.W. TRENORDEN: I do not care whether the minister thinks the world has changed.

Mr R.C. KUCERA: If the member for Avon wants to talk about the Auditor General, it just points out the silliness of some of the things the member talks about. It is remarkable that he is still insisting that we should have 41 or 50-odd different annual reports.

Mr M.W. TRENORDEN: No, I am not.

Mr R.C. KUCERA: Yes, you are.

Mr M.W. TRENORDEN: I am not. I just want the cost details. The minister does not have to do an annual report. I just want the cost details for each of those centres.

Mr R.C. KUCERA: Imagine the cost of doing that! I am quite happy to be accountable -

Mr M.W. TRENORDEN: The minister has not shown any evidence of it.

Mr R.C. KUCERA: I am also quite happy to take on notice what the member is asking me, but I can tell the member, and the future will show, that the world has changed.

[1.40 pm]

Mr M.W. TRENORDEN: Each of those services wants to know what has been delivered.

Mr R.C. KUCERA: That is a different thing. The member is now talking sense. He is asking for outputs and service delivery figures. This is the third budget in a row in which the member has asked what goes in one end.

Mr M.W. TRENORDEN: What comes out the other end?

Mr R.C. KUCERA: Exactly. What comes out the other end is the important issue. It is not always generated by what goes in at one end.

Mr M.W. TRENORDEN: The minister does not want to be accountable.

The CHAIRMAN: Order! It is my understanding that the question will be put on notice and an answer will be provided.

Mr M.F. BOARD: Many health professional groups are waiting for legislation to come before this Parliament. Will the minister indicate what legislation he intends to introduce this year and next year?

Mr R.C. KUCERA: I thank the member for the question because it is causing a high level of correspondence. Health practitioner legislation is being formulated as a green paper. I indicated to concerned parties that we intend to issue the paper by the end of this month for discussion. The health legislation amendment Bill is currently receiving its final instructions. It should be ready for introduction later this year. It deals with personal health information and empowers local governments to deal with complaints about smoke emissions. The Queen Elizabeth II Medical Centre Act will be subject to amendment. The member's question refers particularly to health practitioner legislation. A template will be in the green paper for agencies that want to become involved. The member for Riverton has been very active in ensuring that Chinese medical associations will be able to comment on the legislation. I understand that the legislation will be based on template legislation for the Osteopaths Act. A green paper will be released within a matter of weeks. The human reproductive technology amendment Bill reflects the undertakings of the Council of Australian Governments and legislation that has passed through the federal Parliament. There is to be a conscience vote on the legislation in the House. The Bill is currently being drafted. The Government is waiting on two small issues before establishing the committee. Matters should be resolved this week. The legislation will be before the House as soon as possible. Drafting was approved in March on the food Bill. The first stage will be before the House when I can arrange it. There will also be repeal Bills to the Alcohol and Drug Authority Act to reflect changes to that authority. I also hope to introduce the new medical Bill this year. The director general earlier referred to an urgent Bill. It is a two-clause Bill that will make it mandatory to report sexually transmitted diseases. It is one of the key information issues that resulted from the Gordon inquiry.

Mr M.F. BOARD: Are there any plans for the Dental Act?

Mr R.C. KUCERA: I believe some prosthesis issues will be taken care of. I do not have specific information. I am happy to provide supplementary information. I am not being given any indication of any intentions.

Mr M.W. TRENORDEN: I intend to introduce a private members Bill.

Mr R.C. KUCERA: In relation to what?

Mr M.W. TRENORDEN: Dental prosthesis.

Mr J.H.D. DAY: Like all other health professional Acts, there is a review of the Dental Act; it has been going on for ages.

Mr R.C. KUCERA: Whether it is included in the health practitioner legislation is unclear. If it is, that is fine. The green paper should be released in a matter of weeks.

The CHAIRMAN: Will the minister clarify for Hansard what he has agreed to supply as supplementary information?

Mr R.C. KUCERA: I can do that out of session, without the need to provide supplementary information.

Mr J.H.D. DAY: As the minister is aware, when the funding was provided for the construction of the new Armadale-Kelmscott Memorial Hospital, there was provision for the inclusion of a high dependency unit, with 10 beds in it. Funding was provided in the initial capital works allocation. That unit has not been provided, as I understand it. Can the minister tell us when it will be operating?

Mr R.C. KUCERA: Before I tell the member when it will be operating, I will tell him that I have asked John Burns to look at the contractual arrangements, because I think they are an absolute scandal.

Mr J.H.D. DAY: The minister has described them as bizarre in the past. As far as I am concerned, the only bizarre thing is the minister's understanding of them. What is wrong with them?

Mr R.C. KUCERA: That may be. However, to turn around and say to a private provider that a publicly funded expensive piece of hospital system, I suppose, will be provided to support that private provider so that it can charge private patients is bizarre.

Mr J.H.D. DAY: But it pays for the use of it.

Mr R.C. KUCERA: It does not pay for the use of it; that is the problem.

Mr J.H.D. DAY: Tell us what is wrong with it.

Mr R.C. KUCERA: To then link that to non-payment of rent for the rest of the private hospital until the unit is set up is quite bizarre.

Mr M.F. BOARD: It is the agreement under which the building was constructed.

Mr R.C. KUCERA: I am not happy with it.

Mr M.F. BOARD: The Government has the building up front, at no cost to the State.

Mr J.H.D. DAY: The whole point is to try to get services -

Mr R.C. KUCERA: I am not happy with it, and if that is the cavalier way in which the previous Government threw away public money -

Mr M.F. BOARD: Threw away public money?

Mr J.H.D. DAY: That is absolute rubbish.

Mr R.C. KUCERA: Anyway, the member has asked his question.

Mr J.H.D. DAY: As some of the people sitting close to the minister know, there was an arrangement to provide services closer to the areas in which large population growth was occurring and on which the people in those areas were missing out.

Mr R.C. KUCERA: Not at public cost.

Mr J.H.D. DAY: Can the minister tell us what is wrong with the contract and when the unit will be in operation?

Mr R.C. KUCERA: The member must agree that it is a bizarre contract. I have never seen a contract like it.

Mr J.H.D. DAY: I have no idea why it is bizarre, as the minister says. Tell us why.

Mr R.C. KUCERA: It is like the Ford Motor Company saying to me that I can have a car providing I put the engine in it, and it will supply the body.

Mr J.H.D. DAY: As I understand it, there was a cooperative arrangement to make a service available for public and private patients.

Mr R.C. KUCERA: It is an absolutely bizarre arrangement, and I will keep saying that.

Mr J.H.D. DAY: The minister has not convinced me. Tell us why it is bizarre and when the service will be operating.

Mr R.C. KUCERA: I will refer this to Mr Burns, and he will tell the committee where we are at with that unit.

The CHAIRMAN: Before Mr Burns responds, I indicate that it would be preferable if the member for Alfred Cove sat with the other committee members if she is to seek to ask questions.

Mr BURNS: The Armadale hospital comes within my jurisdiction as the Chief Executive, South Metropolitan Health Service. The Armadale hospital was obviously developed for a number of years. It is my assessment at the moment that the 10 beds under the high dependency unit are not required for the purpose for which they were built. It is within our budget allocation. I have decided that we will not operate those beds. I do not think I should go into the contractual arrangements, except to say that I now have Crown Law and a private law firm looking at the contract and how those beds relate to the contract.

Mr J.H.D. DAY: What is the problem with the issue? Tell us.

Mr R.C. KUCERA: I believe Mr Burns has indicated that we are not happy with the contractual arrangements. We now have Crown Law examining those contractual arrangements. When I get advice from Crown Law, it may be that the member is right. It may be a contract that we cannot get out of and are locked into. However, it is quite bizarre to have an undertaking that a highly priced unit must be provided before the private operator even starts to pay rent.

Mr M.F. BOARD: But it built the building, did it not? Is the Government not the beneficiary of the private sector -

Mr R.C. KUCERA: The way the member for Murdoch would operate our health services is that he would get a private operator to build a building, and then the private operator would tell him which services to put into it. I am also advised that we built the building.

Mr M.F. BOARD: Who is "we"?

Mr R.C. KUCERA: I am sorry; all my advisers are nodding and telling me that we built the building. In any case, that is beside the point. I do not believe that we should use public funds to build a building, and then have a private operator tell us which services we should put into it; and if we do not put the service into it, we do not pay rent. Goodness me!

[1.50 pm]

Mr J.H.D. DAY: Goodwill and cooperation might go a long way. It is not the real issue. The minister does not want to provide the recurrent funding to the operation of the unit.

Mr J.B. D'ORAZIO: I refer to the first significant issue and trend on page 1075. In a review by the Public Accounts Committee recently, reference was made to centres of excellence. Not long after that, Dr Cohen referred to centralising some of the specialists in what he called centres of excellence. Will the minister advise the situation regarding centres of excellence? Can we see some activity along those lines? Which professions would contribute to a better process being available to the community?

Mr R.C. KUCERA: Dr Cohen's report has been released for consideration and comment. At this stage, that is as far as it has gone. We have not taken it any further. I need to have public comment. Some of the issues Dr Cohen raised as a direct result of the Douglas report need to be addressed. It raised some interesting issues. At this stage, I would like the public to enter into real debate about the report.

Mr J.B. D'ORAZIO: My question does not refer to only that report; it gave an indication of it. The issue of centres of excellence is a broader issue.

Mr R.C. KUCERA: I am sorry, I thought the member for Ballajura was seeking comment on the Cohen report.

Mr J.B. D'ORAZIO: I am seeking information on centres of excellence, which would target into one area specialists from various fields. The Cohen report referred to an example of centres of excellence.

Dr LLOYD: It is true to say that some of that work has been put somewhat on hold while the health reform committee is reviewing role and service differentiation. However, we had progressed the work on obstetrics. That report contains a recommendation, for people who have not read it, that a state obstetrics support unit is based around the centre of excellence at King Edward Memorial Hospital for Women, which has gained tremendous support, particularly from our country colleagues, who are very keen to get it up and running. In the meantime, I believe that the work being done in the health reform group will lead us to centres of excellence. On the other front, the clinical senate is up and running. It had its first meeting last Saturday. It is selecting an executive and I am sure that group will in time address the issue of centres of excellence.

Mr J.B. D'ORAZIO: Does the minister see that process as a vehicle to create extra specialist training? As he knows, there are some shortages of specialists. Can the training for extra specialists be provided through these centres?

Mr R.C. KUCERA: I see it picking up on the safety and quality issues and much of the talk is centred around role delineation of hospitals because such a large number of specialist units are doing the same work. I stand to be corrected but I am advised that doctors are not undertaking enough individual procedures to justify some of the stuff that Professor Barraclough has been talking about at a national level. It is a matter of bringing together the people who will do that. I suspect that will open up the door for better specialist training. Last week I met the Australian Competition and Consumer Commission on questions it referred to the colleges about further pressure to make sure we get a proper flow of specialised training. That may open that door to us also.

Dr LLOYD: We are just completing a review of training sites at which the volume of work would justify a training centre. That will relate to producing more trainees in the future. Centres of excellence come into that work.

Mr M.F. BOARD: There are some references to the Health Administrative Review Committee in the budget papers. When will the clinical senate be established? Can the minister indicate what the parameters are for HealthWatch and how the community might benefit from it?

Mr R.C. KUCERA: First, the clinical senate has already met. One of the reasons for the hold-up was the pressure from certain interest groups. The clinical senate wanted a very bureaucratic and almost appeal-driven

process. I am not sure why. I understand it is in the process of choosing its own executive. Does the member want more information on that from Dr Lloyd?

Mr M.F. BOARD: There has been no announcement about the establishment of the clinical senate, has there?

Mr R.C. KUCERA: Not an official announcement; we have just gotten on with it. Like everything else in health, we just get on with the job.

Mr M.F. BOARD: We are so used to seeing five press releases on the one issue that I am surprised we have not seen that one yet.

Mr R.C. KUCERA: It is under way.

Dr LLOYD: The senate met last Saturday morning. It has about 25 per cent rural representation and a broad mix of people from across the various disciplines. It had a background briefing on a number contemporary health issues in Western Australia and then went into a business mode to elect its executive. The executive will be finalised early next week, and it will select its own chairperson and set the agenda. It was addressed by Professor Mick Reid, who was in Western Australia to show it the work program he has under way. Most people felt it was a good meeting, although not strictly all business

Mr M.F. BOARD: Is the make-up of the clinical senate public information?

Mr R.C. KUCERA: Yes. I have not made an announcement about it because I wanted it to finalise its executive. It is not just doctors, it has a broad range of people.

Dr LLOYD: I could read it out now.

Mr M.F. BOARD: I am happy for the minister to provide that by way of supplementary information.

Mr R.C. KUCERA: I am happy to provide the member with the make-up of the clinical senate by way of supplementary information. No doubt we will issue a press release in due course.

[*Supplementary Information No A60.*]

Mr DAUBE: The make-up of the clinical senate has been well agreed, and a number of organisations have nominated. I am feeling extraordinarily guilty that we have not given the minister enough press statements! We will try to work harder on that! HealthWatch has also met; in fact, it has had a number of meetings. It has two broad areas of focus - health issues in the community and health system issues. I understand it has worked out a number of issues that it will investigate. It has done preliminary work on some issues and will report further once it has decided which issues it will take further. One specific issue has been assigned to it; that is, some matters arising out of the Gordon inquiry. I reassure the member that it is looking at both health issues and health system issues. It is now developing a number of courses of investigation. As one would expect from any group that is chaired by Professor Holman, it will produce some pretty meticulous reports.

Mr M.W. TRENORDEN: Given the minister's very unsatisfactory standard with the late submission of the annual reports of the Department of Health, can he advise what additional costs were incurred by the Department of Health to bring the health reports up to standard?

Mr R.C. KUCERA: This is the first year that we have had to deal with the production of the annual reports in this nature. It is not intended to go through that process in future. We will change that. I am more than happy to quickly talk about that. I will refer that matter to Andrew Chuk.

[2.00 pm]

Mr CHUK: I am not aware of any specific additional costs that were incurred by the department.

Mr R.C. KUCERA: I suspect there would be some savings.

Mr M.W. TRENORDEN: There will obviously be costs.

Mr R.C. KUCERA: Yes; however, in raw terms there would probably be some savings. Rather than have every individual health agency -

Mr M.W. TRENORDEN: As only one minute remains before the Estimates Committee concludes, I ask that the answer be provided by way of supplementary information; it will not be answered within a minute.

Mr R.C. KUCERA: I will refer the question to Philip Aylward. If he cannot quickly provide an answer, I am happy to provide it by way of supplementary information.

Mr AYLWARD: We will have to provide the answer by way of supplementary information. We are currently compiling the information.

[*Supplementary Information No A61.*]

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.

Committee adjourned at 2.00 pm