Division 9: WA Health, $4 970 270 000 —

Ms W.M. Duncan, Chairman.

Dr K.D. Hames, Minister for Health.

Professor B. Stokes, Acting Director General.

Dr D. Russell-Weisz, Chief Executive, Fiona Stanley Hospital Commissioning.

Mr P. Aylward, Chief Executive, Child and Adolescent Health Service.

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

Professor F. Daly, Acting Chief Executive, South Metropolitan Health Service.

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

Mr R.W. Salvage, Executive Director, Resource Strategy.

Mr C. Xanthis, Director, Performance.

Professor T.S. Weeramanthri, Executive Director, Public Health and Clinical Services Division.

Professor G.C. Geelhoed, Chief Medical Officer.

Mr G.A. Jones, Chief Finance Officer.

Mr C. Allier, Chief of Staff, Office of the Minister for Health.

Ms M. Hayes, Principal Policy Adviser, Office of the Minister for Health.

Mr M. Miller, Principal Policy Adviser, Office of the Minister for Health.

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

It is the intention of the Chair to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point. The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. Questions must be clearly related to a page number, item program or amount in the current division. It will greatly assist Hansard if members can give these details in preface to their question.

The minister may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. I ask the minister to clearly indicate what supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the committee clerk by Friday, 30 May 2014. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office.

I now ask the minister to introduce his advisers to the committee.

[Witnesses introduced.]

The CHAIRMAN: We will commence with a question from the member for Kwinana.

Mr R.H. COOK: On behalf of Her Majesty the Queen's loyal officials, I thank all the advisers for attending today. This is an important part of our democratic process and we appreciate them making the time. I refer to the first paragraph on page 140 of budget paper No 2 under the heading "Emergency Department" and the Abbott government's proposed general practitioner co-payment and this state government's proposed co-payment for patients presenting to emergency departments. What is the department's estimate of the number of people it thinks will be diverted from GPs to EDs? Does the department agree with the Grattan Institute's estimate that this will be about a five per cent increase in ED presentations? What category of patients does the department propose to charge for receiving treatment at EDs and who will decide which patients get charged and how much?

Dr K.D. HAMES: That is an easy answer because there is no proposed co-payment by this state government, so I reject the member's words.

Mr R.H. COOK: The Premier specifically said it on 28 April.

Dr K.D. HAMES: Never mind, this is still my answer and not the member's. We must pass through many hurdles before the commonwealth's change in charges comes into place. Firstly, it does not start until 1 July 2015, which is a year away. Between now and then the proposal has to go through both houses of federal Parliament, and as the member will have heard there is significant opposition to it going through. We do not know whether the legislation will actually go through. If, for the record, we assume that it does go through, in the case of a general practitioner who does not bulk-bill—they privately bill—and charges $60, normally a

patient would pay that $60 and get back something in the order of around $36. Under the new legislation, $5 would be removed from that, so the patient would get back around $31. If, however, the doctor bulk-bills, that doctor would normally get back as a rebate the $36 rebate plus an amount of money, $6 per patient, for making that decision to bulk-bill. That $6 will go but then come back again if the doctor charges the patient $7. Of that $7, the doctor will keep $2, and $5 will go into the research fund proposed to be $20 billion. If the doctor still decides to bulk-bill and not to charge that $7, he will lose both the $7 that he would otherwise get by charging the patient and the no-gap charge. In effect, the doctor will lose $11. It will be very difficult for doctors to continue to bulk-bill. We are extremely concerned about that and think it will force patients who cannot afford to see the doctor to go to our hospitals. Most tertiary hospitals have a closely situated GP-offset clinic, and the fours and fives—GP-type patients as they are largely called—see that general practitioner. We subsidise those clinics by providing staff, receptionists and the like to get those doctors to agree to bulk-bill. If, suddenly, we continue to bulk-bill and there is an $11 deficit on top of what we already pay, not only would it be unaffordable, but also a huge influx of patients would see those GPs. A GP practitioner in Rockingham told me that if that happened, his clinic would lose all its patients to that clinic. If a hospital tells a patient to go to another clinic and they refuse because they will get charged, the hospital is obliged to see them. We do not want to bulk-bill patients in a hospital; that is not what hospitals are for. Hospitals are there to provide mostly emergency care, and to try to work out who will pay and how much they will pay is a huge management issue. Hospitals would prefer not to do that.

At this stage we will wait to see what happens. If the federal legislation is passed, then we will probably wait to see what impact it has—whether huge floods of patients go to the emergency departments and clog them up, and how the system copes. The problem is that if the system copes, the chances are that more and more patients will go to the EDs. Potentially it is a massive problem into the future, but we will make that judgment as we get closer. The Premier said that if it becomes an issue for our emergency departments—I do not have his words in front of me but clearly the member does—we will consider it at that time. It may become necessary to stop our hospital system from being clogged up by patients who should be seeing their general practitioners. The hospitals are there to provide emergency care to the community and not general practice-type services.

[9.10 am]

Mr R.H. COOK: The Premier said that the general practitioner co-payment has merit. Is the minister now saying that he does not support the Premier's position, which is to support the GP co-payment; and, if he does oppose it, what is he going to do about it beyond his rather measured statements in Parliament, as opposed to his colleagues in the other states, who seem to be dead against it?

Dr K.D. HAMES: I will talk about whether it has merit. I have worked in a general practice and know that there is a huge over-servicing of patients in general practice. I bulk-billed for a period, but in the end, I bulked-billed only seniors, children and repeat visits—and a whole pile of things that equated to about 70 per cent—but I charged those who had a job, because I would get patients coming to my surgery over and over again. Without being too disrespectful to GPs, those who struggle to see enough patients get people to come back for repeat visits. They say, "Your blood pressure's a bit high. I'd better check it again in two weeks." That is another visit and another $36, which happens more often than I would like it to. The number of people visiting a general practice will ease off as a result of that, partially because patients may choose to go to hospitals and partially because some patients see their GP more often than they need to. It will be an issue for us; I do not downgrade that for a second. Remember though, patients who choose to go to a GP who bulk-bills will have to pay $7 for the visit, $7 if they have a blood test and $7 if they need an x-ray; and, up to a maximum of $70 in one year for anyone who has a concession card. People may choose to do that as opposed to going to an emergency department, but there is a difference in that if doctors are running late, as they often are, patients can still book a day to get in, provided that person is not acutely ill, but even then most practices are able to accommodate that. Patients can book the day and get in; they might wait half an hour or an hour, but it is pretty certain they will be seen. If patients go to an emergency department where there is a four-hour rule, they may have to wait up to four hours for treatment; and, when they see a doctor, it will be a doctor with whom they are not familiar because they are seen by whoever is on for the day. Moreover, they have to find and pay for parking to get to that doctor, and if a lot of other people are doing the same thing, the wait times will inevitably become longer. I think a lot of people will choose to see a GP, so it might not create the burden we expect; hence, we should wait and see before making a decision.

Mr R.H. COOK: The "National Healthcare Agreement 2012", to which the minister is a signatory, reads —

> States and Territories will provide health and emergency services through the public hospital system, based on the following Medicare p:
>
> (a) eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided, by hospitals;

Does the minister agree with the Medicare principles of free universal health care?

Dr K.D. HAMES: If we were to start charging patients in our hospitals, we would need to change the legislation; that legislation would be brought before Parliament and cabinet would make a decision about whether to support the principle. My view, as the member for Kwinana has already heard, is that I do not want to do that; indeed, I would do it only as a very last resort.

Mr R.H. COOK: But not the Premier; he has proposed it and supports the GP co-payment, which the minister says will force his hand.

Dr K.D. HAMES: The member is misspeaking the statements of the Premier. The Premier said it would be considered if required.

Ms J.M. FREEMAN: The minister did not answer the question; does he support universal health care?

Dr K.D. HAMES: I did answer the question. I said that cabinet would make a decision. My basic principle is that that is something I support, but at the end of the day, I have to look after the proper and efficient running of my hospitals—your hospitals, our hospitals.

Mr R.H. COOK: A senior surgeon once asked me why there is no consensus between the main political parties on the issue of hospitals. On behalf of the opposition, when it comes to free universal health care, these are the issues that divide us.

Dr K.D. HAMES: I doubt very much that that is the case. That is a very easy statement for the member to make while in opposition. If he were in charge of a hospital at which thousands of people were lining up —

Mr R.H. COOK: I would stand up to the Premier and to the federal government!

The CHAIRMAN: Order, members!

Mr R.H. COOK: The minister has done nothing.

Dr K.D. HAMES: Sure.

The CHAIRMAN: Member for Kwinana, do not start pushing the Chair so early. The minister has the floor.

Dr K.D. HAMES: The cameras are on; that is why.

The CHAIRMAN: Minister, when I am speaking, you will remain silent.

Dr K.D. HAMES: Sorry.

The CHAIRMAN: Thank you. Has the minister finished his response?

Dr K.D. HAMES: I was reflecting on the fact that the member for Kwinana's raised voice was the result of a camera pointing his way.

Ms J. FARRER: I refer to the number of Indigenous people in the Kimberley, Pilbara and elsewhere. How will the $7.00 charge under the co-payment strategy affect them because, as the minister knows, a lot of people out there are on very low incomes. They are also on BasicsCard, which does not allow for payment to change hands. How will it work for low-income earners who are on BasicsCards?

Dr K.D. HAMES: I think it will make virtually no difference to the Kimberley because there are very few GPs in the Kimberley, so patients seldom get to a GP. As the member for Kimberley knows, they usually go to an Aboriginal medical clinic, to one of the health clinics in those remote communities or to Derby Hospital or Broome Health Campus. There is no reason for us to bring in charges at any of those hospitals. There will not be a huge surge of patients going to the hospitals and clogging them up, because those patients are already being seen at the hospitals. I have not seen any figures about how many patients in the Kimberley go to a GP. I suspect that there are very few bulk-billing practices in the Kimberley. Is anyone aware of any bulk-billing general practices in the Kimberley?

Mr J. Moffet: I do not have any details, but I imagine that general practices in Broome would have conditions for some clients in which they would bulk-bill. Broome is really the only town with a viable general practice at this stage.

Ms J. FARRER: A lot of Indigenous people are referred to specialists in Perth. There again, how will they be affected if they are on the BasicsCard?

Dr K.D. HAMES: Patients who are referred to specialists in the Kimberley do not normally go to the specialists' private practices; rather, they see the specialist at an outpatient clinic at hospital. Again, outpatient clinics are not proposed to be covered by a charge for those patients in any of the options.

Ms J.M. FREEMAN: I refer to "commonwealth funding" on pages 152–153 of the *Budget Statements* and to the various contributions from the commonwealth. Can the minister confirm that contributions from the commonwealth will be reduced as a result of the Abbott government's budget cuts? Can the minister confirm that the cuts will commence from 1 July 2014? What impact will the cuts have on hospital activity, including bed numbers? The New South Wales Premier said his state will lose up to 300 beds from 1 July, while the Queensland Premier said that his state would lose 1 700 beds over 10 years. What impact will the cuts have on other programs, such as dental, Closing the Gap, long stay, aged care and subacute care?

The CHAIRMAN: That is a fairly complex question; we might give the minister the opportunity to come back to parts of it.

[9.20 am]

Dr K.D. HAMES: We might have to do it in parts. The member would have seen the answer to her question about the effects of the major changes that have been made to the commonwealth in today's paper. The changes in the amount mean that we will lose $7.7 million in 2014–15, $43 million the following year, $83 million the following year, and $174 million in the final year, 2017–18, which is when the commonwealth guarantee of 40 per cent and the change to consumer price index kicks in—it does not kick in until then. Overall, it is a $308 million loss over those four years, which is slightly different from what the member saw in the paper, which stated $327 million. The paper did not get right the effect on this year, which is actually pretty well zero. have heard three different versions of what will happen this year, from minus $18 million to plus $18 million. Our latest calculation is that our contribution this year will be$18 million or $19 million less than what was in the *Government Mid-year Financial Projections Statement*, but a one-off payment of about the same amount will bring it pretty well to zero this year. We are being far less affected than are the other states. The other states that are complaining much more are affected a lot more. There are two reasons for that. Firstly, when the commonwealth committed to us getting $1.6 billion extra over the forthcoming years, given the financial state of the commonwealth government we did not really believe that it would have the capacity to do that. Secondly, our population and activity growth gives us extra activity-based funding, which means we will not lose as much as the other states lose. Over $300 million over four years is still a significant amount, but by far the bulk of that is in the final year. As I said, it will be roughly $7 million in the coming financial year, and then $40 million and then $80 million roughly in total funds. I think the member needs to ask the second part of her question.

Ms J.M. FREEMAN: What will the impact of these cuts be on hospital activity, including bed numbers?

The CHAIRMAN: Can you please just speak up or get closer to the microphone?

Ms J.M. FREEMAN: I am sorry. I am suffering from a bad headache—I am taking some tablets for it.

Dr K.D. HAMES: We have some people on this side who might help!

Mr R.H. COOK: That is all right; we will rely on Graham, if that is okay.

Ms J.M. FREEMAN: What will the impact of these cuts be on hospital activity, including bed numbers? The New South Wales Premier said that the state is losing up to 300 beds from 1 July, and the Queensland Premier said that that state is losing 1 700 beds over 10 years.

Dr K.D. HAMES: We are not talking about 10 years; we are talking about the forward estimates. Clearly, getting the same amount of money in the coming financial year, minus $7 million in a budget of $8 billion, does not affect our capacity to provide services. There is a small amount of money that I have not talked about. It is not so small; it is about $20 million a year in reward payments for waitlist surgery and emergency department operations that have now ceased. But those payments were not in the forward estimates, they were not things that were promised.

Ms J.M. FREEMAN: How long has the state been getting these reward payments?

Dr K.D. HAMES: Only for three or four years.

Ms J.M. FREEMAN: Three or four years of regular $20 million payments.

Dr K.D. HAMES: It was reward funding for us doing so well. I am glad the member raised the point; we have done exceptionally well in reducing waitlist surgery.

Ms J.M. FREEMAN: It looks good on paper.

Mr R.H. COOK: Do not go for too long; he will take some of our questions.

The CHAIRMAN: Order, members. It is difficult for Hansard if members go backwards and forwards like this.

Dr K.D. HAMES: We have done very well and achieved the targets for the four-hour rule, waitlist surgery and the like; so that funding will not continue. Overall, the minus $7 million will not have an impact on an $8 billion budget. The $40 million and then $80 million become more problematic, but looking at this year's budget and the growth in funding this year, it is a significant amount. While we are talking about those cuts in promises, the member is not reflecting the fact that there is a huge increase in commonwealth funding. Commonwealth funding is not going backwards. Over the next four years it will grow by 11 to 13 per cent each year. The commonwealth is giving us huge amounts of funding.

Ms J.M. FREEMAN: If the Labor Party had done this to the government, the minister would be sitting here lambasting us, but because it is the minister's colleagues doing it, he sits there justifying it.

Dr K.D. HAMES: I am not justifying it. The member did not ask me to justify it. She asked me to tell her what the effect of it would be. I am telling her. The effect is that while we are losing $7 million from what was promised next year—I will hand over to Mr Salvage to tell the member what we will actually gain in commonwealth funding from last year to this year —

Mr R.H. COOK: Could Mr Salvage also say from which areas the money will be withdrawn?

Mr R.W. Salvage: With reference to commonwealth funding for public hospital services, the total contribution for 2013–14 is $1.532 billion, and in 2014–15, it is $1.722 billion. That is an increase in commonwealth funding to the state of about 12 per cent, which is just under $200 million.

Dr K.D. HAMES: My point is that we will get $200 million extra in commonwealth funding next financial year; under the previous commitments, we would have got $207 million.

Mr R.H. COOK: Is that money out of the expanded activity money from the commonwealth? I ask because there are conflicting reports about whether the expanded hospital activity money will continue. I am trying to get a better idea of exactly what that $1.8 million is for.

Dr K.D. HAMES: I understand that it is based on predicted activity growth in this state. As we get greater activity, under the formula that we have, we get additional funding that covers the additional activity. I think the reduction by $7 million is linked into those promises that were part of the National Healthcare Agreement that has now been dropped, which is the movement towards 45 per cent and the change to the consumer price index and growth of the national efficient price. Is that correct, Mr Salvage?

Mr R.W. Salvage: To be clear, 2014–15 is the first year in which activity-based funding from the commonwealth becomes real under the National Health Reform Agreement. In 2013–14 and 2012–13, there was a continuation of funding at levels that would have applied under the former National Healthcare Agreement. There will be a significant increase in the commonwealth contribution to public hospital services next year, notwithstanding that over the forward estimates period it will be significantly less than what the state was factoring in when it struck its 2014–15 budget estimates. I refer the member to page 152 of budget paper No 2 and the line item "Commonwealth Contribution" relating to public hospital services. Those figures are not quite the same as I quoted earlier, because of movements in the estimates. The recalibration of commonwealth funding in 2014–15 will be to do with the state's declaration of its activity growth profile. There would have been a marginal change to the contribution rates, because of what we have decided as a state will be the activity growth profile in our public hospitals. A bigger change, as the minister said, is over the forward estimates period, and there are two points of explanation for that. Firstly, the commonwealth's no-worse-off guarantee has been removed, which will impact funding levels in 2015–16 and 2016–17. In the final year of the forward estimates period, there is a substitution of growth indexation based on population and consumer price index in place of the NHRA's promise of moving to 50 per cent of the efficient cost of growth in activity from that point forward.

Dr K.D. HAMES: We are predicting four years out and we get funded according to activity, so it could well be that those predicted amounts lost are made up in the future if the state continues to grow and get increased activity. I am not saying it is a good thing; I do not think it is a good thing. We signed the National Healthcare Agreement based on certain principles, and I believe the commonwealth should have stuck with those principles. Every state is complaining because we have had our forward estimates —

[9.30 am]

Mr R.H. COOK: Not every state.

Dr K.D. HAMES: The member cannot say that it is not every state, because I am complaining now. I do not think it is fair to cut those funds in the forward estimates. I understand the reasons for it. I understand the state of the national economy, but at the end of the day we had a commitment and that is not proceeding.

Ms J.M. FREEMAN: The minister had not finished his answer on reductions in those other programs—dental, Closing the Gap, long-term-stay aged care and subacute care.

Dr K.D. HAMES: I hope someone has written those down.

Mr R.H. COOK: They are the national partnership agreements that are expiring.

Dr K.D. HAMES: There are lots of those agreements; they are not the only four.

Mr R.H. COOK: There are.

The CHAIRMAN: Thank you, member for Kwinana; the minister can answer the question.

Dr K.D. HAMES: The federal government has pushed funding for the national partnership agreement for adult public dental services back a year, so we will start that a year later, but it will still be at the same level. The subacute care agreement has been dropped, and that will create difficulties for us.

Ms J.M. FREEMAN: How?

Dr K.D. HAMES: I will get to that in a minute. Previously, the former Labor government stopped its funding for Closing the Gap and told Western Australia that it would roll that into general funding. I have yet to see good evidence of that. Some of those programs are continuing, but they fund Aboriginal communities directly, mostly to Aboriginal health organisations. Their funding never came through us. We had our own commitment as part of the Closing the Gap agreement. We started at something like $112 million over four years and added an extra $30-odd million to that in this last year, and then for this coming year we have added $32.3 million to keep our share of that former agreement going. Western Australia is continuing with that agreement. As I said, the previous federal government stopped it and the Abbott government has shown no sign of wanting to continue, although I gather it is still assessing some of the programs it provides. I do not know the answer to the question on long-term aged care, and I hand over to Mr Salvage.

Mr R.W. Salvage: This was a national partnership agreement of three years' duration. The total value to the state over those three years was $32 million. It recognised particular difficulties in this state with discharging patients from public hospitals into aged-care facilities because of problems in that sector. It is effectively a compensation payment to the state for that situation, and it has been confirmed through the commonwealth budget that it will be discontinued. There will be a funding loss to the state of about $11 million.

Mr R.H. COOK: I appreciate the other members' indulgence with these questions. Commonwealth funding is obviously a pretty important aspect of what we are talking about today. I notice in the media release on community controlled health organisations that the minister put out prior to the budget that he branded it as footprints towards better health. Is it the minister's view, given what the commonwealth has now done with Closing the Gap funding, that that Closing the Gap program is now dead?

Dr K.D. HAMES: We have rebranded it, as the member said, but all the programs under Closing the Gap funding have continued. We renamed it, because we have melded into it the early childhood development program. We had two commonwealth partnership agreements—Closing the Gap and Early Indigenous Childhood Development. We merged those into one and called it footprints towards better health. That name was largely developed by some of the Aboriginal members of our team, because on the poster for Closing the Gap were footprints and it was decided that footprints towards better health for Aboriginal people was a good name to use. As the member knows, the government has continued to fund those this year.

Mr R.H. COOK: Well done, too, by the way.

Dr K.D. HAMES: I do not have funding for that in the out years, and we did not have it for this year coming. We had to argue strongly about the benefits of that program. We in health are huge supporters of it. We think it is doing an excellent job. I know the Aboriginal Medical Service continues to say it is the best program in Australia because we partner with both Aboriginal and non-government organisations, particularly the Aboriginal Medical Service. We contract with them to provide a lot of those services, and we think it will close the gap. My job and the health department's job is to prove, through key performance indicators, that those programs are working and justified. We have just appointed D'Arcy Holman to undertake a review of those programs, the task being to convince Treasury and cabinet that those programs are worthwhile and doing what they set out to do. It does not mean, because there is no Closing the Gap funding from the commonwealth government any more, that those funds are not continuing. The advice we got from the former Labor federal government was that it had rolled the end of funding for those programs into mainstream programs. The commonwealth was not going to call it Closing the Gap anymore, but it would continue with a lot of those programs. Frankly, we could not get any evidence that that was happening and still cannot now. We do not know who they funded and who they are continuing to fund, because they were funding them all directly. In fact, they never told us who they were funding—ever.

Mr R.H. COOK: I want to be clear on that, because I do not think the minister really answered my question. I asked, in relation to the partnership between the commonwealth and the state: is the Closing the Gap program effectively dead?

Dr K.D. HAMES: I did answer the question, because I said that it died under the former Labor government. It stopped the Closing the Gap agreement.

Mr R.H. COOK: That is not true.

Dr K.D. HAMES: It is true. They did not re-sign. The agreement came to an end. I talked to our Premier who raised it with the federal government at a Council of Australian Governments meeting. He asked what it was going to do about Closing the Gap. The Premier said that Western Australia was keen to continue it and asked what the federal government was going to do. The former Labor government decided it was not going to progress it.

Mr R.H. COOK: The minister is misleading the Parliament again.

Dr K.D. HAMES: It is absolutely true, and I challenge the member to show evidence that I am wrong.

Ms A.R. MITCHELL: I refer the minister to the third dot point in "Sustainable Delivery of Health Services" on page 130 of budget paper No 2. I note that this 2014–15 budget provides additional funding of $204.1 million for public hospital services, which as the minister has indicated already, takes the total expenditure on hospital services to $5.8 billion. What does this increase represent and how will it improve health services for Western Australians?

Dr K.D. HAMES: It is a good increase in our budget. As the member knows, we are moving to activity-based funding. Strangely enough, that came about through conversations I had with John Hill, the Labor health minister from South Australia—an excellent minister in my view. South Australia had activity-based funding. We decided to move in that direction, and then came the National Healthcare Agreement, which required us to move to activity-based funding. We were well on the way in our planning, and it has been implemented since then. This reflects the estimated growth in demand in our hospitals, and funding is commensurate with that. It has meant that since we came to government, roughly, we have gone from about 25-plus per cent of total state expenditure on health to 28 per cent, and just past $8 billion for the first time. This is a reflection of the demand in those hospitals. I ask Professor Stokes to answer further or to ask someone else to provide further information on what that does in terms of how many patients we can treat.

[9.40 am]

Professor B. Stokes: It increases the number of patients to about 60 000 non-admitted patients over these estimates. That will make a significant difference. The second thing is that we will be able to look at whether we can do more work outside hospitals; more community activity. Unfortunately, there is still this great thing that hospitals are the whole essence of health care whereas they are only a component of it. What happens in the community is the major issue. We hope we will be able to do that with some of that extra funding.

Ms J.M. FREEMAN: Given that the department wants to do further work out in the community, why have we not seen a new health bill introduced into Parliament to give the minister the capacity do that? The current Health Act does not provide the capacity for preventive health care and that community health aspect. If that is a priority, why has the minister been sitting on the health bill?

Dr K.D. HAMES: The member does well to beat me around the ears over this because I have been the minister now for five years but I still have not managed to get the health bill introduced.

Mr R.H. COOK: The minister has been trying to get it here for six years.

Dr K.D. HAMES: It is a 100-year-old act.

Part of the issue has been around state government liability for services not being as good as they need to be; that is, the state government's responsibility and what the cost of that would be. Lengthy discussions with Treasury are ongoing about how that might be a component of the bill. The majority of the bill is already complete. The member for Mirrabooka is asking the Deputy Leader of the Opposition to ask a question about the same thing. I will finish there before she finishes asking. He knows the question!

The CHAIRMAN: Member for Kimberley.

Mr R.H. COOK: I was going to a different aspect of the member for Kingsley's question. If the member for Kimberley wants to ask something about the health bill, I am happy for her to do so.

Dr K.D. HAMES: I will answer the question that I know the member for Mirrabooka will ask. That will make it much easier. What happens now, particularly in remote communities, is that the state government is not bound

by the normal laws governing housing. For example, if the toilets in a house are not working or the quality of the house is not adequate—this actually happened in Halls Creek—the council could put a demolition order or a non-inhabitable order on that house. Chances are it is a Homeswest house with an Aboriginal family in it. The state government is not bound by those acts, so the state government does not have to fix all of those things. Instinctively, the member says that is not right, it should not happen and the government should be bound by those things. But the reality is there are huge numbers of houses in remote communities and the government is already spending hundreds of millions of dollars trying to bring those things up to normal. If there was suddenly a requirement in place through legislation that the council could shut down that house because the sewerage was not right, in effect, the family would have to move out but would have nowhere to go. The state government would be obliged to fix those things or shut the house. That would potentially be a huge financial burden on the state. It has to be done sensibly and in an orderly fashion. We try to bring those houses up to standards that they quite rightly should be; hence our difficulties in working with Treasury to get a landing point. Original drafts of the budget were binding on the crown; now we are seeking a variation of that. It requires a lot of redrafting of the legislation. Sadly, there is still work to be done.

Ms J.M. FREEMAN: When will the new health bill land so that we do not have 101 —

Dr K.D. HAMES: It will land immediately after I get it through cabinet and through the party room.

Ms J.M. FREEMAN: When will the minister get it through cabinet?

Dr K.D. HAMES: I have no idea when that will happen. It will depend totally on our draftspeople who are putting together now, hopefully, the final version.

The CHAIRMAN: Members, I think we are straying off the budget.

Mr R.H. COOK: I have a follow-up question that is directly related to the member for Kingsley's question. It goes to the issue of activity-based funding and indeed the predictions around hospital activity. In 2012–13 there were 910 000 presentations to emergency departments, and in 2013–14 that was predicted to rise to 935 000. The budget papers show that the figure was actually 995 000, which is a 9.3 per cent increase on the 2012–13 figures. From that point of view, why does the minister anticipate such a low increase this year, which is around 3.3 per cent? Before the minister answers that question, I remind him of his answer to this question last year which was "because we have seen a drop-off in activity and we expect just modest growth in the coming year". Given that the minister was so woefully inaccurate in terms of these estimates last year and, quite frankly, most years, why is he so confident this year?

Dr K.D. HAMES: Someone else will comment for me on those growth figures, but I can say we have seen an easing off in growth. There was huge growth previously in Joondalup for example, which is at 18 per cent but which then settled down to 11 or 12 per cent. That is now back down to six or seven per cent. In hospitals such as Sir Charles Gairdner Hospital, there has almost been a levelling off of activity. Mr Salvage is doing some frantic work to provide an answer.

Mr R.W. Salvage: I will make a comment on the way the activity-based target is set and then deal specifically with the emergency department issue. Through the 2012–13 budget, the government agreed to set an activity target for public hospital services based on a weighted volume measure. That weighted volume measure delivers an increase in activity, year on year across the forward estimates, of just under three per cent. It reflects movements in size of population plus the age-weighted utilisation of hospital services. That measure was first applied in the 2013–14 year and has proved to be remarkably good at forecasting actual demand. It is a weighted activity measure. We are talking about a weighted activity measure within which emergency department activity is relatively low weighted. Variations in numbers do not necessarily impact in terms of the weighted value.

Dr K.D. HAMES: To expand on that: the Deputy Leader of the Opposition is looking at the wrong figures. He is reading the emergency department presentations, which is not weighted activity.

Mr R.H. COOK: But it is hospital activity.

Dr K.D. HAMES: It does not matter. The cost of activity needs to be based on weighted activity. I will explain the reason. If suddenly tomorrow Sir Charles Gairdner Hospital went from its current ED presentations of around 60 000, and charging came in and suddenly we got 70 000 patients, and those extra 10 000 patients were all GP–type patients who were seen relatively quickly and easily and very few of them required admission, that does not relate to an extra 10 000 weighted activity units because the big cost is admission and management in the hospital, which is over $5 000 per patient. Growth cannot be judged in weighted activity of three per cent by ED presentations. I am sure the member understands that.

Mr R.H. COOK: I appreciate that, but my point is that the minister gets it so wrong in terms of EDs —

Dr K.D. HAMES: But it was not wrong.

Mr R.H. COOK: Why should we be confident it is correct in relation to other aspects?

Dr K.D. HAMES: My point is that I was not wrong. The Deputy Leader of the Opposition said I predicted growth in activity of a certain amount and that that was incorrect. I will ask Mr Salvage to tell us what the weighted growth for the last year has been.

Mr R.H. COOK: I did not ask for the weighted growth.

Dr K.D. HAMES: Nevertheless, I am sure Mr Salvage will provide that number because I would like it.

Mr R.W. Salvage: I will provide an update of where weighted activity growth is at the end of March 2014. On a year-to-date basis we are tracking marginally below the weighted activity target. This is the 720 000-odd that appeared in last year's budget papers. The forecast for this year is that we will be in line with the weighted activity target agreed for this year. There is a plus variation.

[9.50 am]

Dr K.D. HAMES: An interesting figure in relation to that is that we know that our state is above the national efficient price by a few hundred dollars. Our costs are more; about a third of that is due to staff costs because we pay doctors and nurses far more than they do in other states. But the reality lies in the cost per 100 000 people in this state. If you take how many patients per 100 000 go to their doctor and get admitted and relate that to a weighted activity unit, ours is, I think, 216 per 100 000, whereas other states are much higher than that. WA is the second lowest in terms of cost, and even though our cost per patient is marginally higher, our total expenditure per 100 000 people in this state is low. Why would that be? Are we younger? Are we fitter? We know we are healthier because our combined male–female long-term survival rate is higher in this state than it is in any other state. We live longer; I think we are healthier. How much of that is related to us doing better preventive health, better home care, better care with Silver Chain and keeping people out of hospital? It is difficult to tell. The only difficulty I have with all those numbers is that the lowest per 100 000 of any state and territory is, in fact, Tasmania, which is down to, I think, 169 per 100 000. That could not be because they have a better health system. I wonder whether all those people duck off to Victoria because the treatment in Tasmania is so bad.

Ms J. FARRER: I refer to page 133, volume 1, budget paper No 2, under the heading "Improving Aboriginal Health Outcomes". What amount of funding will be allocated to the Wyndham Early Learning Activity Centre? What amount of funding has been provided in the years 2011, 2012 and 2013?

Dr K.D. HAMES: It happens that I know this answer off the top of my head, because I have been talking to Mrs Parker; in fact, I plan to visit her in the not-too-distant future. She runs the Wyndham Early Learning Centre, which has an interesting story. It was funded for a new building. The previous Minister for Education insisted that it be on Department of Education land which has made it difficult for them to source outside funds. But all their funding was commonwealth funding. I have a briefing letter from her in my room which goes through in detail the funding that was provided. It was all commonwealth funding; not state funding. That funding expired at the end of June, so it is very difficult. They provide a fantastic service, particularly given that not only is there a large Indigenous population in Wyndham, but also when this state government closed Oombulgurri and most of those people from Oombulgurri moved to Wyndham that resulted in additional demands on the early learning centre. I am a strong supporter of that. As a state government, we cannot suddenly go and take over everything that the commonwealth stops funding. The member for Kimberley knows that we have funding difficulties of our own, but I am fairly determined to try to help her find a solution. I have had conversations with the Minister for Education about it, because we are keen on supporting preschool learning for Aboriginal children to help close that gap in education where they are not getting that early learning experience. How we do that, I do not know yet. Just off the top of my head, I do not remember all the funding that they get, but I think in the last year they had reduced funding from the commonwealth, so they were down to operating for about only 20 hours a week. But even if that is all they are able to keep doing and we can find a way to fund that so that perhaps we can even start it earlier as an early learning centre for Aboriginal students into the future, that is what I am looking to do. None of the health department staff knows about that yet, because I have not had that conversation. This is something we have been working on over the last fortnight when I became aware that their funding was stopping.

Ms J. FARRER: Of the 100 Aboriginal health services the government plans to fund, how many are Kimberley organisations? What amount of funding will be allocated to each Kimberley organisation?

Dr K.D. HAMES: We fund through the health department a large number of non-government organisations across the state; a significant component of those are Aboriginal communities, again across the state. They are split up according to how many are provided in the Kimberley region, but I have only the health department ones. There are lots of other state government departments that also provide funding—and, of course, commonwealth departments. We do not know what commonwealth departments are involved, but we are only

now starting the process of finding out what funding state government departments provide for those communities. It is very difficult to put together because the communities themselves do not tell us where they get all their funding—in fact, they keep it quite secret. Sometimes the health department finds that it is funding something and the Department of Local Government and Communities and the Department of Sport and Recreation is funding something similar. We are currently putting all those together to find out who funds what, and it is only when we finish that I will know the answer. I cannot provide even a supplementary answer, because it is not until we have finished collating all those things that we will know. May I suggest that in six months' time, the member for Kimberley ask a question on notice when, hopefully, we will have put together all those funding models for the whole state and from that we will easily be able to extract the Kimberley components.

Mr R.H. COOK: My question relates to item 7 in the table "Service Summary" on page 129. I assume it comes under this because my question relates to the administration and monitoring of poisons. I refer to the Carabooda crime family recently revealed in the media and a question the opposition asked the Department of Agriculture and Food yesterday.

Dr K.D. HAMES: We saw that. Luckily I have an answer.

Mr R.H. COOK: This is like chasing the rabbit down the burrow, and they said to ask the Department of Health. I am asking: did the Department of Health monitor the poisons in relation to that particular property either before the operation was exposed by the Australian Federal Police or after the operation was exposed? What was the nature of those findings and what course of action did the department take to ensure the protection of both neighbours and consumers in relation to the tomatoes, which I understand was the major product from that facility?

Dr K.D. HAMES: I thank the member for Kwinana for asking the Minister for Agriculture and Food, because he told me yesterday that the opposition had asked that question and he gave me warning and time to find out the answer.

Mr R.H. COOK: That is what we were hoping.

Dr K.D. HAMES: There are two matters here. I will get the director general to answer once I have had my try. What I do know is that the Department of Health was part of that initial investigation—going to the centre and looking at what they were doing. Contrary to reports in the media, all the products used are able to be licensed to use for pest control. There was one aspect that was not being done properly; a chemical that is licensed was extremely diluted but was used on the tomatoes prior to them being provided to the shops, so that was an issue. Just to make sure I have it right, I will hand over to the director general, and then Professor Weeramanthri if we need to.

Professor B. Stokes: The minister has answered very clearly. The Department of Health was involved in the initial raids on the Carabooda properties and investigated the pesticides, which were all legal and registered pesticides. According to the information given to me, they were being applied properly except for one aspect—that is, the tomato washing, which apparently concerned a fungicide they washed the tomatoes with before they were sent off for sale. I understand from the information given to me last night that it was a very diluted fungicide and that the tomatoes would have had to be ingested in enormous amounts to have caused any human issues. That matter is still being pursued and we are finding out more detail on that. That is the information we have at this moment.

[10.00 am]

Mr R.H. COOK: Were the concentrations of the chemicals involved a threat to the public? Was there any danger to the public, both the immediate neighbours to the Carabooda property and the consumer public, from the activities that went on?

Dr K.D. HAMES: Frankly, I think Professor Stokes has just answered those questions. The chemicals were licensed. They were being used properly on the farm itself; therefore, there was no risk to the neighbours because those things were being done correctly. The only thing that was not being done correctly was using a fungicide to wash the tomatoes in the shed after they were picked and before they were sent off for sale. The fungicide was extremely diluted. One would have had to eat 30 kilos of tomatoes for it to have any effect. Nevertheless, what they were doing was improper. Perhaps it would be best if we asked Professor Weeramanthri to provide any advice from his department because he has responsibility for that.

Professor T.S. Weeramanthri: The question is an important one. We take our responsibility around pesticides regulation and the protection of the public very seriously. The legislative framework of pesticides regulation comes under the Health Act 1911. We have a small expert team in the environmental health directorate. As the member knows, it routinely ensures compliance with the pesticides regs, ensures that the chemicals that are used

are licensed by the Australian Pesticides and Veterinary Medicines Authority, a national authorising body, and works with licensed pesticide operators.

In terms of this particular investigation, we had been involved with the police in the weeks leading up to the raids; the environmental health directorate was part of the team working under the direction of police. Since that time we have also reviewed any risk to the public. The minister and the acting director general are correct in saying that we have not received any advice from our experts around any threat to public health as a result of the operations that are being referred to.

Mr R.H. COOK: Was the fact that they did not use enough of the fungicide or use it in the appropriate concentrations therefore a danger to the public? In order to save time, was there any danger to workers who were working with that fungicide and the way that the company managed the chemicals?

Dr K.D. HAMES: I will ask Professor Weeramanthri to continue his answer.

Professor T.S. Weeramanthri: As with all toxicology, the key features are dose and routes of exposure and then duration of exposure. The dilute nature of the chemical and the issue around the quantity one would have to ingest et cetera are very relevant when assessing public health risk. Any risk to the public is extremely low, if not negligible.

The member's point about exposure to workers is very important. That is certainly at the top of our minds. We have not received any reports of high exposures to workers but we will certainly find out more about that and would be happy to provide written confirmation of our investigations.

Dr K.D. HAMES: I would like to ask a question of my own. If the workers were not adequately protected, is direct contact with that fungicide a risk to human health if it is not ingested—that is, contact through skin if they are not wearing gloves or whatever; and, if so, what test could be done to show whether those workers had been affected?

Professor T.S. Weeramanthri: A direct exposure to the chemicals would clearly have an acute irritant effect. The most sensitive indicator of harmful exposure would be irritation to the skin or the eyes. No other test could be done later to determine that exposure. Very clearly, the workers exposed would have experienced symptoms at the time. We have no evidence of that and I do not know the level to which appropriate protection was used. Again, we are happy to provide written detailed information.

Mr R.H. COOK: Finally, did the department instruct Woolworths to take those products off the shelves or does it know why Woolworths took those products off the shelves?

Professor T.S. Weeramanthri: I am not aware of the exact communications between our department and Woolworths on this matter. I cannot tell the member that.

Mr R.H. COOK: Could the department provide that information in addition to the previous offer for follow-up information?

Dr K.D. HAMES: We are happy to do that. We will have that as our first supplementary answer—to provide information on the communication between our health department and Woolworths and to see whether there was any involvement in withdrawing that product from the shelf.

[*Supplementary Information No A17.*]

Mrs G.J. GODFREY: I refer to the first dot point under "Implementation of Activity Based Funding for Public Hospitals in Western Australia" on page 130 of the *Budget Statements*. I am aware that WA has comparatively high costs for delivering public hospital services. Why is this the case and what is being done to bring our costs more into line with the national efficient price for delivering services?

Dr K.D. HAMES: It is an issue for us. We are not completely happy with the national efficient pricing; in fact, we are moderately unhappy with it. We do not believe it sufficiently takes into account the increased costs that Western Australia bears because of the high payments to our doctors and nurses, not brought about specifically through government decisions other than a reflection of ensuring we keep our staff in a state that has very large incomes, particularly in the mining sector.

Mr R.H. COOK: It was an election tactic.

Dr K.D. HAMES: I do not agree with that. When the Labor Party was in government during the boom, it had huge problems with staffing of doctors and nurses. They had some of the lowest paid —

Mr R.H. COOK: Why is the minister always happy to give us a hit but never his colleagues?

Dr K.D. HAMES: The member's interjections stimulated me. Mr Chairman, I am trying to tell you something really important.

The CHAIRMAN: Forgive me, minister.

[10.10 am]

Dr K.D. HAMES: We were losing nurses who could earn more by driving a Haulpak. Trying to keep our nurses was very difficult. We did not have enough nurses in the system, and they were underpaid. We as a state decided to increase payments to our staff to ensure we could keep adequate nurses, doctors and allied health services within the system. We have gone from having the lowest paid staff in Australia to having some of the highest paid staff in Australia. That has come at a cost. It is a cost higher than services are provided in New South Wales and Victoria, yet we have a national efficient price that we are supposed to meet. We are above that. About one-third of that increased cost is because of staff wages. It may well be that for the other two-thirds, the inefficiency of our system is at fault and we have to work on it. We have an agreement with Treasury that we will get to that national efficient price over a five-year period, although we are negotiating on exactly where that needs to be.

The changes to the commonwealth have now lowered what the national efficient price will be because it will go up in line with the consumer price index and population growth, which is again problematic because that has a landing point lower than where we are at present, even with the national efficient price. A lot of work has to be done around that to find out those costs. Another good reason that we should be higher than the national efficient price is that it does not adequately recognise Aboriginality as a cost. It has a weighting for Aboriginality, but it is nowhere near the actual increased cost that is reflected. Someone will remind me of the loading for Aboriginality, but the increased cost for Aboriginality is in the order of at least 150 per cent. That is a result of not only the frequency of service, because that is covered in activity-based funding, but also the complexity and cost of the service that has to be provided, which can include having to send vehicles to pick up patients and bring them to a central base. Also contributing to that is the high cost of accommodation—for instance, in the Pilbara—and the lack of doctors and GPs in those very remote areas, which means we must pay doctors and nurses and allied health staff a lot of money to get them to live there. In our view, the weighting for those things is nowhere near adequate. Does Mr Salvage want to make a comment on what those weightings are?

Mr R.W. Salvage: No, I do not have that detail.

Dr K.D. HAMES: They are nowhere near enough. That is the answer to the question. We are required to get to the national efficient price in five years. In the budget is a community service subsidy, which reflects the difference between the national efficient price and the state price. Members will notice that it gets smaller and smaller as we approach the end of those five years, when we are supposed to hit the national efficient price, but we will have long-term and incessant discussions with Treasury over our glide path.

Mr R.H. COOK: I accept what the Minister for Health has said about the national efficient price. I think we all support the government in getting a better deal for Western Australia and recognising those remote and demographic issues. The relationship between the transitioning price in Western Australia and the national efficient price is interesting. As the minister has observed, we have the community service subsidy from the Department of Treasury, which the minister has signalled will reduce to zero by 2017–18. Between 2013–14 and 2014–15, the weighted average unit price in Western Australia will go from $5 319 to $5 540, so that gap is widening. The trajectory is not getting back to zero; we are going in the wrong direction. What will the government do to arrest that glide path? I accept that in the current context we will always be higher than the national efficient price, but we are not getting anywhere near it and we cannot expect the feds to chase us up the curve.

Dr K.D. HAMES: That is a very good point and I will ask some of our directors to explain why we are getting higher and not coming closer. I make a couple of points that may give Treasury a small amount of comfort. One is that, as I said before, although our cost per patient is higher, the number of patients whom we treat is lower. Our overall cost to the state per 100 000 patients is less than the overall cost in other states because we have fewer people in our hospitals. The second is: what will we do about it? That is difficult. We have three options to make it work better. One is to make the services we provide in our hospitals more efficient and all our hospitals constantly strive to do that. The four-hour rule to increase efficiency is part of that. We strongly expect that our new hospitals—Midland Public Hospital, Fiona Stanley Hospital and Perth Children's Hospital—will have greater efficiency because of the nature of the services that they will provide and because we have been able to plan them.

There are two other options for the state. One concerns income. As we move forward, we will go to 28 per cent of total state expenditure and a lot of that is made up of income from other sources. The income can be commonwealth income or income from private patients choosing to use their private insurance in a public

hospital. We are far below every other state in using private insurance. For example, in New South Wales about 16 per cent of patients in public hospitals choose to use their private insurance. In Victoria it is about 10 per cent. In Western Australia it is just more than five per cent. The member for Mirrabooka and I have had this argument before, but we have some capacity for patients in hospitals—providing that there is no gap, which is what is happening in our hospitals now—to choose to use their private insurance. Obviously, it costs more for the private insurance companies, but those in other states —

Ms J.M. FREEMAN: And the patient.

Dr K.D. HAMES: No, not if there is no gap. Other states are using that as income for the state. The second option is to keep patients out of hospital. The generally accepted view is that about 30 per cent of hospital patients do not need to be there and could get better service in the community. As members know, coming to government we committed to fund Silver Chain to the tune of about $25 million a year to provide better home care services. Silver Chain is providing on any one day in the order of 600-plus services throughout the state. About 160 to 170 of those are patients who would otherwise be in hospital. In effect, we would need 160 to 170 hospital beds to provide that service. We would expect it to cost us $500 million or $600 million in capital expenditure to build a hospital to cover 160 beds and about $500 million a year in recurrent costs to run it. We have saved that by spending $26 million a year on Silver Chain. There is enormous capacity. That home care has just been accepted by the commonwealth as an activity-based service, so from now on we can claim funding for growth in that area through the commonwealth for roughly 40 per cent of the service. Our intention is to look very seriously at working with general practice to better service people at home who do not need to be in hospital, which will take some of the weight off our public hospitals. They are the only three ways we can see to address that growth in cost in the future because, as the member knows, we are an ageing and growing population and we have to look at doing things differently to stop health consuming more and more of the state budget.

Dr G.G. JACOBS: The disparity between activity-based funding and projected average cost is made up by the community services subsidy. Is it true that last year that subsidy was $384 million and this year it is about $320 million? Does that indicate that we are moving in the right direction in efficiencies in the health service?

Dr K.D. HAMES: I am not sure where the quote from last year is. Can the member for Eyre show us?

Dr G.G. JACOBS: It is in last year's budget paper No 2.

Dr K.D. HAMES: Can the member for Eyre direct us to a page in this year's budget?

Dr G.G. JACOBS: It is page 130 in this year's budget. I refer to the sixth dot point, which refers to those issues about the projected average cost and the activity-based funding.

Dr K.D. HAMES: I do not have the answer. I will hand over to Mr Salvage, who will do his best to answer that question.

[10.20 am]

Mr R.W. Salvage: I believe the member is referring to last year's *Budget Statements*; in 2014–15 a value of $121 million for the community service subsidy was put into those budget papers. This year it is shown as $300 million in the Department of Health division of the estimates and an additional $20 million in the Mental Health Commission division of the estimates, giving a total CSS of $320 million. Partly that reflects changes in the construction of the projected average cost, so the advice from the Independent Hospital Pricing Authority last year compared with this year has lowered the projected average cost, and that has obviously increased the gap between the measure and state expenditure. Also, there was a correction to the budget in 2013–14 that will be effected in a flow-through to the 2014–15 budget setting.

Dr K.D. HAMES: There we go!

Dr G.G. JACOBS: If I may quote last year's *Budget Statements* —

The CHAIRMAN: Member, I really do not think you can ask the minister to answer questions related to the previous year's budget papers.

Dr G.G. JACOBS: On page 133 of last year's *Budget Statements* there is specific reference to $387.4 million related to the community service subsidy. I am not necessarily taking issue with this, but the figure in this year's budget papers is around $320 million and I suggest that we are moving in the right direction if the community subsidy is less, because it could indicate that we are working towards that five-year goal.

Dr K.D. HAMES: That would be a lovely scenario and I would like to back up what the member said, except that I think if the member looks at that page again and reads to the end of the line, he will see that it states that that $380-something million is over four years.

Dr G.G. JACOBS: I do not think so.

Dr K.D. HAMES: I have just read it. Can we go back to the first paragraph on page 133 of last year's *Budget Statements*?

Ms J.M. FREEMAN: Can the minister just clarify, for a layperson, that the community service subsidy in Western Australia has gone up from last year to this year? I have a nod.

Dr K.D. HAMES: Yes.

Ms J.M. FREEMAN: It has gone up; it has not gone down. It needs to go down because we will have activity-based funding, but we are going up.

Dr K.D. HAMES: That is right.

Ms J.M. FREEMAN: My question to the minister is: are we going up because that helps the government get more funding from the Western Australian Department of Treasury and we will worry about the funding from the federal government later, because there is so much going on with the feds in any event and anything could change —

Dr K.D. HAMES: Could the member ask a question in lay terms?

Ms J.M. FREEMAN: All I am saying to the minister is that it is about this Ponzi scheme that is health, for me. There is this mechanism that is supposed to be around activity-based funding that will fund the department, and the minister is supposed to bring it down to zero, but he is not; it is going up. Is there a reason it is going up? Is the reason it is going up that it is an advantage to the Department of Health when the minister goes to Treasury to get funding for its operation? The minister has grown the percentage of the operation; is that the fundamental reason that we are not really worried about the movement of this community service subsidy?

Dr K.D. HAMES: I think the answer is that the definition of the subsidy is still currently being developed. The national efficient price determination and the agreement with the commonwealth on a national efficient price has only just come into being. We moved to an activity-based funding agreement with the commonwealth only in the current financial year. Whatever funding was in previous years' budgets, as the Treasurer said, was actually a combination of other things, not just the difference between the national efficient price and what our cost was. We are just now moving into that and, sure, the predicted amount is higher than it was and perhaps Mr Salvage is able to explain why it is higher than it was supposed to be. I do not think it is a good answer.

Mr R.W. Salvage: There are two impacts. One is that the effect of the convergence to the national efficient price determination we expected to see in 2013–14 did not materialise. Our public hospital costs relative to the projected average cost have remained constant, so there was that issue. The other impact is that the projected average cost has been lowered by the Independent Hospital Pricing Authority, so it is a moving target over time and we have to expect it will continue to be a moving target over time as the price setting for public hospital services is adjusted.

Ms J.M. FREEMAN: It is like the GST!

Mr R.W. Salvage: I will quote from the two determinations we are working on just to compare the two prices.

Dr K.D. HAMES: While Mr Salvage is looking for that, I might say something. It is a concern to us that the national efficient price determination authority is a commonwealth body that determines what it believes is the national efficient price. We have involvement as ministers; whenever we have a ministerial conference, the head of the national efficient price determination authority talks to us about how that determination is made, but we are concerned with some of the actions that it has taken that, in effect, gives it the ability to reduce at its will what that national efficient price should be, often against our views as state ministers. Given that it is a commonwealth body, I become concerned that it continues to set these efficient price targets that become more and more difficult to attain.

Mr R.W. Salvage: I will just provide the facts. In relation to the 2014–15 price for public hospital services, its determination last year—which was the basis for last year's community service subsidy—was that the projected average cost for public hospital services across the nation was $5 394 per weighted unit of activity. In its 2014–15 determination—which is the one we are currently working to, obviously—the value of each weighted unit of activity is $5 116, so there is a drop of just over $160 per weighted unit in the price that we are working to.

Dr G.G. JACOBS: I refer to the last dot point on page 130 of the *Budget Statements*. It states that the price determined for the activity, inclusive of the community service subsidy, for 2014 is estimated to be $320.2 million. Is that the figure we are talking about for this year for the community service subsidy? If it is, it is quite different from the figure from last year, which, as the minister rightly pointed out, was $387.4 million over four years. I make the point that this is an important issue: if we are going to rein in some of this cost, that

subsidy appears to be blowing out, when I actually initially thought we were doing well. How do we address that? I obviously understand that Western Australia is a very large and sparsely populated state, and over long distances it is difficult and expensive to provide health services. How are we going to try to match this? That is a significant challenge in the state of Western Australia and it will be very difficult to bring the CSS back.

[10.30 am]

Dr K.D. HAMES: I think I need to go back to the answers I gave before on this topic, because the member is right; it is a big challenge for us. An average weighted activity unit—it can be the weighted cost of a knee replacement, say—is the average cost per patient who comes largely through admissions into our hospitals. Our cost per average weighted unit is in the order of $5 540, and the national price, as the member heard, was supposed to be $5 200-odd and now it is down to just $5 000 in the authority's estimation. I have to say that we do not agree with that estimation, but that is the difference, and Treasury is setting that target telling us we have to get that national efficient price. First, we have to negotiate with Treasury, and we are having aggrieved negotiations, about what our price should be. I contend that our price will never be $5 000 because of state issues, such as costs, a lack of doctors in outer areas, the wages we pay our staff, the fact that a metropolitan population of this size in Melbourne might not have its own heart transplant unit, whereas we do and have to, and some of the very high specialty things we need to do in this state that might not be done for a similar sized population in other states. Inevitably there will be a subsidy component because we cannot get the costs down. However, the gap between that and what it actually costs us suggests that our hospital services are fairly inefficient compared with other states. A lot of that may have to do with the difficulties we face with not getting sufficient loadings for Aboriginality and remoteness. How can we make our hospitals more efficient? In our view, contrary to what the opposition thinks, we can do that through contracting-out some of the work, particularly for the St John of God Midland private and public hospitals and Joondalup Health Campus, for example. That will reduce our overall average cost because private hospitals operate more efficiently, in general, than do public hospitals. That is one way to reduce costs. We could decide to not pay the highest wages to our nurses and staff and to lower their wages to the average wage across the state—staffing costs form 70 per cent of hospital costs—but we do not want to do that because we would lose all our staff again to other countries and states. I like our state being in the top echelon for staff wages. As I said before, one way to get costs down is to have less weighted activity units per head of population so that the overall cost is less than in other states. We are already doing that, and part of that is about preventive health, home help and so on, although we are doing that less than the other states. The other ways relate to the other things I talked about earlier, such as better care for people in their homes so that they do not have to be in hospital, which costs far less to the state. That is the area we must work on if we are to keep the costs to this state affordable.

Mr R.H. COOK: The minister said that staffing is a large contributing feature to the weighted average unit cost. Would the minister say that the intervention by the Premier via the director general of the Department of the Premier and Cabinet during the election campaign to reach an agreement with the nurses has directly impacted upon the inefficient pricing, as revealed in the budget papers?

Dr K.D. HAMES: It has directly impacted upon the cost of providing a health service because, as a result of that decision, our nurses are the highest paid of all nurses in Australia. I will leave it up to the member to decide whether he thinks that is a good or bad thing.

Mr R.H. COOK: Obviously, all this stuff is predicated upon hospitals, administration and everyone being ready for the full rollout of activity-based funding practice at the end of 2014-15.

Mr R.W. Salvage: The first year when commonwealth funding to the state is to be activity based will be 2014–15.

Mr R.H. COOK: I thank Mr Salvage. What is the minister's assessment of the level of preparedness for activity-based funding, particularly at our suburban hospitals; the training of our key leadership teams in those hospitals; and the administration in secondary hospitals in particular? Are we ready for activity-based funding?

Dr K.D. HAMES: That is a very good question and my initial response is that we are not as ready as I would like us to be. It is rolling out and a lot of work is being done to make sure that when we put in our bills for our activity, they are complete records about what we have actually done. I can tell the member that even as a general practitioner that does not always happen. A GP, for example, can bill for one thing and then do something else, but he might not tick the box that that is what he did. Lancing an abscess is a good example. As part of their consultation, many doctors might lance an abscess, which is an activity that has an item number and which adds only a few dollars to the bill to cover the GP's costs. Some doctors do not even know they have to record that and would miss out on the commonwealth funding that they might otherwise get. If a procedure is not categorised correctly, then we will miss out on that commonwealth component of funding. A lot of training with our staff is required to make sure that they know about all the things they must bill for activity-based funding.

I will now hand over to the acting director general to tell us what he is doing to make sure that we get up to speed.

Professor B. Stokes: The issue really is to consider activity-based management. Activity-based funding is just a mechanism, as the member is aware. We have joined the performance, activity and quality division with the resource strategy division, run by Mr Salvage, to form a finance, purchasing and performance group. That group is now going through the process of getting activity-based funding into activity-based management within the hospitals. The group includes the chief executives of the hospitals and a member of Treasury as well as the two divisions in the department, and they are slowly working through that process. The member asked if we are ready for activity-based funding. I must honestly say that activity-based funding has been worked up in the department for the last two years. The work on that started in 2011 but it had not really progressed into the hospitals, which is the process we have been going through over the past six months. How successful we will be depends on getting that message through to the people at the rock face. The heads of department must know how much their budget is to manage their activity. I managed a neurosurgical department for many years and I never knew how much money I had to manage that department.

Mr R.H. COOK: The good old days!

Professor B. Stokes: They were the good old days, I must admit. But they were also the bad days because we did not know, and clinicians must now do that work. Activity-based funding is coming on board. How successful will we be? It will probably be an 18-month to two-year turnaround to get people to really understand this process.

Dr K.D. HAMES: I will add two things to that comment: the first is that coming on board has not mattered so much to start off with because although we are going into activity-based funding this year, there is still a lot of block funding. A lot of that commonwealth funding goes to the different regions to make sure that they still get the same total funding as before. The hospitals, doctors and departments will miss out if they do not properly bill. There is a huge incentive for them to get it right because if they do not, they will not get the money in the future as we move more and more towards activity-based funding. There is a massive incentive, as there would be for doctors, to make sure they charge for all they are entitled to and record exactly what they are entitled to do. It is not rocket science.

From my conversations with people who work in private hospitals, including the theatre staff at Peel Health Campus, which is run as a private hospital that has worked with activity-based funding for a long period, I know that they plan exactly for the activity that will be carried out from the minute a patient arrives. Hospitals such as those at Joondalup and Peel that work on funding from the state government based on activity have nailed down that process for a long time. Our public hospitals have not had to worry about that previously, but now they will, and my view is that they will very quickly get up to speed.

Mr P.B. WATSON: I refer to the table on page 146 of the *Budget Statements* under the heading "Completed Works".

Dr G.G. JACOBS: Mr Chairman, I have not received my assigned question.

The CHAIRMAN: The member has had about four or five follow-up questions.

Dr G.G. JACOBS: I am talking about my assigned question. When I was in the other place where you were Chairman previously —

The CHAIRMAN: I think I looked after you very well!

Dr G.G. JACOBS: The Chairman told me I would get a question after everybody else had had one.

The CHAIRMAN: I have decided to let the member for Albany have one question.

Mr P.B. WATSON: I am very offended; I thought the member for Eyre was my friend! I refer to Albany Regional Hospital on page 146 under the heading "Completed Works". I congratulate the minister and all the staff for the great work done for Albany Regional Hospital. However, I am concerned about the magnetic resonance imaging machine. The hospital was completed and tenders were put out for the actual working of the MRI machine. A room is available but nothing was set up for the MRI machine. Why was it not fitted out in the first place when everything else at the hospital was fitted out? What were the extra costs?

[10.40 am]

Dr K.D. HAMES: Someone will get all those details, but all I need is the letter that I sent, which I thought I sent to the member for Albany; certainly, I sent it to others who wrote to me about this issue. One of the member for Albany's constituents wrote me a letter using strong language and stating that we are a stupid government because we had not done all those things. The letter also asked why the machine had not opened. The reality is

that it is not yet licensed to be open. The member for Albany knows all about it; indeed, Tanya Plibersek visited his electorate —

Mr P.B. WATSON: No; she came here, minister. I have a great photo!

Dr K.D. HAMES: Wherever it was, she made an announcement about the MRI when the state government did not know anything about it. The MRI was approved for a group going into our hospitals, but the former federal health minister failed to let us know that that was the case. Nevertheless, the licence is not yet due. I hope someone can tell me the date that it will come onstream, but certainly it is not due to be licensed.

Mr P.B. WATSON: It can be used, though, minister.

Dr K.D. HAMES: Yes; but not in a public hospital without patients paying. There is no licence, but we are doing the work to get the room ready. It was done with a lot of stuff that gave the capacity for an MRI knowing of the chance coming in the future.

Mr J. Moffet: Magnetic resonance imaging licences are controlled by the commonwealth government, which has the regulatory and licensing provisions for public patients in Australia. It conducts rounds of licence applications to manage the number of machines throughout Australia. There was a regional round for MRI licensing in 2011–12. The planning for Albany Regional Hospital predated that round and that was not a foreseeable round. The provider was successful in applying for a machine at that time. The licence becomes effective in January 2015. Currently, it is not possible to get a rebate on an MRI in Albany. We have obviously worked with the provider to install an MRI, so a project is currently underway.

Dr G.G. JACOBS: This question may be a little mundane, but it is important to the Esperance community. I refer to the "Esperance Health Campus Redevelopment" on page 145 of the *Budget Statements* and to the significant funding of $32.7 million for the redevelopment of Esperance Hospital. Can the minister provide advice on the scope and time line of this much-awaited development for the Esperance community? Noting the funding announcement in September 2013 about renal dialysis chairs and the regional component of the regional dialysis plan—the minister and Brendon Grylls made an announcement about the $7 million last year—will the staged development incorporate renal dialysis chairs as part of the announced satellite services for Esperance?

Dr K.D. HAMES: I will ask Mr Moffet from the WA Country Health Service to go through those details. The $32.743 million has been allocated, with an estimated expenditure of $4.14 million this financial year and $18 million and $6 million in the next two financial years.

Mr J. Moffet: Esperance health campus incorporates stage 1 of a four-stage development, which includes refurbishment, expansion of the emergency department, construction of a new four-bed day surgical unit with a pre-admission unit and refurbishment of the ward area to include birthing suites and theatre upgrades. It is fairly expansive. As the minister confirmed, the budget is $32.7 million, comprising $18.8 million from royalties for regions, $12.5 million from the main WA Health capital expenditure program and $1.4 million from a WA Country Health Service holding fund. The main project went to tender on 9 April 2014 and closed recently on 14 May. The tender evaluation is currently being confirmed by Building Management and Works and Country Health. The tender award is scheduled for 20 June, with construction planned to commence in July 2014. What was the question about renal dialysis chairs?

Dr K.D. HAMES: Can the member for Eyre repeat the second part of the question?

Dr G.G. JACOBS: There was an announcement in September last year about regional renal dialysis and Esperance was mentioned in the assignment of renal dialysis chairs. Is there provision in the staged development for the renal dialysis chairs to be incorporated in this development? It would be really sad to have to go back to make provision for them when the funding is already there.

Mr J. Moffet: The short answer is yes. Two chairs have been allocated to Esperance out of those available, and they are being incorporated into the hospital redevelopment as part of that program.

Ms J.M. FREEMAN: The minister would be aware of the recent Education and Health Standing Committee hearings —

Dr K.D. HAMES: What page?

Ms J.M. FREEMAN: I refer to Fiona Stanley Hospital and to the line item "Commissioning and South Metropolitan Health Service Reconfiguration", the budget for which is $80 million, on page 128 of the *Budget Statements*. At a recent Education and Health Standing Committee hearing, Dr Russell-Weisz explained changes to the contract for facilities management and said that facilities management would include patient records as administration and bookings. He said that it was the view of the Department of Health that the administration was a patient-facing service and, for many reasons, would be better provided by the state. We

were told how it brought back the records, administration and bookings because they were not locked down. Given that patient care assistants, orderlies and cleaners provide patient-facing services because they interface with patients, should they not also be brought back in-house and taken out of the facilities management contract?

Dr K.D. HAMES: Although that is an excellent question, it in no way relates to the fifth line down, "Commissioning and South Metropolitan Health Service Reconfiguration" and the $80 million. I will ask Dr Russell-Weisz to explain what the $80 million relates to.

Dr D. Russell-Weisz: The $80 million relates to additional funding for the reconfiguration of the South Metropolitan Health Service and for the Fiona Stanley Hospital commissioning project. Papers provided to the Education and Health Standing Committee include a detailed breakdown, which I will not go through here, of the different components of that. Ostensibly, the largest component is clinical readiness for Fiona Stanley Hospital and the reconfiguration of Royal Perth and Fremantle Hospitals, dual-site operations and the like.

The $80 million is additional funding to that already received by South Metropolitan Health Service and Fiona Stanley Hospital for clinical readiness for those three hospitals.

[10.50 am]

Ms J.M. FREEMAN: Can the minister confirm that that $80 million includes taking back in-house the patient records, administration and bookings? Why could the government not take back in-house patient care assistants and orderlies, given that they also have an interface with patients and that aspect of patient-facing services in terms of safety and health at that campus?

Dr K.D. HAMES: I ask Mr Salvage to talk again about that $80 million.

Mr R.W. Salvage: I confirm that that $80 million is essentially funding that was announced at the midyear review. Essentially, it was the $75 million announced at the midyear review. Reflected here is $80 million because of a cash flow change from the prior year, which is also shown, of $6.9 million. It is essentially the same as reconfiguration funding that was announced at the midyear review.

Dr K.D. HAMES: I have had my fun. The question has nothing to do with that line item, but it is an important question nonetheless: why did we not put patient care assistants back into the mix? It was a decision of government that that package of services we had been negotiating with Serco about who was going to provide the services did not include those patient care assistants and orderlies. It was on that basis that the decision was made.

Ms J.M. FREEMAN: The issue before the Education and Health Standing Committee was that records administration and books were not locked down in the contract, so they could be returned to the Department of Health, and because they were patient-facing services they were important for the delivery of safety to patients in the hospital. Can the minister say that he would also have brought back in-house patient care assistants, orderlies and cleaners if the department had not locked down and signed a contract for them with Serco?

Dr K.D. HAMES: I will not speculate on what we may or may not have done. I think Dr Russell-Weisz has an answer of sorts.

Dr D. Russell-Weisz: As the member rightly says, these services were not as well defined as the other services. A number of things were factored into that decision, and it was not just that they were patient-facing services. A number of things happened over the last calendar year in which we did a substantial amount of work on commissioning and our department service plans, and the information and communications technology solution for health records management was different from what was originally envisaged in 2010–11. A number of those issues were factored into that decision, as well as the fact they were patient-facing services. For example, clinical coding negotiation is done now much better by WA Health than it was ever done in the past. Clinical coding relates directly to activity-based funding and is directly related to activity-based management, and it is done very well through the South Metropolitan Health Service. A number of reasons led to that decision, not only that the services were patient-facing.

Mr R.H. COOK: I have a further question on the line item that the member for Mirrabooka highlighted. Has the department yet determined what the operating costs of the reconfigured South Metropolitan Health Service will be in 2014–15 and into the forward years; and, if not, why has that not yet been determined? What provision has been made in the forward estimates on the reconfigured South Metropolitan Health Service? I apologise, minister, I was looking at Mr Salvage, because I suspect he was always going to come up with the answer.

Dr K.D. HAMES: I know the answer, to a degree—it has not yet been completed. Part of that relates to the work that is still being done around that reconfiguration and who goes where. We are still finalising exactly which staff come out of Fremantle and Royal Perth Hospitals and negotiations around that as to the numbers that

will refill the new hospital and how those numbers and costs will work. A considerable amount of work has clearly already been done, and I hand over to Mr Salvage to provide a response.

Mr R.W. Salvage: The short answer is consistent with the budget papers. We have set ourselves a target at the end of June to determine the operating costs of a reconfigured South Metropolitan Health Service, so we are not in a position today to confirm the expected values. There are some known elements of the Fiona Stanley budget already, some of which will be the reconfiguration funding that has already been announced, plus the additional funding that flowed through from the midyear review for the facilities management contract; and there is also a significant amount of money budgeted for depreciation expense because the facility is now past its construction phase. The unknown part is the activity profile for the hospital in 2014–15. At the global level, we have funding for growth inactivity, as the budget indicates. The apportionment of that with Fiona Stanley consistent with the phasing that will occur over 2014–15 is still being worked through, and therefore the defined value for Fiona Stanley's activity-based budget next year is not yet known at this stage. Then there is the broader reconfiguration that also needs to be completed.

Dr K.D. HAMES: We have been here for five hours. I ask for a five-minute comfort break.

Ms J.M. FREEMAN: Can I have a further question to finish it off before we leave?

Dr K.D. HAMES: The member is not interested in our comfort then, clearly.

Ms J.M. FREEMAN: I am sure the minister wants to answer this question. Given that Fiona Stanley Hospital was not a commissioned hospital at the time of the minister signing the facilities management contract and, because of that, the delegation to the director general comes under his signature to delegate responsibilities for operation of commissioned hospitals, does the minister take some of the responsibility for not managing the ICT blowouts and the workforce development in the delivery of Fiona Stanley Hospital?

Dr K.D. HAMES: As I have said before in this house, I take full responsibility

Meeting suspended from 10.58 to 11.02 am

Mr R.H. COOK: I refer to page 144 of budget paper No 2 and the cost blowouts for information and communications technology at Fiona Stanley Hospital.

Dr K.D. HAMES: Is the member referring to the first dot point under the heading "Asset Investment Program", which states —

- Construction and commissioning of the:

  — Fiona Stanley Hospital;

Mr R.H. COOK: Yes. When I get to the full question, the minister will understand I have not got a project in terms of the works in progress.

Dr K.D. HAMES: The job of the opposition is to find the questions and find the line items.

Ms J.M. FREEMAN: The minister told —

The CHAIRMAN: Minister, it is my job as the chair to ask the member to define his question and he is in the process of doing so. Member for Mirrabooka, I expect to be heard in silence.

Mr R.H. COOK: I was referring to the cuts to the Osborne Park Hospital reconfiguration, stage 1, Joondalup Health Campus redevelopment, stage 1, and the Princess Margaret Hospital for Children works provision. These are all cuts that are essentially there to pay for the minister's blowout in the information and communications technology costs at Fiona Stanley. Can the minister please provide the details of these now cancelled works, and the impact of these cuts?

Dr K.D. HAMES: I will hand over to Dr Shane Kelly for an answer to a component of that question.

Dr S.P. Kelly: The redistribution of funds for Joondalup Health Campus was a consequence of the works at Joondalup Health Campus coming in under budget; there have been no cuts to the facilities planned there. It was merely a case of very efficient management of the available dollars, and we have therefore been able to redirect those funds to other needs. In the past, there was a plan to build a 50-bed mental health unit on the Osborne Park Hospital site. That funding was a little over $40 million, but there has now been a redistribution of funds of $14 million, leaving about $26 million for that work. We expect that the future mental health facilities will be outlined in the forthcoming 10-year mental health services plan from the Mental Health Commission.

Mr R.H. COOK: And what about the Princess Margaret Hospital for Children works provision?

Dr K.D. HAMES: I will hand over to Mr Aylward for a response to that question.

Mr P. Aylward: Those funds are allocated as funds for fit-for-purpose works to hold us through from where we are now until the transition into Perth Children's Hospital in November 2015. At the moment those funds are not required, and there is a small amount of funds to deal with unexpected contingencies that might arise.

Mr R.H. COOK: I thank the minister for that information. I am particularly anxious about the $14.3 million taken out of the Osborne Park Hospital reconfiguration. Every year in estimates, it has been explained to me that the reconfiguration and building of 50 mental health beds at Osborne Park Hospital is necessary to provide capacity at Graylands Hospital so that we can redevelop a lot of the wards, particularly the Murchison and Smith wards at Graylands Hospital, which are essentially out of date, substandard and quite frankly, I think, contravene patients' human rights. Can the minister confirm that he is now cancelling the building of these beds at Osborne Park Hospital and subsequently the Graylands Hospital redevelopment because of his mismanagement of the ICT issues at Fiona Stanley Hospital?

Dr K.D. HAMES: No. Although there is a relationship between the requirement for additional funds, it was a consideration of where the funds are not required at present. It was not to fund the ICT work. I remind the member that $350 million was in the budget in 2007–08 or 2008–09 for ICT that covered Fiona Stanley Hospital and other hospitals—and roughly $250 million of that funding was removed by Treasury. This is therefore nothing to do with the opposition's constant use of "blowout". Opposition members are experts in blowouts. This is a replacement of funds that were taken away. I do not need to elaborate on the blowout component, because I did that in question time the other day.

Mr R.H. COOK: A question, Madam Chair —

Dr K.D. HAMES: I am still going with this answer, because it is a good question and I have not answered the key component of it—mental health. As the member knows, we have a Minister for Mental Health and a Mental Health Commission. I absolutely agree with the member's comments about Graylands Hospital; it is a facility that is badly in need of replacement. As part of the plan on what should happen with Graylands and mental health services in the state, the Mental Health Commission and that minister have done a huge amount of work, and I think we are very close to announcing exactly what that total plan is. However, it involves replacing services at peripheral hospitals. I will leave it to the Minister for Mental Health when she is ready to announce those exact changes—but in the meantime, the full amount of that funding is not required at present.

[11.10 am]

Mr R.H. COOK: I draw the minister's attention to page 175 of budget paper No 3, which states —

> Reprioritisation of WA Health's existing AIP —

That is, asset investment program —

> will redirect a total of $18.5 million to partially meet the additional ICT costs for Fiona Stanley Hospital.

These things include Osborne Park Hospital, which the minister has confirmed over a number of years is the contingency that is needed to provide the capacity at Graylands to redevelop that particular campus. I say again: this is a blowout because the budget papers state that additional funds are required. That is the definition of a blowout. Can the minister confirm that this blowout comes at the expense of mental health patients at Graylands, which I remind the minister were taken out of his budget in the midyear review?

Dr K.D. HAMES: No, I cannot. Under the definition of "blowout" provided by the Labor Party, the cost to build Fiona Stanley Hospital started at 400 and something million dollars and ended up at $1.7 billion. There was a $1.2 billion or $1.3 billion blowout in the cost of providing Fiona Stanley Hospital. It is not a blowout. If there was a blowout, they may well use the word "blowout", but they have said "provide additional funding". If $250 million is taken away from $350 million but then some is given back, then sure, additional funding is provided on what is currently available but it is not a blowout. It is clearly not a blowout. It is the replacement of funds that were originally in the budget that were taken away, because at that stage we did not know exactly what the total cost would be. We needed funds to use at that time; I think it was associated with the children's hospital. That happens all the time in budgets; that is, funding comes back when working on what the total cost might be. Take Royal Perth Hospital for example—there was $180 million. As the Deputy Leader of the Opposition pointed out last week, a significant component was taken away because we are working on what the exact cost will be. Is the Deputy Leader of the Opposition saying to me, when I get that funding back in the budget to do the work we need to do at Royal Perth Hospital, that if it comes in at less than $180 million or whatever it may be, he will call it a blowout? Clearly not—it will be a replacement of funds taken away. That is the case here. Those funds were required for information technology services. The fact that it came from that particular area is irrelevant. The funding needed to come from somewhere within the budget out of consolidated

revenue. It just happens that that funding was determined as not being required. It was an easy configuration for Treasury to put together those particular components that were not needed now to fund something else that was needed now.

Mr R.H. COOK: I will never have to pull the minister up on what he spends at Royal Perth Hospital because he will never spend anything! Let me confirm that the minister is taking the Graylands Hospital and Osborne Park Hospital redevelopments out of the budget to meet the information and communications technology costs at Fiona Stanley Hospital, which comes at the expense of Graylands patients.

Dr K.D. HAMES: I have just finished saying that that is not true.

Mr R.H. COOK: It says it in the minister's papers. His budget says that it is being done to pay for ICT!

The CHAIRMAN: Order! This is not a debate. Member for Kwinana, let the minister respond, please.

Mr R.H. COOK: It is on page 175. Can the minister read?

Ms A.R. MITCHELL: I refer the minister to page 132 —

Mr R.H. COOK: People at Graylands are suffering because of the minister's mismanagement.

The CHAIRMAN: Order, member for Kwinana! I will call you if you continue to interject.

Mr R.H. COOK: When will the minister stand up for mental health patients?

The CHAIRMAN: Member for Kwinana, I call you.

Mr R.H. COOK: The minister is a joke!

Dr K.D. HAMES: That must be a camera up there, is it?

Mr R.H. COOK: No; that is outrage on behalf of mental health patients!

Dr K.D. HAMES: No, it is not. It is pretend outrage because the member knows it is not true.

The CHAIRMAN: Order, minister! Do not inflame this situation.

Mr R.H. COOK: It is true. Every year in estimates you put it off.

Dr K.D. HAMES: You are not telling the truth.

The CHAIRMAN: Order! Member for Kwinana, do not inflame this situation; and, minister, I say the same to you. I have given the call to the member for Kingsley. If you continue to shout across the chamber, member for Kwinana, I will be forced to call you again.

Ms A.R. MITCHELL: I refer the minister to the heading "Expiring National Partnership Agreements" on page 132. The second dot point identifies the continuation of expiring national partnership agreements as they are at risk. In the 2014–15 budget, the commonwealth announced that funding under a number of programs will cease. Can the minister tell us what these programs are and what will be the impact?

Dr K.D. HAMES: I will need to hand over to Mr Salvage for the answer to those questions.

Mr R.W. Salvage: The commonwealth's 2014–15 budget confirms the intention of the commonwealth to terminate the following national partnership agreements. The National Partnership Agreement on Improving Public Hospital Services will be terminated from 1 July 2015. Reward components relating to that NPA are undetermined at this point. The National Partnership Agreement on Indigenous Early Childhood Development element 2 will be continued for only one year, and Western Australia will receive $6.1 million of commonwealth funding for that. Other terminating NPAs are the long-stay older patients NPA, which we referred to earlier; the home and community care program; a small NPA related to services provided to veterans; and the preventive health NPA.

Ms J.M. FREEMAN: I refer to the line item "Total Appropriations" on page 127. I want to ask a question about the future health medical research fund. In the total appropriation for Health in last year's budget, there was a breakdown showing an allocation of $4 million for 2014–15 and the same amount again for 2015–16 and 2016–17 for the future health medical research fund. There is no mention in the 2014–15 budget of the future health medical research fund. Can the minister please advise the specific allocation in this year's budget for the future health medical research fund, as well as in the out years 2015–16, 2016–17 and 2017–18? What is the total amount allocated for expenditure on medical research for 2014–15 and in the out years 2015–16, 2016–17 and 2017–18, including the future health fund?

Dr K.D. HAMES: The reason that amount was in last year's budget was that it was in major changes in spending. That major change in spending has occurred and now it is locked into the body of the budget. I can confirm that as per our election commitment, there is $6 million in the current financial year and $8 million a

year in the out years. Two million dollars of that is part of our linkage with Telethon, which adds an additional $1 million to that. The future health fund has yet to be created. Some difficulties were put forward by the State Solicitor's Office about how we structure that fund, partly around making sure it is able to take tax deductible philanthropic donations from the private sector. I received advice that I cannot do that and still have it under the auspices of state government. We are a bit reluctant to just hand over our money to an organisation without having influence over its direction. At the end of the day, I have no choice but to do that, so that body will be created because it is critical to the future of research in this state. We provide other funds for research. For example, we provide something in the order of $1 million a year to what was the Western Australian Institute for Medical Research and is now the Harry Perkins Institute of Medical Research. That keeps the lights on money. We do that because that facility, including the previous facility, is also used by other researchers. Similarly, we fund an amount close to that for the Telethon Institute for Child Health Research, which is now the Telethon Kids Institute. We will keep some of the funding that we provide to go to them, but that is not part of the $6 million or the $8 million. That $8 million will go to the research facility—$2 million will go towards adding to the $1 million coming from Telethon, and $6 million for general research. This year, because the body was not ready, we have passed the funds on directly ourselves. We have done it slightly differently this year from what we have done in the past. Although there was an opportunity for people to make applications and get funding, we have looked particularly at doing things like funding young researchers across the system to try to help them get into research, helped those who just missed out on National Health and Medical Research Council grants to boost their applications for next year and assisted in training people in how to put together NHMRC submissions to try to improve this state's share of NHMRC funds. The member for Mirrabooka may know that that figure fell to something like 3.5 per cent in past years. I think it is up to about six per cent now, but our rightful position should be at least in line with our population, which is 11 per cent, and we are nowhere near that. We have to work very hard to get our share of those funds. This $8 million a year will help potentiate that by providing a significant increase in funds to help those organisations. A lot more of those organisations are working together on collaborative arrangements, both in their applications and proposals, to ensure that we are more able to get NHMRC grants.

[11.20 am]

Ms J.M. FREEMAN: By way of supplementary information, can the minister provide a breakdown of the disbursements from the future health fund that, obviously, the department has been spending this financial year and other allocations to medical research in 2013–14? The minister went through them, but can he provide it by way of supplementary information?

Dr K.D. HAMES: I think we did it by way of press release. We have a press release that details where all that money was allocated, both for the children's research fund and for adult research funding. Professor Geelhoed can give a response.

Ms J.M. FREEMAN: I am happy to take it by way of supplementary information.

Dr K.D. HAMES: We can give it now. We do not have to give a supplementary. We are more than happy to give it to the member for Mirrabooka.

Professor G.C. Geelhoed: The general principle we tried to apply to the $6 million that was acquitted from the future health fund this year was to try to access federal funds, as mentioned by the minister. Our take of the NHMRC funding and so on is much lower than we might have expected, so there was a feeling in the research community to target young researchers. Of the money that was put out, we have handed out so-called near-miss NHMRC grants as well as NHMRC fellowships. Seven were given out—that was about $350 000—to people who just missed out on those fellowships so that they could continue to be competitive. There were 20 NHMRC near-misses—that is roughly $75 000 for each of those people across all the universities' different campuses. There was mentoring of these young people, and, again, a certain amount was given to the various universities. One of the strengths in Western Australia in research is the data linkage system, and $900 000 was given to support data linkage and databases, which include the Busselton Health Study, which people know is a real gem in the Western Australian research firmament; the Raine Study; and the newer rare diseases study. That was about $3.2 million. As mentioned, $2 million went to match Telethon funding into direct grants and $800 000 was put into the commitment we had given to create an ethics and research database, as promised, with the commonwealth.

Ms J.M. FREEMAN: Again, by supplementary information, could the minister provide which universities got it, for what, and those sorts of details?

Professor G.C. Geelhoed: Sure, we can provide them.

Ms J.M. FREEMAN: I got a yes, then; so by supplementary information, can we have that?

The CHAIRMAN: It is up to the minister to decide whether he wants to provide supplementary information. He said that he does not need to, but I ask him again.

Dr K.D. HAMES: It is not hard for us to do that. We will agree. The member for Mirrabooka could get it herself by going on the net and getting our press releases; nevertheless, we will provide it.

Mr R.H. COOK: It is called transparency, minister.

The CHAIRMAN: Order, member for Kwinana! Minister, can you define what you are going to provide?

Dr K.D. HAMES: We are going to provide details of our research funding distribution for this financial year. Would that be suitable?

[*Supplementary Information No A18.*]

Dr G.G. JACOBS: I refer to the table on page 128 and the patient assisted travel scheme, which is a very good system for people in my region. Some issues of contention each week are faced by individual applicants who feel that they need full compensation instead of assistance.

Dr K.D. HAMES: Which line?

Dr G.G. JACOBS: I refer the minister to "Royalties for Regions", under which the patient assisted travel scheme line item has $10.981 million in the forward estimates for 2017–18. Is that allocation of money for some expansion of the service? What is that extra expenditure for? What are the ongoing allocations this year and for the intervening years—both the health department's contribution and indeed the royalties for regions contribution?

Dr K.D. HAMES: The member for Eyre will notice that the heading on this page is "Spending Changes". The reason that figure appears in the final year is that there was agreement that a component of the total funding of the patient assisted travel scheme would come from royalties for regions. In last year's budget, it was a four-year allocation. Now we are moving into the next year, so that spending changes to reflect money that is already in those previous years but needed to be added in the last year or we would have had, in effect, a drop of $10 million in the total amount of money that was available for PATS. So that the member for Eyre knows, the total expenditure on PATS has increased enormously since we have been in government. When we were in opposition, there was a Senate inquiry into PATS Australia-wide. A number of recommendations were made about how states should change, so we made that commitment in opposition to do virtually everything that was recommended by the Senate committee. It was a huge boost for country people in the state because at the time it increased total PATS funding by 50 per cent, and it has continued to grow. A lot of the changes helped people with cancer and helped change the rules under which they could get funding. Before they would get funding only to drive from places like Albany, Kalgoorlie and Geraldton—I am not sure whether Esperance was in that too-close bracket; it had to be more than a significant distance from Perth.

Dr G.G. JACOBS: It is not too close to anything.

Dr K.D. HAMES: The changes we made meant not only that people could fly, but also there was a broader understanding of which carers could be taken and increased subsidies for accommodation. But it is a supplement. Part of the work was to make sure that we covered rising costs of petrol, so now the subsidy reflects the cost of petrol. However, for accommodation, we clearly did not have the capacity to increase accommodation costs to allow everyone to stay in expensive accommodation. In fact, it is very difficult for people to find accommodation. Yet it is a huge increase in funding for the state and is far, far better than any other state could contemplate. As the member would be aware, an upper house committee is doing an excellent inquiry into PATS—one that the government has strongly supported. The government will be looking at what that committee recommends. I will hand over to the director general who will make a few additional comments.

[11.30 am]

Professor B. Stokes: We are also looking at a WA patient transport strategy for both the metropolitan and rural areas, looking at all those things that will improve the moving of patients between hospitals and in and out of the metropolitan area. That strategy is underway at the moment.

Dr K.D. HAMES: One of the key components of that patient strategy is mental health patients. Members would be aware that we have had significant problems achieving four-hour rule targets in our hospitals because of mental health patients and issues with transporting them, largely to Graylands. The requirement to have both police and ambulance present at the same time has proved extraordinarily difficult to coordinate. Under the mental health strategy, specialist transport officers are now employed, with responsibility for transporting patients and moving them from our emergency departments.

Dr G.G. JACOBS: Very briefly, what does the state government assign to the PATS program each year?

Dr K.D. HAMES: I think it comes under patient transport. That covers the total, but I do not have it broken down specifically for PATS, so I will read out the figure for total transport while someone is looking for the information.

The CHAIRMAN: Minister, can you advise what page you are on now?

Dr K.D. HAMES: I am referring to item 6, "Patient Transport", under the service summary on page 129. The total transport cost for this year is $205 265 000. Does anyone have the PATS component of that funding?

Dr G.G. JACOBS: Can the minister provide it for me?

Dr K.D. HAMES: Yes, we will provide the PATS component of that funding by way of supplementary information. I have seen it lots of times in briefing notes.

[*Supplementary Information No A19.*]

Mr R.H. COOK: I wish to ask a quick follow-up question to the royalties for regions question asked by the member for Eyre. Could the minister explain the reductions in the renal dialysis service expansion program and the wheatbelt renal dialysis program? Some significant funds have come out of the system over the forward estimates. I am referring to "Royalties for Regions" under the spending changes on page 128.

Dr K.D. HAMES: I do not think any funds have come out. It appears to me, from looking at that page, that they have moved sideways.

Mr R.H. COOK: It is the same thing, minister.

Dr K.D. HAMES: It does not mean that the funding has been withdrawn; it means that the program has been delayed. Mr Moffet will answer that. Mr Moffet also has a fair idea of the answer to the previous question relating to PATS funding.

Mr J. Moffet: In terms of wheatbelt renal dialysis, the changes indicated in the *Budget Statements* are a cash flow change—$2 million being converted from recurrent to capital; recurrent, $896 000 has been pushed out to 2017–18 as requested by us to align with the programming of the construction and then operation of those clinics. There is no reduction; it is a change in timing.

PATS expenditure is approximately $35 million for this year.

Dr K.D. HAMES: I will ask Mr Moffet to explain that change from recurrent to capital. What has that done to the timetable for the provision of renal dialysis services? We are pretty keen to keep that going.

Mr J. Moffet: I will need to provide more detail on notice.

Dr K.D. HAMES: I have asked a question to which Mr Moffet does not have the answer, so he will provide it to me by way of supplementary information. I do not need a number for that.

Mr R.H. COOK: We are curious, too.

Dr K.D. HAMES: Members opposite would like the answer as well. We will provide that by way of supplementary information. We are providing information about the rollout of the expansion of the renal dialysis service—how it is occurring, when it is occurring and the changes to that program.

[*Supplementary Information No A20.*]

Mr R.H. COOK: I refer to Royal Perth Hospital under "Works in Progress" on page 145 and the allocation of $8 million for "Redevelopment Stage 1", which is all that remains of the previous $180 million for the redevelopment of Royal Perth Hospital—a key election promise by the minister in both the 2008 and 2013 elections. That $8 million is now essentially described as planning money. Can the minister please provide a report to the committee on where this planning is at? Given that he commissioned the member for Ocean Reef to chair a committee, which provided him with planning and scoping information, why does that need to be done again? Can we have a copy of the report prepared by the member for Ocean Reef and his committee? Will the minister be issuing a clarifying statement to people in the electorates of Perth, Mount Lawley and Morley about his broken election promises?

Dr K.D. HAMES: My election commitment has not been broken. The election commitment was that we would provide those upgrades that were proposed for Royal Perth. We made two commitments. The first was to retain Royal Perth as a tertiary hospital, which we have clearly done. The second was to provide upgrades to Royal Perth Hospital. That was to be done in our second term of government. We are currently in our second term of government and we still have three years of our second term of government to complete. Clearly, that promise can only be deemed to be broken if we get past the 2017–18 election and it has not been undertaken.

I am not providing that report, and I have said so on numerous occasions. In determining the $180 million, a view was formed that although we wish to build a new wing to the north block to provide for the 450 beds that will go there, that proved to be unaffordable in the context of the financial capacity of the state. We then needed

to look at other options. One of those other options—I have made it clear that it is my preferred option—is to do a major redevelopment of the component of the hospital on the church side of Wellington Street. It is called the A block. It is an H-shaped block with one wing that goes along Wellington Street and one wing further inside that has the emergency department at one end. My view is that the structure of that building is still sound but it would require a major redevelopment to see it performing at the standard we would expect into the future. We have now referred that to strategic projects, which is going through the process of determining all the options and doing a proper business case that will then go to Treasury, and through the Economic and Expenditure Reform Committee to cabinet to make a decision on exactly which option will be chosen. That is what that funding is for.

The committee has been meeting. It is close to forming a recommendation. Once that recommendation is accepted, we need to get full details of what it will cost to carry out those works. Then I will go back to Treasury, seeking the funding to do that. I will just let members know my preferred option, as I did the other day, and ensure everybody here is listening. There is sufficient capacity on the church side of that H-shaped block to move all the patients out to that area, and then, without the encumbrance of the patients being around, do a complete redevelopment of the Wellington Street side. We could then move the patients back into those brand-new internal facilities on the Wellington Street side, and at a later stage redevelop the church side of the building for administration components, moving whoever is in that building to the WACA ground end of the hospital past where the clinics are. I believe that that would be a good outcome. My preferred outcome would be a brand-new building, but it would probably cost $1 billion to build something like that and we do not have the funding or capacity to do that. The north block will still require some upgrading. We will probably need a new emergency department within that complex somewhere, but that will provide first-class facilities within the envelope of the existing A block of the hospital.

[11.40 am]

Mr R.H. COOK: Can the minister please indicate the projected building time for the redevelopment of the hospital following the development of the business case?

Dr K.D. HAMES: I cannot answer that because we need to see exactly what all the costs are and then, clearly, I will need to get the money confirmed by Treasury to do that. I will not be able to put that in place until I can confirm the funding streams for that redevelopment. Clearly, having only three years to go makes things difficult, but not impossible.

Mrs G.J. GODFREY: The first dot point on page 144 of budget paper No 2 refers to the construction and the commissioning of the Perth Children's Hospital at the Queen Elizabeth II Medical Centre site. How is the work on our wonderful new Perth Children's Hospital progressing?

Dr K.D. HAMES: Thank you, Dorothy!

Mrs G.J. GODFREY: What a wonderful minister we have!

Dr K.D. HAMES: I will ask staff involved in the construction of that hospital to respond, particularly Mr Aylward, but clearly it is going exceptionally well. The building is on time and on budget. There is still significant work to do, again around IT. Nevertheless, a magnificent hospital is under construction. We have been through the issues with total bed numbers. We will have 298 beds at that hospital, which is an increase of 48 beds. We have had discussions about our view on the adequacy of that. At the end of the day, the state-of-the-art Perth Children's Hospital will be a huge source of pride for all Department of Health employees and the state. I hand over now to Mr Aylward, who is the very proud man responsible for the project.

Mr P. Aylward: The project is on time. The expected practical completion is the middle of next year, with commissioning to take place over the following four to six months, and the commencement and full opening of all services and new services in November 2015. It is quite a remarkable building in its design. It will have far more single rooms, which will allow for better care to be provided to patients. For the first time, young people who require admission to a mental health facility will all be contained in a single place and provided a service at Perth Children's Hospital. In addition, we have embarked upon a significant transition phase involving clinicians and back-of-house staff. As part of that we are investing in new information systems that will start prior to the commencement of the Perth Children's Hospital. Also, an integrated health solution will start six months after opening. We will also use relevant existing health information systems that have been developed within health. They will form part of the suite of IT systems for an exceedingly modern and advanced paediatric hospital for WA.

Mrs G.J. GODFREY: How old is Princess Margaret Hospital for Children? When was it built?

Mr R.H. COOK: It was when Gary started working there!

Dr K.D. HAMES: Mr Aylward.

Mr P. Aylward: My recollection is that it is about 104 years old.

Mr R.H. COOK: One of the key learnings from the government's mismanagement of the ICT at Fiona Stanley Hospital was that it would buy an off-the-shelf IT package for the new Children's Hospital. Can the minister give us some advice on whether that IT package is on track for implementation and how it will be integrated with the platform at Fiona Stanley Hospital?

Dr K.D. HAMES: That is a very good question and Mr Aylward will give the member those details.

Mr P. Aylward: Lessons learned have been taken on board in the design and the development of the information systems for the Perth Children's Hospital. First of all, we will not customise or develop our own in-house systems. We will purchase off-the-shelf systems. Therefore, we will change our processes. The first tranche of those systems, which we term back-of-house systems, has been to the market and our team is reviewing those bids. They will include elements such as catering, scheduling and works management systems. We will bring across and use existing systems that are functioning well within our hospitals. WebPAS is an example; we will still maintain that system. Obviously, we will need to create interfaces to ensure that the information is available for paediatric care throughout the metropolitan area and country area. The most significant change in our hospital will be the acquisition of an integrated health solution. That will be a first for Western Australia. The proposal is to go to the market in the very near future. A lot of pre-planning has gone on with our clinicians and our Health Information Network and other support from throughout government. That request for proposal or tender will certainly be in the marketplace within the next month. The concept is that we will purchase off-the-shelf products that require only configuration and not modification. The medication management systems will be deployed six months after the opening of Perth Children's Hospital. That system is not required to be in place to open the Perth Children's Hospital safely in November next year, or to open it on time. We are de-risking the very significant training and change management from the implementation of that health information system to be delivered post the opening of Perth Children's Hospital.

Mr R.H. COOK: Is it on time?

Mr P. Aylward: Yes.

Ms J.M. FREEMAN: Is it on budget?

Dr K.D. HAMES: Members will clearly see that because of my knowledge and skill in IT management and configuration, I have direct responsibility for and involvement in all the IT systems that were just spoken about!

Mr R.H. COOK: Excellent.

Ms J.M. FREEMAN: It is a shame the minister did not do something about it previously. I refer to "Land Acquisition" under "Works in Progress" on page 145. It would be remiss of me if I did not ask this question: now that the health department has the titles for the land near the intersection of Milldale Way and Mirrabooka Avenue, what is it doing with that land and when will it develop it?

[11.50 am]

Dr K.D. HAMES: I notice, looking at this particular line item for $4.8 million, that only $400 000 is listed for 2014–15, and I do not actually know what it is for. The member might much rather I gave an answer to her actual question, which bears no relation to that line whatsoever. We are continuing down the path we have discussed before in providing that land for aged persons accommodation. It took some time, but we have reached the stage at which we have that title.

Ms J.M. FREEMAN: The government has had the title for a while now.

Dr K.D. HAMES: I had a briefing note a few weeks ago. The director general has advised me that we cannot say much more than the member already knows; that is, we are having intimate discussions with MYVISTA about the process involved in transferring the land that will allow it to develop that aged-care accommodation. I have to say it is an unusual step for government to hand over funds to an organisation like that for aged-care accommodation that does not usually provide health services. Given there were no funds in the budget, we may have chosen to retain that land and use it for some future health activity, but our view, which was essentially my view, is that that land has, as the member knows, been unoccupied for a long time—I will not go into the history of it and make embarrassing comments for the member. At the end of the day, nothing has happened there for a long time. If we look at where health services are needed, we certainly need something in that area. It is a huge detraction not to have anything for the development of that Mirrabooka shopping centre region, and the reality is that if we are providing additional health services for which the state government is responsible—that is, hospital services—it will not be at a location like that on a block that size. It would need to be done at Osborne Park,

Joondalup or elsewhere. We know we have a significant lack of aged-care accommodation in this state, which is causing us costs in our hospitals because people are staying there when they do not need to and would otherwise go to aged care. We have been aware of the problem with the commonwealth for a long time, and I am not blaming just the former Labor government; it has forever been an issue that the commonwealth has not provided enough money to enable aged-care accommodation in this state to work. Our aged-care accommodation has gone down over time, whereas that of all the other states is going up. The only way to get around that, in my view, is to help those organisations by providing land, and that is what we intend to do. We will make that land available. We are looking at other opportunities on that location to see what else we can do, such as a dental clinic, but those negotiations are currently underway, and until they are concluded, I cannot give a longer answer, which is a shame really!

Dr G.G. JACOBS: I refer to "Improving Aboriginal Health Outcomes" on page 133 of the *Budget Statements*. The prevalence of preventable disease, particularly treatable ear disease, but also eye and oral health problems, in Aboriginal children living in rural remote communities is somewhat concerning, and, in fact, the minister will remember that the former Education and Health Standing Committee, under the chairmanship of Janet Woollard, looked at the high incidence of deafness in Aboriginal children, with up to 70 per cent of kids in some communities being deaf. These conditions have the potential to have lifelong implications. I understand that there are issues in and around Closing the Gap funding from the feds, but, as the minister said, $30.3 million was committed to deliver a range of measures. I wonder whether the minister could touch on those, including the outreach services to improve ear health.

Dr K.D. HAMES: There are two components to funding for improved Aboriginal health outcomes. Part of it is the Closing the Gap funding. The member will see there is $30.3 million in the budget. I talked about $32.3 million before, because we have added $2 million to that to make that total package $32.3 million. Separately, there is $6 million in the budget for a particular ear health program in remote Aboriginal communities. It is something that I initiated after discussion with specialists providing voluntary support in ear health for Aboriginal communities, particularly Professor Harvey Coates. His advice to me was that one of the critical shortages in addressing this issue of deafness in Aboriginal communities was people employed on the ground to provide continuous health care for Aboriginal children. Therefore, we have decided to employ in Aboriginal communities a 0.2 full-time equivalent Aboriginal health worker for the smaller communities or a 0.3 FTE for the bigger communities. Most of those Aboriginal health workers are already there doing part-time work, so we are looking to recruit those people in those communities. An Aboriginal health worker, for example, will spend their two days walking around the community with a tonometer measuring ear pressure, looking for glue ear, doing ear toilets, doing otoscopy where required and having linkages through iPads and telehealth through to specialists in Perth who can guide treatment. They can in fact help coordinate children who need grommets to be inserted by taking them to places where that surgery is done by the specialist. As well as doing ear health, at the suggestion of the director general, we have added eye health, looking for trachoma in particular, and we have access to some commonwealth funds to improve trachoma management in this state. Separate to that, these Aboriginal health workers will be checking children for trachoma and also looking at teeth. For example, we see a lot of dental caries in Aboriginal kids. There is now a method of painting their teeth with a fluoride substance that stays there for six months. Therefore, if they do not have good oral hygiene, we can still significantly reduce the incidence of dental caries. That is what those people do, and the good thing is that these people will live in the community. They will be checking their friends' or their family's ears and they will be able to do it right through the day. They can go to schools and work with the schools, and they can go to homes and work with parents. The state government has responsibility for something in the order of over 100 large communities, and we will be putting those people in those communities where there is significant demand. We think that will have an enormous impact on reducing the incidence of poor health. As I said, those communities already have Aboriginal health clinics provided either by us through the WA Country Health Service or by the Aboriginal medical services. We will be working with both of those to ensure that when people need treatment, they can get it. If they need antibiotics, those Aboriginal health workers will take the children to the clinics and make sure they get antibiotics or ear toilets when they are required. That will significantly improve the care of Aboriginal children. I just want to pay a compliment to Professor Harvey Coates for putting forward the idea that has led to us implementing this program.

Dr G.G. JACOBS: Professor Harvey Coates, when he appeared before our committee, had introduced the concept of a surgical bus to take the surgery to these very remote places, because, in fact, if surgery is required, it is enormously difficult logistically for these children to get that surgery. I wonder what the minister's view is of the concept of taking those procedures to remote places on a surgical bus and whether there is any mood to promote it.

[12 noon]

Dr K.D. HAMES: My initial reaction was guarded support, the difficulty being the cost of running that sort of service when there is probably still capacity within our existing hospitals. I have had discussions in Broome. We have a location where we could put a bus like that, and I think we could get donations that would allow for the purchase of that bus, but it would need a staff member to coordinate the driving. It would be used for not only ear services—that would be a waste—but also other services such as dental or plastic surgery requirements. From a base in Broome, the bus could be driven to places like Fitzroy Crossing or Halls Creek, but that would be if there were only one bus; Kalgoorlie and the south west region would be left out unless an additional bus was bought to do the same thing. We would then have to move all the theatre and anaesthetic staff and technicians to the location, which is not impossible, but accommodation would have to be provided for them as well. There are a lot of logistic difficulties, so the question is: do we need it or not? My view is that we need to pause and see what these new health workers do, because one of their jobs will be to find that child in the remote community and transport them to the site of the surgery. Instead of Professor Harvey Coates doing all these tours and surgery at different locations, he could go to Kununurra, Derby and Broome where there is theatre space, the staff and the capacity to do it, and accommodation as well. We are building hostels in those areas—we are about to build an Aboriginal hostel in Broome or Derby—so we will see how that works first. If that does not work as well as I would like, there is still the option to have a bus and, certainly, I would consider that in future if we do not get the impact that we require.

[Mr I.C. Blayney took the chair.]

Ms A.R. MITCHELL: I refer to the second dot point on page 135 under the heading "Joondalup Health Campus (JHC), Telethon Paediatric Ward". The minister announced funding for a 37-bed ward at Joondalup Health Campus to replace the existing 24-bed ward. Can the minister give some more detail about this development?

Dr K.D. HAMES: This is a fantastic step forward. As the member knows, we just announced the expansion of the 24 existing beds at Joondalup Health Campus to a total of 37 beds to form a new paediatric ward. This has received combined funding, with the state government providing $6 million, Telethon providing $6 million and Ramsay Health Care providing $3 million. The total cost is approximately $15 million, although we have not yet determined the final figure and will not know that until we get expressions of interest and the final quotes, but that is the indicative budget. The set-up will be based along the lines of what is happening at Princess Margaret Hospital for Children, with 75 per cent single beds and 10 day-surgery beds as part of those 37 beds. This is all part of our plan around Perth Children's Hospital to ensure that a significant number of patients will go to peripheral beds in Perth, rather than go to the tertiary Princess Margaret Hospital. Part of that plan is the expansion of bed numbers at Fremantle Hospital and Fiona Stanley Hospital, and the increase at Midland Health Campus from eight to 12 paediatric beds.

Large numbers of patients who currently go to Princess Margaret Hospital have secondary health needs, but they go there because that is just what they do. A parent with a sick child does not care what is in the way; they get in the car and go to Princess Margaret Hospital because of the quality of care it provides. I understand why some parents now might not want to stop at Swan District Hospital or Joondalup hospital along the way; they are not as confident with the quality of care received there, and with reason, because we do not have a high level of specialists and experienced caregivers available in these hospitals. We must change that, hence the very high quality of care that will be provided for children at Fiona Stanley Hospital, with their own separate entrance, emergency department and paediatric ward, and similarly now at Joondalup hospital, with very high quality specialists to care for children. Even for those patients who have a more significant illness, such as an asthma attack or cystic fibrosis, and who will require tertiary care, it is far better for their parents to stop at the nearest available service that is of high quality, to have their child's condition assessed and stabilised, and then be transferred to a tertiary hospital. We anticipate that these beds will get significant extra use. As a comparison, the occupancy rates at Fremantle Hospital, for example, vary between 50 and 60 per cent; therefore, even though the increase in the number of beds is not huge in Fremantle Hospital and Fiona Stanley Hospital, the occupancy rate will be significantly higher, and I think we will see the same at Joondalup hospital. It is an excellent move forward in the provision of paediatric care. The state government must ensure that it continues on that journey to provide additional services close to home. We have adopted the paediatric implementation plan that puts in place changes to the way we manage our system, which means that the increased capacity of 48 beds at the children's hospital will be sufficient with its significantly increased focus on tertiary care.

Ms J.M. FREEMAN: Is the department using money raised by Telethon to put into the general delivery of paediatric services at Fremantle and Joondalup hospitals?

Dr K.D. HAMES: Just at Joondalup.

Ms J.M. FREEMAN: Is the Joondalup project a capital works project? Is the government using charitable funds from Telethon to do a capital works project at Joondalup hospital?

Dr K.D. HAMES: The concept came from Kerry Stokes, head of Channel Seven and Telethon, when looking at the funds that Telethon had available for donations to children for a range of things. As the member knows, Telethon has raised significant funds. Telethon was providing many extra services at Princess Margaret Hospital, but given that we are now building the new Perth Children's Hospital where all the services are significantly catered for over the next few years, Telethon in its discussions wanted to look at how else it could support the quality of high-care services for children in this state. Telethon put forward to us the proposition of expanding that service at Joondalup hospital. Clearly, we were strongly supportive. Telethon put together as its component $6 million and negotiated the $3 million from Ramsay Health Care, dependent of course on government providing the other half of the funding and on calling it the Telethon Paediatric Ward. It is a great move on Telethon's behalf and all those people who provide donations to help support children's services in this state would be more than happy to have some of the funds go to a state-of-the-art children's ward that supports the northern section of the metropolitan area. Dr Kelly would now like to clarify the funding arrangements.

[12.10 pm]

Dr S.P. Kelly: The $15 million estimated capital cost comprises $6 million from Telethon, $3 million from Ramsay Health and $6 million from the state.

Dr K.D. HAMES: There is a total of $15 million. We matched Telethon's money, so both the state and Telethon are contributing $6 million and Ramsay Health is contributing $3 million.

Mr R.H. COOK: Was it Mr Stokes' idea?

Dr K.D. HAMES: I do not know whether it was his idea. We did not approach Telethon, it approached us.

Mr R.H. COOK: Telethon approached the government out of the blue and said it wanted to put $6 million towards a new paediatric facility.

Dr K.D. HAMES: I do not know how it came to develop that concept. I repeat: we did not approach Telethon; it approached us.

Mr R.H. COOK: Is the minister saying that he did not have plans for a new paediatric wing at Joondalup Health Campus? If he is saying that he did have plans for a new paediatric wing, how much money was in the forward estimates to pay for that capital expenditure?

Dr K.D. HAMES: We had plans to further expand paediatric services at Joondalup Health Campus. The paediatric implementation plan was put out last year, so it was last year that we released that that was what we were going to do. But no funds were available at that stage to put that plan in place. We needed to do further work on it, because we did not have costings for providing those additional services.

Mr R.H. COOK: Is the minister saying that Mr Stokes read the paediatric implementation plan, thought it was a great idea and decided that Telethon should put $6 million towards a child's wing at Joondalup Health Campus, and that the Minister for Health did not know anything about this?

Dr K.D. HAMES: I did as soon as Telethon spoke to us about it. It is fair to say that the Deputy Leader of the Opposition would need to ask Mr Stokes how he came to that concept. I understand that he had conversations with people in the health system.

Mr R.H. COOK: So effectively it was unfunded.

Dr K.D. HAMES: It was unfunded until Telethon put forward the proposal to make a significant contribution to get it up, and it asked whether the state government would be interested in partnering with it. Quite clearly we were, and are.

Mr R.H. COOK: If I can be clear, the minister had a policy implementation plan around the paediatric implementation plan, the capital expenditure for which was unfunded. Telethon stepped in to take over the plan because the government was unable to implement it. Is that correct?

Dr K.D. HAMES: I think that is putting a very negative spin on what is a very good project. We planned to do it, but it had not yet made its way to our capital works funding. When we received the offer to partner in providing that, we subsequently found $6 million, which was our component of the funding. It was a fantastic offer, one that we were very pleased to accept. Clearly, it is in the best interests of the state.

Mr R.H. COOK: I refer to the second dot point under "Mental Health" on page 132 of the *Budget Statements*, which outlines the $144 million additional funding for mental health activity. I note that the most common mental health condition affecting adolescents is eating disorders. I am curious to know whether any money has been dedicated to implement the recommendations of the "Youth Eating Disorders: Inpatient Service: A

Staged Approach to Developing an Integrated Service" report. This project was undertaken by the Department of Health in 2013 to establish an adult eating disorder inpatient service for 16 to 25-year-olds. If so, how much money has been dedicated and over what time frame? Is there any additional funding to reduce the unacceptably long waiting times experienced by eating disorder outpatients when trying to access counselling at the Centre for Clinical Interventions?

Dr K.D. HAMES: I will hand over to Mr Kelly and Mr Aylward.

Dr S.P. Kelly: A business case is under development about providing an inpatient-based eating disorder service. I am not aware that any money has been allocated to it at this stage because —

Mr R.H. COOK: Is it for adolescents?

Dr S.P. Kelly: Yes. Obviously, the services for children are already provided at Princess Margaret Hospital for Children, but the only service currently available for adolescents and adult eating disorder clients is the outpatient-based one to which the member referred; hence, the plan and the business case under development at the moment to provide inpatient services for eating disorder patients.

Dr K.D. HAMES: Mr Aylward will talk about children's eating disorder services at Princess Margaret Hospital and at Perth Children's Hospital.

Mr P. Aylward: Princess Margaret Hospital for Children already has a comprehensive eating disorders program, which is multidisciplinary and involves paediatricians and mental health staff. It provides both outpatient day services and inpatient clinical care. It is intended that the new Perth Children's Hospital will have a dedicated area that will be specifically allocated for children with eating disorders who require services as inpatients. We will have the capability and flexibility to flex-up; in other words, depending on the demand, we will have the capacity to provide for those young people and children who are afflicted with this disorder. The hospital will be limited to looking after those up to 16 years of age. The work we are doing collaboratively with the North Metropolitan Health Service will ensure a bridge across in transition because, regretfully, eating disorders do not disappear quickly and have long-term effects. We will be heavily involved in the development of the proposal that will come through probably in the latter half of the year.

Mr R.H. COOK: There is a lot of information there. Are there any dedicated eating disorder beds at Sir Charle Gairdner Hospital by virtue of a space for adolescents to be cared for and at Princess Margaret Hospital? I want to revisit the issue of the business case, because it was my understanding that the business case was done and that the government knows how much it will cost and where the beds will go and that it is just a question of funding. Can the minister clarify those two points?

Dr K.D. HAMES: I will need to go back to the two people who spoke before. The question about the children's component was answered; there is an area and it will be a dedicated area at Perth Children's Hospital.

Mr R.H. COOK: Will they be dedicated eating disorder beds?

Dr K.D. HAMES: We will go to Mr Aylward first, so that he can reiterate what he just said about the eating disorder area.

Mr P. Aylward: Currently at Princess Margaret Hospital there are dedicated beds. The beds are configured as part of an area used by adolescents. It is not ideal in terms of being fit for purpose, but it is adequate for the present, given that we will shortly be moving to the new Perth Children's Hospital, where there will be dedicated spaces and the capacity to provide the model of care that is needed for these young people. They will be part of the adolescent ward area, but will have designated beds. As I mentioned previously, we work on the basis of providing care based on demand, so we flex-up and use the beds that are available at PMH and we will do the same at Perth Children's Hospital to cope with and meet the demand for inpatient care as it arises.

Dr K.D. HAMES: We will go back to Mr Kelly for the business case.

Dr S.P. Kelly: Just confirming my previous advice, both Mr Aylward and I and our staff are in close collaboration about the business case. In terms of the services that are currently provided, Sir Charles Gairdner Hospital provides services for patients with serious eating disorders, including inpatient services.

Mr R.H. COOK: For adolescents?

Dr S.P. Kelly: Anyone who is over the age for the services that are available at Princess Margaret Hospital.

Mr R.H. COOK: So they are not dedicated adolescent beds?

Dr S.P. Kelly: They are not dedicated beds at this time. I anticipate that this will also be reflected in the mental health services plan that is due for release shortly.

[12.20 pm]

Mr R.H. COOK: Can the minister confirm my understanding that we are the only state not to provide dedicated beds for adolescents with an eating disorder?

Dr K.D. HAMES: It depends on who the member regards as an adolescent.

Mr R.H. COOK: The 16 to 25 age group.

Dr K.D. HAMES: We have adolescent beds at the Princess Margaret Hospital for Children. We regard them as children up until 16 years.

Mr R.H. COOK: They are either an add-on in the children's hospital or an add-on in the adult hospital.

Dr K.D. HAMES: I am just asking, for my own information: is there a definition of an age group for adolescents?

Dr S.P. Kelly: We use the term "youth services", and the youth age group is from 16 to 25.

Dr K.D. HAMES: So, Mr Aylward, when you refer to adolescents, they are from what age to 16 years?

Mr P. Aylward: We probably refer to them as around the 12 to 13 age; it is not hard and fast.

Dr K.D. HAMES: They are using the word "adolescent", but the adult hospital is calling them "youth". There are no dedicated beds for youth. I presume the Minister for Mental Health is aware—I am not—whether or not we are the only state without them. The acting director general has a comment.

Professor B. Stokes: There will be dedicated mental health youth beds in Fiona Stanley Hospital.

Mr R.H. COOK: I am aware that there will be general mental health beds, but not beds dedicated to eating disorders, which Professor Stokes would be aware comprises the major incidence of mental health issues amongst adolescents.

Mrs G.J. GODFREY: On page 134 of budget paper No 2, mention is made of additional funding for the Royal Flying Doctor Service, which is an iconic organisation that provides a crucial service to people living in rural and remote parts of Western Australia. What support is being provided in the 2014–15 budget for the Royal Flying Doctor Service?

Dr K.D. HAMES: The Royal Flying Doctor Service has been a significant recipient of state government funding. All members will recall the comments by the former Labor Minister for Health in 2008, who referred to it as "just another interest group" when the RFDS was seeking a significant increase in funds. The problem at the time was that the RFDS was not getting adequate funding for the increased demand on its services and it was not able to meet key performance indicators around attendance times across the length and breadth of the state. When we were in opposition, we committed to increase those funds and, of course, as soon as we won government, we did that with the support of royalties for regions funding. This made a huge contribution to our capacity to increase those services—mostly through a plane replacement program but also by expanding services through a dedicated service coming out of Broome. I will hand over to the acting director general, who will give us some further information.

Professor B. Stokes: In 2008–09, the state government approved increased funding of $38.5 million for the five years to 30 June 2013 to build the capacity of the RFDS. Of this funding, $29.9 million came from royalties for regions. The contract with RFDS expired on 30 June 2013 and had been extended for one year. I mentioned earlier that we would be doing a total transport examination. The RFDS contract has now been extended to June 2015. In this budget period of 2014–15, $8.05 million has contributed 40 per cent of the cost of four new PC12 Pilatus aircraft, so there has been some increase in the fabric.

Ms J.M. FREEMAN: I refer to the total cost of services on page 126 of budget paper No 2.

Dr K.D. HAMES: This is a left fielder, is it?

Ms J.M. FREEMAN: Yes. I refer to the freeze on government advertising and recruitment for the remainder of the current financial year. Why are the government's television advertisements for health, the Bigger Picture, still on our screens? What is the total cost of the Bigger Picture advertising campaign? Does the freeze on recruitment apply to areas in which the health system is currently under-resourced, such as child health nurses and difficult-to-staff locations, especially in regional and remote Western Australia; and will the freeze on recruitment be lifted from 1 July?

Dr K.D. HAMES: That seems like two totally separate questions—one is on the Bigger Picture campaign and one is on the staff recruitment freeze. It will help my answer if the member for Mirrabooka explains how she has tied those two things together.

Ms J.M. FREEMAN: It is connected to how the department is spending money on the total cost of services and how the minister is managing our health budget efficiently and effectively, given that previously he was not managing our budget efficiently and effectively because we had a blowout at Fiona Stanley Hospital. If the minister would like me to go through and detail the blowout and things like that, I will.

Dr K.D. HAMES: I would love to go through that with the member.

Ms J.M. FREEMAN: I just want to see how the minister is managing the health budget and what is going on at the present time. The fact is that money is being spent on the Bigger Picture ads to defend what happened with Fiona Stanley Hospital.

Dr K.D. HAMES: I asked for a clarification of the question, not a statement about what we are doing or not doing. I am pleased to answer that question now that I understand the long bow that is being drawn by the member. There are two components to that question and I will deal with them separately. The first one is the advertising campaign. When the government announced that advertising campaign, and just in case Labor members decided to give me a hard time, I had a list of all its spending when it was in government—I think I read some into *Hansard*. Unfortunately, I do not have that with me today. Our program costs something in the order of $1 million. I read into *Hansard* that just the advertising campaign by Mr McGinty in the local newspapers cost $1 million over two years. The Bigger Picture advertising campaign directs people to the services available in their community; in fact, it is dedicated to taking them to a website that allows members of the public in any area to look at what is happening in their area. We found that particularly necessary with Midland Public Hospital, because during the last election, members on the other side were campaigning and suggesting that there was not going to be a public hospital and that people would have to pay. I had some very strong concerns expressed to me by elderly people in that area about the suggestion that they would have to pay to go to a public hospital, which was clearly not true. The government decided it would tell people what was available. We have had a massive response. A record number of people got on that website; it has been a record for any promotional website that this state has put up in the past. We have had far greater numbers of people accessing that information than occurred on any other website in the past, including the website that provided information on protection against fire. This surpassed all of those previous campaigns. The campaign is letting people know what is available, particularly in country areas, such as that which the Chairman (Mr I.C. Blayney) represents, to get online to find out what services are available. It is not political in the sense that it also provides advice on services provided by the previous Labor state government. For example, the former government built the hospital at Port Hedland, and people will be able to get on a website for that region to see what is available there. It is an excellent campaign. I wish I could recoup the costs of all those other campaigns by the Labor Party when it was in government, because clearly they significantly surpassed the money spent on this. The member is trying to suggest that that money would be better spent in health. There are always lots of ways to spend money in health. Perhaps the member should have told the Labor Party's previous health minister to stop spending so much money on advertising campaigns and put that into health—from memory, I might have done that.

[12.30 pm]

Ms J.M. FREEMAN: What was the total cost of the Bigger Picture advertising campaign?

Dr K.D. HAMES: I said in the order of $1 million. I could get the exact figure. That campaign is for this year at a cost of $1 million. A similar amount is for next year.

Ms J.M. FREEMAN: So is it $2 million?

Dr K.D. HAMES: For the two years of the campaign, yes.

Ms J.M. FREEMAN: I refer to the revenue and savings measures outlined on page 6 of budget paper No 1. The savings measures include a freeze on government advertising and recruitment. Clearly, if the minister is doing it this year and next, the Department of Health is not contained within that freeze on government advertising. Does government policy not impact the Department of Health?

Dr K.D. HAMES: The freeze policy applies from the date it was announced until July, but that is on additional advertising that might be initiated. This program was initiated prior to that date, so it is not affected. It is the same for all advertising campaigns; those already initiated are not affected by that reduction. Since the previous Labor government was in power, we have significantly reduced advertising costs across the whole of state government, as we promised we would. These advertising funds are already in budgets. They are in budgets particularly related to the construction of hospitals and have a component for community information—that is, to provide advice about the new Fiona Stanley Hospital, the new hospitals at Midland, Busselton and Bunbury, and the proposed new Karratha hospital. All of those have a budget component for community consultation. Those funds are being used for this program.

Ms J.M. FREEMAN: The savings measures refer to a freeze on recruitment. Is that occurring within the Department of Health in terms of the freezing of equipment, particularly in areas where there is under-resourcing, such as child health nurses?

Dr K.D. HAMES: Mr Salvage has a component with that answer, if not all of it.

Mr R.W. Salvage: The announcement, when the freeze came down, was that it would not impact on front-line service delivery. The Minister for Health negotiated a range of exemptions to apply to the recruitment freeze that will apply over the period from 16 April, when the freeze came down, until the end of June, when the freeze is due to be lifted. For the member's benefit, I confirm that the exemption applies to recruitment activities in relation to the commissioning of Fiona Stanley Hospital; the reconfiguration of the South Metropolitan Health Service; other construction projects requiring staff to be appointed in that period; front-line clinical staff as determined by the director general and the minister; and administrative staff in patient-facing roles, such as ward clerks and the like. It also applies to medical staff who are subject to an annual recruitment process—which is occurring right now as part of the national recruitment of junior medical staff—and to staff funded through externally funded sources; for example, commonwealth programs. To the extent that those funds were known and accepted by the state before 16 April, the state has a commitment to employ the staff concerned. It is an internal process within WA Health whereby the director general and the minister sign off on those exemptions, but that exemption process is in place.

Ms J.M. FREEMAN: Does it include child health nurses?

Dr K.D. HAMES: I am pretty sure that it does not, but I will ask Mr Aylward to respond.

Ms J.M. FREEMAN: It does not?

Dr K.D. HAMES: That the freeze does not apply. I think we have sought an exemption.

Mr P. Aylward: Yes, that is correct.

Dr G.G. JACOBS: I refer the minister to the first dot point related to the Southern Inland Health Initiative on page 134. The dot point refers to attracting 27 new private sector general practitioners. How much did the government spend to attract those practitioners? How much money has been assigned to retain those practitioners? Of the 27 GPs, can the minister provide a breakdown of where they were recruited to? In relation to SIHI and its infrastructure, I often drive past the Lake Grace Hospital and see all these signs on the roadside about its substandard nature. The community is quite upset about it. Has any money been allocated to refurbish that small hospital?

Dr K.D. HAMES: The SIHI is a magnificent program that was put in place by the WA Country Health Service. It was funded to the tune of roughly half a billion dollars by the royalties for regions program. There are a number of components to that, including things such as telehealth, improving numbers of doctors, and upgrading hospitals in small and remote communities. To be honest, a large proportion of it should probably have been funded by the commonwealth, particularly in the doctor recruitment space, but it was not working. A huge amount of money has been spent by local government to recruit doctors, provide accommodation and guarantee income. Some towns were just not able to get doctors. The SIHI program has made huge steps forward in addressing that. As the member said, 27 additional doctors have been employed across the system as part of that program. They are not employed by the Department of Health, I might add. We have encouraged the private sector and helped it recruit doctors around hub towns such as Merredin. Doctors are receiving much greater amounts to look after our hospitals while they are doing it. Instead of a doctor having to leave a waiting room full of patients in their general practice to attend the hospital to stitch up someone who has cut themselves, and when they come back they are further behind, there are dedicated GPs in emergency departments, paid for by us at a rate that means they do not need to be in their own practice. Those doctors also perform outreach services linked by telehealth to the central hub, working in conjunction with nurse practitioners. That component of it is set to grow. It is a magnificent program.

Part of that component is to do two things with regard to the upgrade of hospitals. One is to do a demonstration group of Jurien Bay–equivalent centres—that is, centres that do not have inpatient beds for less than 24 hours. It has a range of doctors and allied health services. There are currently two towns doing that—Pingelly and Cunderdin. Three further towns are proposed. The rest is an upgrade of a huge range of health services, including Lake Grace. I have to admit I have been a little cranky that people at Lake Grace have put up all those signs. The proposed timing part of that package has always been made very clear to them along the way. I think they formed the view that if they put more pressure on government, they could get those funds faster than all the other communities that are waiting.

Dr G.G. JACOBS: It is not in my electorate; I drive by Lake Grace.

Dr K.D. HAMES: I know it well. My daughter's partner is from there; I hear all about it. They will get their facilities at the same time as all the other country towns requiring upgrades get their services. I will hand over to Mr Moffet to provide further details about where we are up to with that funding program. We are getting very close to having the capacity to do that work.

Mr J. Moffet: SIHI is a very extensive program that has six streams, as the minister indicated. The stream in relation to small hospital and nursing post refurbishment is relevant to Lake Grace. We are currently planning 26 different sites across the wheatbelt and the central great southern about what the detail will look like. Scope is being developed as we speak, in consultation with communities and staff. We are currently engaged with Lake Grace about a number of key issues, including its priorities.

[12.40 pm]

Dr K.D. HAMES: Another section of the budget papers the member might wish to refer to—not under health, but under royalties for regions—is page 211 of budget paper No 3, which lists the hospitals that are being upgraded and the funding for that, which amounts to $475 million over the next four years.

Dr G.G. JACOBS: I did not hear the minister tell us how much money has been allocated to attracting and retaining those 27 new private practitioners.

Dr K.D. HAMES: We do not have a breakdown of those costs at this stage. I have seen it somewhere; I bet it is in those papers.

Dr G.G. JACOBS: I will take it as supplementary, if the minister wishes.

Dr K.D. HAMES: I will provide as supplementary information the breakdown in costings for the funding stream for the additional recruitment of doctors and where those doctors were recruited to.

[*Supplementary Information No A21*.]

Mr R.H. COOK: I have a follow-up question. Could the minister outline what the $26 million that was taken out of the district medical workforce under the Southern Inland Health Initiative is in 2015–16?

Dr K.D. HAMES: I will go to Mr Moffet first and then Mr Salvage can add to it if he needs to.

Mr J. Moffet: The $26 million change essentially represents a change in conversion from recurrent to capital funding. As the SIHI program is rolled out it is being refined, because we learn more and we are providing enhanced capital to push into the district hospital upgrade programs, and particularly in consideration are both Manjimup and Northam.

Dr K.D. HAMES: That is the answer Mr Salvage would have given.

Mr R.H. COOK: It is the usual slippery story we are used to with royalties for regions.

My question relates to the total cost of services on page 27 of budget paper No 2. Can the minister please provide some information about the availability of placements for internships for medical students and graduate nursing places for nursing students? In particular, can the minister provide details of the expenditure and availability of places for these graduating students next year and beyond? Can the minister guarantee that all graduating medical students in Western Australia will receive an internship placement and all graduating nursing students will receive a graduate nursing position into the future?

Dr K.D. HAMES: I made a commitment to give all WA graduates a position, and that position continues; so, yes, we will give that guarantee.

Mr R.H. COOK: Is that for both medical students and nurse graduate students?

Dr K.D. HAMES: No, it is not for nurse graduates.

Mr R.H. COOK: But that was my question.

Dr K.D. HAMES: I am answering it in two components.

Mr R.H. COOK: The minister just said that he would give that guarantee, but he is not giving a guarantee.

Dr K.D. HAMES: I said that we would give that guarantee for doctors.

Mr R.H. COOK: For doctors, yes; they are different, are they not!

Dr K.D. HAMES: A commitment was never given for nurses under our government, or the member's own government. I will just point out to the member that while in government for seven years, he never made that commitment.

Mr R.H. COOK: I have never been in government, minister, so just answer on the government's performance, please.

Dr K.D. HAMES: I never made a commitment to employ all nurses; nor is it practically possible to do so, but we do recruit a very large number of nurses. By far the bulk of nurses who graduate in this state get positions either with the public sector or with the private sector. The vast majority who do not get an appointment as soon as they graduate get an appointment through their first year out. The opposition goes on about budget deficits. As fast as it says that we are spending too much money, it comes up with alternative ways for us to spend money. If the opposition is suggesting that the government commit to guaranteeing employing in a hospital every nurse who graduates in the state, we will very quickly blow not only the health budget, but also the state budget. It is not practical or possible to do so; however, we work very hard to ensure that we recruit those nurses and give them opportunities. It is a little dependent upon the rotation cycle through nursing because a lot of people go out of nursing to other jobs. Although, I have to say that since we have been in government, nowhere near as many nurses have left as did during the former government's time. Nevertheless, that rotation and the retirement of people who have been there for a very long time and who wish to retire provides a turnover of staff that allows us to recruit those additional nurses, but we are constrained by the total number of patients we have. Remember, we are funded on an activity basis. A certain activity has a certain number of staff costs associated with it, and if we are to have additional staff beyond our requirements, we will never get down to anywhere near the national efficient price. In fact, the member said previously that we were above the national efficient price and recently got slightly worse. That situation would be blown out of all proportion by the additional costs of each weighted activity unit if we recruited more nurses than were required to treat the number of patients we have. I am sure that there was more to that question. I think I need to give a more full answer.

Ms J.M. FREEMAN: I seek clarification of why it is so different for doctors than it is for nurses. How can the minister confirm positions for one group and not the other group, which are the same apart from the predominance of one gender in one group and not the other?

Dr K.D. HAMES: It is different for doctors because the number of doctors who graduate in this state is limited by the amount the commonwealth approves, which is currently in the order of 320 doctors, whereas the number of nurses who graduate is not as well controlled; it is a function of universities and colleges that advertise to the community their capacity to provide training, which is taken up by members of the community, with no control over the total number who do so. We have discussions with the universities and colleges about the number of nurses they are putting through and what the state's needs are. It is difficult, because a lot of those who go into nursing care do basic certificate levels that allow them only to get into aged care, which is not our responsibility at all; it is the responsibility of the commonwealth. Many of those who do nursing training feed through into different areas and, in fact, into areas that are not necessarily in health; for example, nurses who go and work in a pharmacy in the private sector. That is why there is such a big difference between the number of doctors and nurses. The number of doctors is controlled so we know how many we can accommodate in our hospitals and we commit to doing that and taking them all. If it ever reaches the stage, in a future government, when we do not have that capacity, we will not be in the position to make that commitment. The issue is about not only Western Australian graduates, but also graduates from other states and Western Australians who have graduated in other states and overseas; a commitment has been given to try to employ those graduates in the medical field as well. The acting director general will provide a further answer.

Professor B. Stokes: I want to raise the issue that Health Workforce Australia, under the chairmanship of Mr McGinty, looked at this aspect of nurses and doctors. It has been abolished now but, at the time, the HWA board stated in its minutes that it was very concerned about the number of nurses being trained, because there were no jobs for them. As the minister has said, we have had discussions in the past with the universities, and we will have it again, about universities having to be careful about the number of students they train, and the way they advertise for students, because the universities get funding for the number of students they have. It really is a major workforce issue.

Dr K.D. HAMES: There is another response that I have just been reminded that I missed. In order to graduate in medicine, doctors are required to do a year's internship, which is not the case with nurses.

Ms J.M. FREEMAN: But to practise as a nurse, they have to.

Dr K.D. HAMES: No; when they graduate as a nurse, they are a nurse. When doctors graduate, they are not registered until they have done a year's internship. A registered nurse is registered from the day that they graduate.

The CHAIRMAN: Am I given to understand that we are finishing this division at one o'clock?

Dr K.D. HAMES: Yes, we have an agreement with the opposition and that is what we will do.

[12.50 pm]

Ms J.M. FREEMAN: I refer to the $54 million reduction in total funding to the equipment replacement program over the life of the estimates period, under "Works in Progress" on page 145 of budget paper No 2. How has this been achieved? Is some of the old equipment from hospitals that are closing down—for example, Kaleeya Hospital and Swan District Hospital—being moved to the new Fiona Stanley Hospital and Midland Public Hospital?

Dr K.D. HAMES: This government started the massive amount of funding in the equipment replacement program. Members will remember when we were in opposition the huge criticism from the Australian Medical Association about the inadequate funding for equipment replacement and that WA was miles behind the eight ball in the funding required. In fact, the Monash review, conducted in, I think, 2005, showed a significant shortfall and suggested that in the order of $40 million a year was required for equipment replacement. This government initiated and put in place that program. I hope that the executive director can advise me on the variations in expenditure this year over other years.

Mr R.W. Salvage: The value for the program this year is $45 million, which is a significant increase over current year value. Part of the explanation for the decline in the future years is recognition of some of that expenditure as expensed capital. In the past we have allocated funding through the program as capital expenditure, and it has popped up in the recurrent side of the budget.

Ms J.M. FREEMAN: Is it an accounting thing?

Mr R.W. Salvage: It is an accounting thing. In addition to the numbers in the "Asset Investment Program" table, there is a value of about $4 million, which is in the recurrent side of the budget, that is the expense capital component of that, so the reduction is not quite as sharp as the member sees through the AIP.

Ms A.R. MITCHELL: Earlier today the minister referred to the home-based hospital programs referred to on page 139. Could the minister provide more specific information about them and also their benefits to the department?

Dr K.D. HAMES: There are a few components of the home-based hospital programs. One is Hospital in the Home, which is provided by the hospital. That program has been in existence for a number of years. I am pretty sure it was there during the Labor government's time—and it is not going down at all. It allowed specialists who wished to provide continued services out of the hospital in someone's home to do so. A good example of that might be a patient with severe burns, for example, for whom Fiona Wood and her team would continue to provide care, dressings and support at home. There is also the Mental Health in the Home program that provides for patients who have acute mental health problems who need home care. Then there is the program we funded coming into government that came out of my experience as a general practitioner, linked with Silver Chain and its palliative care program, in which we could provide end-stage care to patients in their own homes with the support of up to 24-hour nursing care and their doctors giving support. We decided in opposition that we wanted to expand that, and in our budget we provided at the time $25 million or $26 million a year to expand that program. It has worked enormously well. As I said before, about 600 patients on any one day are being managed and about 160 to 170 of them would otherwise be in a hospital chewing up a hospital bed.

As part of that program, we put coordinators in the tertiary hospitals so that when a patient comes into an emergency department, if the hospital decides that although it could probably admit them, it instead arranges for Silver Chain care at home, either with their doctors or the local GP backing them up, that patient can be safely looked after at home. That has been enormously successful. As I said earlier, my view is that we need to expand that significantly. Currently, about 30 per cent of patients in a hospital would not necessarily need to be there if they had adequate care and support at home.

I might add that the service we provide currently deals with not only those patients and palliative care patients in their homes, but also nursing home patients. When I was a GP, I would often see nursing home patients who did not have significant health problems, but the nursing homes did not have the staff, doctors or capacity to look after them in the nursing home. Those patients would be sent to hospital and the staff at the hospital would say, "For goodness sake, they are not that unwell!" That care is now provided at home as well. It is a fantastic program and we need to expand it.

Mr R.H. COOK: I refer to the information the minister provided previously on public hospital bed configuration and, in particular, the clinical services framework metropolitan bed capacity table. This would come under the heading "Public Hospital Admitted Patients" on page 138 of budget paper No 2. Would the minister provide updated information on the metropolitan hospital bed configuration and capacity for the years 2014–15, 2020–21 and 2024–25?

Dr K.D. HAMES: We will provide that as supplementary information, but I have two minutes to comment. That information is about to all come out. The clinical services framework is nearly ready for release and it details the hospitals and types of services provided. I am not sure—I have seen only a draft of it—whether it covers actual bed numbers in hospitals. Remember that bed numbers are a movable feast. Jim McGinty and I had long conversations trying to understand what bed numbers meant, because they seem to vary week by week and hospital by hospital. We will provide by way of supplementary information the current bed numbers as they are configured in metropolitan hospitals. Will that do?

Mr R.H. COOK: Previously, the tables had only metropolitan beds, so yes. In the past, it has been called the "CSF metropolitan bed capacity table".

Dr K.D. HAMES: We will provide that.

[*Supplementary Information No A22.*]

Dr G.G. JACOBS: I refer to page 134 and telehealth. Minister, it is a great facility and provides a good integrated statewide telehealth service to patients in regional and remote regions. How has the minister overcome the challenges when even though we have technology, the availability of specialists at the other end is a really significant issue? How has that been addressed in emergency scenarios and also in general practice scenarios?

Dr K.D. HAMES: I probably have a longer answer than we have time for, because a lot of work is being done in this area. We do, of course, have telehealth to not only the tertiary hospitals in the city, but also the smaller to bigger towns in the regions, including central hospitals in both Kalgoorlie and, of course, Broome. An overall strategy on how to expand the telehealth service is needed. There is a lot of money in the budget to expand it, particularly through the Southern Inland Health Initiative and the northern health program, and part of that is to ensure that there is coordination at both of ends of the spectrum—in the hospitals in the city and for those who want to access that service. We are looking at the Ontario model, a fantastic service being provided in Ontario, Canada, and a Northern Territory model, which is working well. In the very near future, we will be considering which model to adopt, how that is done and how to significantly improve services in the city. There has been a significant increase in services being provided because we have extra specialists available for the telehealth network. That is all I have time for before we have a break.

The appropriation was recommended.

Meeting suspended from 1.00 to 2.00 pm