Division 70: Health, $2 437 289 000 -

Mr Dean, Chairman.

Mr Kucera, Minister for Health.

Mr M.M. Daube, Director General.

Dr B.L. Lloyd, Deputy Director General (Health Care), Chief Medical Officer.

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

Mrs K.J. Cook, Acting General Manager, Funding Strategy and Management.

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

Mr A. Kirkwood, Acting General Manager, Finance.

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

Dr P. Della, Principal Nursing Adviser.

Ms S. McKechnie, General Manager, Purchasing Division.

Dr A.R. Groves, Chief Psychiatrist and Acting General Manager, Mental Health Division.

Mr C.P. Xanthis, Acting General Manager, Office of Aboriginal Health.

Mr P. Stephenson, General Manager, Public Health.

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

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

Mr A.R. Buckley, Acting General Manager, Asset Management.

Mr BOARD: I refer the minister to the overall appropriations on page 1203 of the *Budget Statements*. The Government's media releases have indicated that there has been a 4.3 per cent increase in the health budget. Clearly, that 4.3 per cent increase is the appropriation for the purchase of outputs. It is not a 4.3 per cent increase in the grand total of what it costs to run health. Compared with 2001-02, there has been an increase of $48 million in the estimated actual figure for 2002-03. That is only a two per cent increase. Why are the figures set out in this way and not in the total cost of running the health portfolio? Also, the Treasurer indicated in his budget speech that there would be a three per cent increase in the consumer price index, and the media releases have indicated that it would be two per cent, yet the Government has ended up with a 2.3 per cent CPI. Will the minister explain the variation in the CPI figure for this year?

Mr KUCERA: Is the member for Murdoch saying that the Treasurer referred to a three per cent CPI for health, or a three per cent CPI overall?

Mr BOARD: He has indicated a three per cent CPI overall.

Mr KUCERA: There may be variations between portfolios. Like the member for Murdoch, I was confused when I first looked at the column on page 1203, and I mentioned this in the Legislative Assembly when the member for Murdoch asked me the same question. This year's moneys are sourced from three areas. The first is the recurrent budget, which is $2 381.374 million. The second is the capital contribution - the second contribution - which can be found on page 1237 of the *Budget Statements*. The table on that page includes a holding account of $67 million. I will refer the member's question to Mr Chuk, because this is a complicated accrual budget.

[9.10 am]

Mr CHUK: The difference is that we are talking about costs versus funding. I think the question made reference to cost increases. These numbers provide for a 4.3 per cent cost increase for the purchase of outputs and administered items.

Mr BOARD: Just to clarify that, I am looking at the total cost of running the health portfolio. If we compare the cost for this year with what is projected for next year, it is a $48 million increase, which is a two per cent increase, not a 4.3 per cent increase. Would it not be appropriate to advertise the real cost of running the health portfolio rather than just the cost of purchasing outputs?

Mr CHUK: Those comments are absolutely correct. The total cost is increasing by two per cent. The presentation that leads to the 4.3 per cent increase has been undertaken to allow comparability with the reporting in previous years. The change in this year's budget is that the former capital appropriation has effectively been split into two streams. About $67 million comes through one stream, and $38 million comes through the stream that is shown on the last line on page 1237 and is headed capital contribution. In looking at the cost of funding

outputs and administered items, the increase as presented by the Health Department is best regarded as 4.3 per cent.

Mrs COOK: The change in the presentation this year relates to the introduction of accrual accounting. Therefore, for the first time, this year we have a draw down from the holding account. That is an account to which non-cash items are credited over the year. Non-cash items include depreciation of assets and accrued employee entitlements. This year the total expenditure on capital works has been derived from a number of areas, and that relates to the depreciation of those assets in previous years. Therefore, we cannot compare this year with last year.

Mrs MARTIN: Good morning, everyone. I have noticed the badges that some of the advisers are wearing. As the only indigenous member of this Parliament at the moment, it is brilliant to see people wearing those badges. This is Reconciliation Week, which is a very important week for us, and members may have noticed the flag that is flying at the front of the building. I refer to page 1203. Can the minister explain, because health is such a complex portfolio, how the health budget is constructed?

Mr KUCERA: The health budget is complicated. We draw funding from a number of sources. The $2.4 billion that is listed for the state health budget is one portion of the budget. Another portion comes from a number of sources, mainly federal, and that takes the budget up to $2.7 billion. The budget is formulated in terms of the health outputs that we will purchase. It is also formulated in terms of the capital works that we will build or that we need to maintain, such as new hospitals. For instance, in the member's electorate, a new renal dialysis unit is to be constructed in Broome, and hopefully that will allow many of the member's people to go from the city back up to where they live.

Mrs MARTIN: I have scrutinised the budget but I have not been able to find that unit under hospitals.

Mr KUCERA: The member may find that it is encapsulated in something called hospital equipment. It is a complex budget, as the member for Murdoch pointed out, and is not easy to understand. I will ask Mr Chuk to talk about the design and construct of the budget, and Mr Buckley can then deal with the question about the Kimberley dialysis unit. Because the health budget is so huge, the budget that is presented in the budget papers is the global budget; in other words, the overall amount of money that the bank is giving us. That is then divided up by means of the allocations that are made as we move into the new financial year. It a bit like a household budget in which money is put into different envelopes depending on whether it is for food, petrol or whatever. The individual health services such as the Kimberley Health Service then get their allocations in accordance with the needs in their areas.

Mr CHUK: The question is best responded to in two parts: the process the department goes through in preparing the budget, and the construct of the budget and the way it is presented in the budget papers. The approach to this year's budget for the department is different from the approach in previous years. The reorganisation of management structures within the department that flowed from the Health Administrative Review Committee and that has created the new management team has led to an approach that has allowed a lot more consultation and engagement across the health system. In previous years, the system was divided. We had the Metropolitan Health Service Board, the Health Department and the various health services, and they did not interact particularly well in terms of budgeting. In developing the budget this year, for the first time in perhaps a decade - certainly a long time - we have brought together as one the heads of the health services, the chief executives and finance directors from the metropolitan areas, representation from country area, and the staff who work in the Royal Street offices who have a policy and governance role in terms of finance. The new management structures have allowed engagement across the system to ensure good input into the budget process and have enabled us to produce a product that is more viable and sustainable than in previous years.

Our engagement with the new budget committee - the Expenditure Review Committee - has also been prolonged and fairly active. The ERC, and particularly the Treasurer, spent some time working with the department, through the minister, to ensure that it had a good understanding and was well informed about the budget decisions that it was making.

[9.20 am]

The first thing the committee focused on was our historical costs and expenditure; that is, the trend over recent years. Rather than tackling the budget consideration through a more theoretical, technical purchasing construct, we looked carefully at recent trends. Recent trends in this State have resulted in a growth in expenditure of about six per cent a year. That is similar to the trends in health services expenditure in other jurisdictions. Total health expenditure for the Commonwealth has grown around seven per cent over the past couple of years. We analysed that information and presented it to the ERC so that it would have a good understanding of the general environment in which this and other health services nationally work. The tension that exists within government -

the huge demands in the funding for health versus the capacity of government to generate revenue through taxes and to fund other government departments - was well understood by the ERC.

Beyond that analysis and comparisons of the trends, we looked, as best we could in the time frame, at our cost drivers. We identified that the big driver is the cost of meeting the increases in the enterprise agreements and awards. The member will be well aware that the department has recently renegotiated all its major enterprise agreements. Only the agreement for enrolled nurses remains outstanding. We have worked through the process of settling the Hospital Salaried Officers Association agreement, the nurses agreement and the medical practitioners agreement, among others. That renegotiation of the enterprise agreements has lead to significant additional costs. However, we have with some surety locked into the next two out years a framework that is consistent with the government wages policy of an increase of around three per cent a year. I think we have a good fix on our wages and salaries costs. That is a huge driver in our system. The additional burden the EBA increases will impose on the health system over the coming 12 months is in the order of $80 million to $100 million. It is a large amount of money. We also identified a number of other streams that impose significant burdens on the system, such as the cost of pharmaceuticals and maintenance and equipment. We would like to catch up on the backlog of maintenance work and equipment. They are the main drivers. We spent some time looking at those, and informed the ERC of that position. The Government considered health funding in the light of its capacity to fund. The ERC made us well aware of the other pressures in government and its capacity to raise revenues. The Government's capacity to raise revenue in the coming year is running at less than two per cent in an environment in which health funding is well exceeding that figure.

That is the process, methodology, engagement and level of detail that took place not only within the department but also between the department, through the minister and the ERC, that led to this budget decision. I believe the budget decision was made on a more informed basis than I have observed to be the case in previous years, and it has a greater chance of being sustainable in the future. I have described the process, and a lot of technicality surrounds the presentation in the budget papers.

Mr KUCERA: I will ask Mr Buckley to explain something that is vitally important; the Kimberley dialysis unit.

Mr BUCKLEY: I refer to page 1236, which lists the capital works. The budget contains a number of funding sources for the Kimberley. The renal dialysis project is included under works in progress in the item "north west plan development - various", which is a $1 million allocation. As the minister said, there are a number of funding sources for projects. The project will also receive a $500 000 commonwealth capital contribution that does not appear on that statement. The total Broome Regional Aboriginal Medical Service project cost is actually $1.568 million. In round terms, $1 million will come from that item in the capital works program.

Mr WATSON: Is the Albany dialysis unit also in the budget?

Mr KUCERA: Again, that is encapsulated in the various equipment budgets. Rather than give one budget for, say, the Kimberley, the money is spread among various items for the development of hospital equipment or buildings. The capital works budget is $109 million. This year, a very large majority of that budget is for the country. The country does well this year, as it did last year.

Mr BUCKLEY: The Broome Regional Aboriginal Medical Service project will be completed in late August. Two chairs are already running at the hospital, as has been mentioned. They started a couple of weeks ago on 17 May. The BRAMS facility will be completed in late August and will have eight chairs.

Mr KUCERA: I understand that will allow us to treat up to 40 patients a week. It will remove the need for those people to leave the Broome environs and live in hospital accommodation in Perth. It is a huge boon for the member's area.

Mr BRADSHAW: I refer to the purchase of outputs on page 1203. According to the Government's estimates, the major cost drivers in health are salaries, which will rise by 4.6 per cent; pharmaceuticals, which will rise by 12.4 per cent; medical and surgical, which will rise by 5.3 per cent; repair and maintenance, which will rise by 5.1 per cent; demand for health services, which will rise by seven per cent; and the ageing population. How, then, does the Government justify a two per cent real increase, and how will it meet these costs?

Mr KUCERA: We will meet the costs in two ways, the first of which is through the real increases in this year's budget. Compared with the original budget for last year, this budget contains an increase of $184.1 million, or 8.3 per cent. In addition, a very broad corporate reform program has been put in place. That is already showing savings in the health system. We believe that, coupled together, those two areas will equate to the needs of the health budget for this year. One of the difficulties that we had last year - that I had in particular - related to the comments that we had not fixed it yet. The member opposite often talked about "the fix". The reality is that one must have a baseline before one can start fixing anything. Last year, I was faced with very little in the way of a

baseline. I compliment the team for the fact that we now have, as Mr Chuk said, a fairly firm baseline from which to work. Those clarities will come. I will ask Mr Chuk to further answer the question.

Mr CHUK: As the minister mentioned, the increase in this year's budget is a significant increase in the true cost of outputs, including administered items, and is in the order of eight per cent. It is appropriate to consider the 4.3 per cent increase for this financial year in that context.

Over the current year plus the new budget year the average increase has been in excess of six per cent. The funding that has gone into health this year is not a one-off; it has been built into the base. It is appropriate to think about the full term. Over the two years there will be a 6.3 per cent increase, which is in line with national trends for a sustainable position for health funding.

[9.30 am]

Mr BRADSHAW: What corporate savings are expected, and how will they happen? How will this stop ambulance bypass?

Mr KUCERA: I will deal first with the issue of bypass, which is not necessarily a budget or funding issue. I will be happy to talk about it at greater length later, because I would like Dr Lloyd to address that question. Bypass is a very complex issue, and is not simply a matter of funding. Mr Chuk will talk about the corporate reforms, and then Mr Daube has something to say on the subject, since that is the nature of his role over the next few years.

Mr CHUK: The increase is eight per cent in the current year, and smaller increases in subsequent years. Holding to that budget will depend on the corporate reform process - saving money on corporate functions. Processes are already in place to assist this. Expressions of interest have recently been requested across all corporate functions for voluntary severance. Certain administrative functions, where there is the capacity to reduce staff, are being targeted. The severance program is designed to be implemented on or about 30 June. Many staff will leave before 30 June, some in July and a few beyond that month. It is intended to have a full-year impact for the new budget year. It is anticipated that the severance program will free up between $7 million and $8 million in the coming financial year. The cost of the redundancies has been funded by the Government in the current year.

Beyond the severance program, efficiencies across the system are being sought. These efficiencies are driven by the changed management arrangements in the health system. The unified system and large metropolitan areas having jurisdiction over multiple sites will result in more efficient delivery of corporate functions such as human resources, finance and purchasing. The administrative costs can thus be lowered while delivering the same quality of service in those areas. Supply functions will also be optimised. Currently, a large amount of money is expended on consumables and other tendered items, perhaps as much as $500 million a year. Over the past six years there have been significant reforms to purchasing arrangements within the health system. Those arrangements have been constrained into two main streams, and that process is now being finalised, so that supply functions will be brought into a single stream. Last Saturday a position was advertised for a new general manager to have oversight of supply functions across the whole health system. That person would bring together a supply group, which would have jurisdiction over all warehouses to standardise and optimise the use of stock and, through economies of scale, drive home better contracts. Savings on that front will be in the order of $5 million, which is about one per cent and is a manageable target.

Mr DAUBE: As Mr Chuk has indicated, the unified system will enable us to drive reforms and to be more efficient in the way we work. In our reforms, we will be looking at working within areas as well as system-wide. We will be rationalising offices. The new management structure is built around one state health management team, rather than having the different sidelines coming in, so there is the opportunity to exert a much greater discipline across the system. It is not the first time in 10 years that that has happened - this is the only issue on which I will disagree with my colleagues. This is the first time since the days of the colonial surgeon that the whole health system has reported in effectively through the one corporate group. Our crucial task is to come in on budget. We will deliver on this year's budget, and we believe that the funding we have will enable us to do so in the coming year, with no concerns about possible excesses. From my perspective, working as a single unified group will enable us to drive those reforms, and our task is to ensure that the discipline is there across the system. Any savings that can be made in corporate or other ways will enable the maximum possible expenditure on services to the community.

Mr KUCERA: We will not, however, be reducing the community or the family of the hospitals. That cannot be done. In many instances, as I have walked around the hospitals in the past, I have noticed that the fabric of those hospitals has been ripped out. Last Saturday morning at the Shenton Park annex, the main complaint was about

food. I am not knocking the contractors, but in some areas of our hospitals there is no longer that feeling of family and community. As far as I am concerned, that will not be affected by any changes or savings that can be made. If anything, savings will be used to re-create that kind of community sense within our hospitals. That is one of the things I found lacking last year, and it needs desperately to be restored.

Dr WOOLLARD: I refer to page 1235, under the heading "Capital Works Program". I note that the estimated expenditure for the coming year is $109 million, and that only five new capital works, with a combined cash flow of $5 million, are proposed. Why is the figure only $5.1 million? I notice that no money has been set aside for the south metropolitan public health unit. Has money been set aside elsewhere in the budget for the south metropolitan public health unit? If so, how much has been set aside, and if not, why not?

Mr KUCERA: I am not aware of that specific development, but $109 million has been set aside for capital works. That must be used according to our priorities. There are three key priorities in health, which I suspect will remain during the term of the Government. The first is the recruitment of nurses. The second is the replacement and renewal of emergency departments. Once people get into the health system, it is by and large a good system in which people are well cared for. Getting into the system through the emergency departments is the problem. The third priority - which was mentioned by the member for Murray-Wellington - is ambulance bypass. Development programs have been aimed specifically at lifting the priority of those three areas. Training facilities and accommodation for nurses, particularly in country areas, are a priority. In some places, particularly in the goldfields, we have forgone the redevelopment of hospital facilities to make sure that accommodation and support for nurses is provided. A range of priorities have been linked to our capital works program this year.

[9.40 am]

Mr BUCKLEY: As indicated on the previous page, the capital works program has allocated $4 million for infrastructure and equipment planning, which allows projects such as that to which the member for Alfred Cove referred to be developed to the stage of a business case and site selection. Further allocations can be made at the midyear review or in a subsequent capital works program. A $5 million allocation for statewide expansion of community health facilities is shown on page 1236, of which $1 million remains unallocated. That is another potential source of funding.

Mr KUCERA: The Department of Health owns many premises; in fact, we are trying to quit assets. The last thing we need is to build somewhere else. Many hospitals in this State run at low occupancy and many health buildings are only partially utilised. The last thing we need to do is to build a new place, or even move into an old place.

Mr BURNS: The public health unit was a new initiative last year established by the Government for the south metropolitan area. It does not make a large demand on capital; it uses recurrent funding. Although our budgets have not been finalised this year, it has been clearly indicated that the public health unit will be fully funded. If any capital is required, we will approach the Department of Health, as explained by Mr Buckley.

Mr BOARD: I understand the rationale for moving from capital injection to the delivery of some services. However, a very meagre injection is allocated for new works. The amount of capital allocated to a portfolio as large as health is a very small percentage compared with the overall state budget for capital works of $3 billion. Although the minister's comments about buildings around the State are relevant, the upgrading of facilities, particularly in the metropolitan area, is under constant demand. On top of that, the hospital equipment and maintenance estimate has decreased to $5 million, which is about one-fifth of what was spent last year. Funding for maintenance and equipment is being ripped out while nothing is projected for new infrastructure. As a result of such a meagre injection into capital works, there should be a greater increase in funding for the delivery of services.

Mr KUCERA: It is all a matter of balance. This State has 651 service facilities, every one of which must be maintained and serviced. In addition, as I said, the Government's key priority in the next four years will be to upgrade our emergency departments. A very large amount of the money allocated is being specifically targeted at the redevelopment of our emergency departments. A new emergency department is being built at the Rockingham-Kwinana Health Service. Many of those issues are addressed within the existing budget and the existing process. We have made a clear commitment to finish existing works in progress.

Mr CHUK: There is a presentation issue in the budget papers under "New works" and "Works in progress". The new works effectively relate to new decisions as opposed to new works. The allocation of $35 million for the Geraldton Regional Hospital redevelopment is listed under work in progress. However, the project plan has been established and the bulk of the money will be spent over the next two or three years. Most people in Geraldton see the Geraldton redevelopment as new works.

Mr KUCERA: And as a new hospital.

Mr BUCKLEY: I refer to the question regarding the estimated allocation of $5 million for hospital equipment and maintenance. The allocation of $30 million against the twenty-sixth item listed in the capital works schedule was increased from $20 million in the last budget to $30 million in the 2002-03 budget. In relation to Mr Chuk's point, we spent nearly $24 million this financial year, including $19 million for the four major metropolitan health authorities on equipment such as CT scanners. We have brought that project forward and only $5 million remains because a huge amount of the allocation was expended in 2001-02.

Mr KUCERA: Included in that expenditure was the replacement of the magnetic resonance imaging machines at Sir Charles Gairdner and Royal Perth Hospitals, which were needed desperately. It also includes expenditure on the very good deal we got on the positron emission tomography scanner. The federal Government did the right thing by us concerning the money for that machine. I am happy to say I understand it will be fully licensed and operational as soon as we can install it.

I refer to my comment that the allocation of moneys is a matter of balance. The dollars are finite and we must set priorities, which, as I said, are our emergency departments and services that allow people to get into hospital.

Dr WOOLLARD: An approach was made by the south metropolitan public health unit staff to house the public health unit at Duncraig House because of its suitability in providing office space, its location and the readily available opportunity to link with the Department of Health and other universities. I believe the unit was told to back off or get lost. Will the minister explain why?

Mr KUCERA: As Mr Burns said, it is not considered that that program requires capital. The main issue is to get people on the ground supplying services. We do not consider that Duncraig House has a use for the Department of Health. As I said earlier in the year, the issues of either retaining or disposing of Duncraig House now fall within Hon Tom Stephens' portfolio as Minister for Housing and Works. We do not see a usage for Duncraig House within this portfolio.

Mr WATSON: I refer to rural surgical weighted separations on page 1219. There has been an increase in the number of surgical services offered to people in the country. Will the minister comment on this? Some rather wild claims were made by the National Party last year that these services will be slashed as a result of budget cuts, which is another negative comment about the country by the National Party.

[9.50 am]

Mr KUCERA: That is a very good point. I thank the member for Albany for the enormous effort he has made to counter some of the misinformation spread in the Albany area. We said last year that we would increase rural budgets, and we have done just that. Rural budgets received a major increase last year. After the boost in funding mid year, I think the increase totalled at least eight per cent, if not more.

The other issue was that despite all the doom and gloom, the number of surgical procedures performed in the country this year will be almost 19 000, compared with about 18 400 last year. Despite all the predictions of doom and gloom and the so-called cuts to services, that has not occurred. All we have seen is the driving of a wedge between the country and the city in that regard. The other good news story for the bush is that the State Government will spend $109 million this year on 52 capital works programs. The bulk of those works will target the regions. I will list those works because it is important that I get them on the record. The State Government will spend $35 million on a new hospital in Geraldton - Mr Buckley made a good point about that - and carry out a $6 million redevelopment of Kalgoorlie Regional Hospital and a $3.2 million redevelopment of Moora District Hospital. I went to see the Moora hospital during the year. It is an absolute disgrace that the hospital was allowed to get to its present state. One end of the hospital has fallen away. The Government will also spend $4.5 million to construct a new hospital in Narrogin, $34.1 million on health service developments in the Kimberley and $2 million to replace the Warburton clinic. Regional services received on average an 11 per cent increase in the 2001-02 budget. Despite all the doom and gloom and dire predictions, I take my hat off to the country managers. In most instances they have come in on budget without any cut to services, which were predicted. The one thing that these statistics show is that all the gloomy predictions about service cuts were simply wrong. Instead of being cut, as was predicted, hospital-based services like surgery have increased. That is one of the most telling statistics in these budget papers in terms of the country health services.

Mr WATSON: May I ask a follow-up question?

Mr TRENORDEN: I was not allowed, so why should the member for Albany?

Mr WATSON: If the member for Avon went out to country areas instead of sitting in the city issuing press releases, more would be done.

There is currently a huge problem with retaining surgeons in Albany. One of our best surgeons is going to Perth. How difficult is it to keep surgeons in country areas, and what can we do to keep them in country areas?

Mr KUCERA: This is a problem worldwide, not just in Albany. I appreciate the difficulties that Albany is facing. A number of surgeons in that area are reaching retirement age or feel that their lifestyles are such that they do not want to work shiftwork or be on call. The issue of visiting medical officers in country areas is a problem right across Australia. I have raised those same issues in discussions with the member for Ballajura. I will refer that question to Dr Brian Lloyd, who, since being appointed Deputy Director General, has travelled to most country centres which have faced difficulties with staff.

Dr LLOYD: There is no doubt that staffing problems in rural areas, particularly for specialists, is an Australia-wide problem. It is also a problem in Canada and other places. It is not a simple problem; it relates to social and professional issues, such as being able to provide a good range of work that is professionally satisfying, or to questions of children's education and so on. The department is looking at each of those problems and is working with the Rural Doctors Association of Western Australia, the Australian Medical Association and other groups to see whether we can make the work more professionally interesting. Consideration is also being given to how to appropriately reward these people. In meetings to date, we have looked at ways that a more unified system could provide better backup from the city to surgeons who choose to work in country areas, so that should a surgeon wish some professional development, he could come to the city without his practice being affected, because support would be provided from a city area. The department will continue to work on these issues over the coming year, because it is a serious problem. I held discussions yesterday with the new president of the Rural Doctors Association to work on some of these issues. It will be a high priority of the department.

Mr WATSON: Have you looked at linking a Perth hospital with a regional centre, so that doctors could rotate?

Dr LLOYD: That was flagged in the Health Administrative Review Committee report. As the rural reviews are completed, we hope to do that when the areas are well set. As the member will be well aware, many rural areas already have linkages with city hospitals, so the aim would be not to disrupt those long established and functional linkages but to help where linkages are not in place. For example, if the doctor in Bruce Rock had always received support from Royal Perth Hospital on any problem, the department would not interfere with that. If a new doctor were to come to Bruce Rock tonight and have troubles at 10 o'clock, he would know that he had a home base in the city that would assume responsibility for taking his calls and working with him through the night to deal with the problem. The idea is to help areas that are not being serviced or, for example, where a service is needed but cannot be managed. It will then become incumbent upon the region to try to help with that problem.

Mr DAUBE: I will add one further point. A view was strongly expressed during the HARC consultations that people in the country want to be run from the country. So although there will be an association, it will not be a matter of a regional service being run from Royal Perth or Sir Charles Gairdner Hospitals.

Mr BOARD: Getting doctors, clinicians and nurses out to rural areas is one of the biggest issues facing the State Government. The minister might be aware that the manifesto of the Wonca world conference on rural health in Melbourne indicated that developed nations should no longer try to poach doctors from other countries for their remote areas. As the minister knows, this State has been reasonably successful at that, particularly with South African doctors. What is the minister's attitude on the changing face of that program? Are we lobbying to increase the number of trainees at the University of Western Australia, and will the minister support the postgraduate program that has been proposed by the University of Notre Dame?

Mr KUCERA: That is an excellent question. I can answer that in a number of ways. Firstly, the Government supports a graduate program, whether it sits with the University of Notre Dame, the University of Western Australia or a combination of all Western Australian universities. I have had discussions with the heads of all the universities. I know that the director general is working with Dr Lloyd to establish a group, to make sure that we can pressure and lobby the federal Government on that issue. An Australia-wide work force program is under way at the moment. Indeed, the whole issue of extra doctors and surgeons is paramount on the list of that group, together with the recruitment of nurses. The simple answer to the member's question is that I will support absolutely a further graduate program in this State if we can get federal government support for higher education contribution scheme places. I will defer that issue to Mr Daube.

Secondly, the way to attract surgeons to the country is to give them good facilities. That is why the bulk of this year's capital works development will be in the country. It is a good news story for the country. If those doctors are given good facilities and accommodation, they will go to the country. It is like *Field of Dreams*: if we build it, they will come.

[10.00 am]

Mr BOARD: We also have to keep them there.

Mr KUCERA: Exactly. However, we need to give them good hospitals and, as Dr Lloyd said, good linkages with the major tertiary hospitals. For instance, I understand there is an orthopaedic training program in Bunbury. We are starting to train people in the country, which is an incentive to keep them there. I met with the member for Kimberley last year at Fitzroy Crossing. There was a young fellow from Sydney who was working for the medical service in the area. I asked the head of the medical service how she was going to keep him there and she said, "We are going to get him married."

Mr BOARD: The reason I mentioned the University of Notre Dame Australia program is that, if my information is correct, it is the only university in Australia that does not require fully-funded HECS places from the Australian Government. As a result, the university can get on with the program. It would not want to do it without the Australian Government's support, but it does not depend on fully-funded HECS places. It is an issue that we should push in this State.

Mr KUCERA: It would be impossible without the support of the federal Government. It is not necessarily the capacity of the university to do on-campus work that is the issue. We are talking about the training provided in public hospitals, which provide most of the training in medicine generally. Suggestions have been made that we provide training in private hospitals. I would be very concerned about even considering that. It is hard enough at the moment to have traineeships and places in our public hospitals and to ensure that the existing facilities are well supported. The issue is not just about the university; it is about a graduate program that is supported across the entire spectrum.

Mr BOARD: It is about training general practitioners. It is about not only the training rate of GPs but also the retention rate. There is the issue of females and people who drop out for lifestyle reasons. It is a matter of attracting different types of people into the profession. That is worth considering in the light of the issues facing our State.

The CHAIRMAN: I have given members a fair degree of latitude with their questions. The committee is addressing the budget, so I ask members to focus their questions on the budget. I am sure they will get the opportunity to make their points.

Mr TRENORDEN: I also commend the minister for that; it is very important. I am concerned about two issues to do with country doctors. Not all doctors have easy access to the Internet. The process that the minister has referred to is excellent. We must ensure that doctors have the capacity to access the Internet, and I am sure the minister understands that. Is he asking other agencies to spend money or is he spending any of his department's money to ensure access is possible? The minister also said that housing and families were important. Country doctors keep telling me that backup is essential and that they need to feel confident about new procedures and new information. About 18 months ago, there was strong evidence to suggest that overseas doctors who were not recognised in the Australian system were excluded from receiving that information.

Mr KUCERA: That is an important issue. The member for Avon has raised a good point. When doctors whose wives or partners are lawyers come to Western Australia, it is difficult to get them to go to some of the smaller country towns.

Mr DAUBE: These are important issues for both our short and long-term future. We have been having some good discussions with the University of Notre Dame and the University of Western Australia. Although there are some slightly different agendas, I am confident that we can work through the issue. I will ask Dr Lloyd to address some of the issues for country doctors.

Dr LLOYD: Both the University of Western Australia and the University of Notre Dame have an interest in developing a graduate school. The decision about such a school obviously rests with the Australian Medical Council and the Commonwealth Government. A quirk of the legislation allows Notre Dame to be potentially the only medical school in Australia that could charge private fee-paying students. It is an oddity of the legislation, whether intended or unintended. HECS places cannot be applied to a graduate school for undergraduate courses. At this point, the Commonwealth Government does not intend to extend HECS places, so we are keen to get a graduate school.

With regard to our budget, it is very important that we are able to accommodate graduates of the school in the early years, because the Australian Medical Council needs to be confident that if it produces more medical students, we will employ them in the government hospitals for their training years. We have been working with the universities to provide that support in their application to the Australian Medical Council so that it is clear that the government health system will pick up those graduates. We are giving whatever support we can to the new developments in the rural clinical school that the University of Western Australia is running for its undergraduates. We are keen to make available building sites on land contiguous to the hospitals or to use

hospital buildings so that those students will go to the country, work in our hospitals in the country and, hopefully, develop a liking to stay in the country. We will continue to encourage that line as well.

As a system, we have not been actively campaigning in South Africa, but there is no doubt that South African doctors are applying to come to Western Australia.

Mr TRENORDEN: And are here already.

Mr KUCERA: And are very good doctors.

Dr LLOYD: Indeed, we are finding that they are good doctors. They have various reasons for leaving South Africa. We are not actively encouraging them to come by advertising, but if they apply, we would be keen to have them here.

I am picking up as I go the issues about supporting the Internet, and I meet with the doctors concerned as well. We are trying to pick up the various nuances that we can be more malleable to make their employment more enjoyable and, in particular, to help them multi-skill. In this budget, we are keen to keep the Collaborative Training and Education Centre running so that country doctors can come to Perth and up-skill at CTEC if needed. Indeed, we have run some courses for up-skilling along those lines.

[10.10 am]

Mr DAUBE: I will come back to an issue that was raised earlier; that is, recruitment of medical staff from developing countries. There is a consensus among various countries, which was confirmed at a meeting of commonwealth health ministers recently, that commonwealth countries should not be pillaging staff from developing countries. That said, we need to recognise that there are people from those countries who want to come to WA, and if those people have the appropriate skills, language credentials and so on - some of them have to go through various courses for that - we will not bar the door on them. We also need to be aware of the way in which other countries are addressing this. I gather, for example, that the United Kingdom observes this splendidly in principle, but has arrangements with certain districts in India, or wherever it might be, to attract people. We must have a sensible balance on this. We have to be sensitive to the needs and concerns of developing countries, but also we should be very willing to accept people with the appropriate training credentials and language skills.

Mr KUCERA: There is a third issue. For many South African doctors and doctors from developing countries, coming to Australia is the only way they can get exposure to the kinds of technology we are using. I was at King Edward Memorial Hospital for Women this week looking at its equipment needs, and a number of young doctors from overseas who were working in the obstetrics and gynaecology areas had come to WA on one-year sabbaticals to train in what is now one of the most unique women's hospitals in the world. It is heartening that they are coming to this State to train with a group of professional people to pick up skills that they will not get elsewhere. I agree with Mr Daube that we need to maintain a balance. We should not be actively recruiting doctors from places like Timor, where they are desperately needed. However, we should be opening our doors to ensure we can assist in training them, and at the same time get some benefit for our country people by making services available to them. It is as simple as that.

Mr TRENORDEN: This has nothing to do with you, Mr Chairman. However, I note that it has taken me one hour and 10 minutes to get the call in this committee process.

I want to get back to statements made earlier, when I tried to get the call, about the methodology for putting the budget together. I am concerned about that. I agree with the minister's implied statements that the accounts of the department have been a disaster for some years. I was amazed to hear a statement that this is the first year of accrual accounting. That was meant to have been part of the department's processes for several years. I am aware, through the Public Accounts Committee, that the department used to throw accrual accounting together at the end of its processes; that is, it ran a cash system throughout the year and then it would throw together an accrual process at the end of the year. I thought that had died out a few years ago. I want to know when it did die. The minister is saying this is the first year of accrual accounting; does that mean that last year the Department of Health's budget was run on a cash basis? If so, the department's end of year spending problems may be a part of that. I would like the minister to comment on those issues.

Mr KUCERA: I am not sure what the member means when he says that accrual accounting is dying. It is my understanding that accrual accounting is becoming the norm across the financial area. I would like to take up the member's comments about disasters. The only matter that I referred to along those lines was the state of the theatres at the Moora District Hospital

Mr TRENORDEN: I do not want the minister to misunderstand me. I want to talk about the way the process is put together.

Mr KUCERA: That is fine. Perhaps Andrew Chuk and Alex Kirkwood can take the member through the technicalities of the way that was constructed. There have been some changes this year. It is my understanding that the Government and the financial sector generally are moving to accrual accounting, so I am not sure that I understand the member's question.

Mr TRENORDEN: For five or six years, the state system has been moving to accrual accounting; in fact, the last three budgets were supposed to be based on accrual accounting. However, I have been aware that the Department of Health, for whatever reason, was slow in that process. A few members of the Public Accounts Committee are in the Chamber today and they will know what I am talking about. Health was slow in that process. It used to run a cash system physically in the hospitals, but it would then throw its records into accrual accounting to comply. I know that happened over a number of years, but I thought that practice had died out. However, the inference from answers today is that it occurred last year.

Mr KUCERA: I will defer to Mr Chuk and his team, in particular Alex Kirkwood, on that rather than try to go into the technicalities. I do not profess to be an accountant.

Mr KIRKWOOD: The comment made by Kathryn Cook earlier that this was the first year of accrual accounting was a reference to accrual appropriation; the two things are different. Last year, for the first time, our money was accrual appropriated. In terms of accrual accounting, I was initially employed by the department in 1992 to start that process. We commenced with 18 hospitals in that first year - all the major teaching hospitals and the major hospitals in the rural areas. We progressively moved through to the point at which we introduced an accounting system called H-care that is both an accrual system and a cash system; it does both. The member will appreciate that the larger country towns and cities like Kalgoorlie and Bunbury have very skilled people who can run a full accrual system. In the smaller places like the Murchison, people may not have the appropriate skills. Some of those people have continued with cash accounting. We have been strongly encouraging them to move to accrual accounting. Certainly, the bigger rural hospitals have been on true accrual accounting for some time. In the metropolitan area we introduced the Oracle system some six or seven years ago, which is full accrual accounting. The Royal Street office operates on full accrual accounting.

Mr TRENORDEN: So there are no cash procedures in the metropolitan area?

Mr KIRKWOOD: No. Basically, we have moved strongly through that process; it has been a skills transfer issue. I want to make it clear that the accrual appropriation that Kathryn Cook referred to is a different subject from accrual accounting.

Mr TRENORDEN: I wanted to clear that up. It is a mechanical issue, but it is important.

Mr KUCERA: I agree that it is important. The budgets are complex enough. I am happy to clear up any of those kinds of confusions.

Mr D'ORAZIO: Like the member for Avon, this is my first question and I have been in the Chamber for one hour 20 minutes.

The CHAIRMAN: It might help the anxiety of the committee if I read out the order of speakers that I have before me: member for Ballajura, member for Murdoch, member for Kimberley, member for Murray-Wellington and member for Alfred Cove; and then we can start all over again.

Mr D'ORAZIO: Somewhere along the way I missed about three goes.

The CHAIRMAN: I apologise to the member for Ballajura, but that is the list I have in front of me.

Mr D'ORAZIO: I love it when the Opposition asks questions.

The CHAIRMAN: I will put pressure on the committee to ask direct and precise questions on the budget, and I will put pressure on the minister to answer those succinctly.

Mr D'ORAZIO: On page 1203 reference is made at item 113 to the net amount appropriated to purchase outputs. I pointed out to the House last year the announcement by the federal Government that Medicare bulk-billing had reduced by 0.6 of a per cent in the last quarter, which comprises 2.5 million transactions in the quarter or 10 million over the year. With bulk-billing, patients do not pay any fees. We have a problem because the number of bulk-billed transactions is reducing and in every other area of the health system costs are increasing. I am worried that the patients of doctors who no longer bulk-bill will now attend the emergency departments of public hospitals because they will not have to pay. That will have a flow-on effect on the State Government for the cost of not only the visit to the hospital but also pharmaceuticals, radiology and pathology services, and on-costs. I have a question in three parts. First, has the Department of Health costed the flow-on effect? Second, has it highlighted that this is a cost-shifting arrangement - it is cost-shifting by stealth on the part

of the federal Government? The federal Government will forever and a day blame the State for the cost shifting that it has had to wear. This is the best example of the worst cost shifting that can be experienced. Third, is there a formal arrangement whereby the Commonwealth recognises its lack of commitment to the Medicare system? We must highlight this area because it will be a huge cost for Western Australia. A 10 per cent take-up fee in the reduction of the bulk-billing rate is costing the State in the vicinity of $50 million. I am not privy to the department's figures, and I do not know if it has carried out an absolute costing. If it has, will the minister advise me of the numbers? Has the Government applied pressure on the federal Government about its cost shifting, especially in the light of the new Medicare agreement that will have to be stitched? The federal Government will try to argue that the States have cost shifted back to it, but no-one has mentioned the cost shifting involved for the States.

[10.20 am]

Mr KUCERA: The member for Ballajura may recall that last year I had fairly robust discussions about this very matter with the then federal Minister for Health, Dr Michael Wooldridge. When I looked at the Medicare agreement, I realised that all the States were operating a pharmaceutical benefits scheme within their hospitals, and, to a large degree, they were also operating general practitioner clinics in their major hospitals. When Western Australia tried to follow suit, there was a clear indication from Dr Wooldridge that the federal Government would penalise it through claw back. It concerns me that all other States, particularly New South Wales and Victoria, implemented these measures before the previous health care agreement. For some reason, Western Australia missed out. I have asked both the director general and Dr Lloyd to ensure that those measures are in place before we even enter into discussions for the next agreement.

A number of federal Government measures have placed huge pressures on the Government. The lack of commonwealth funding for GPs has essentially resulted in the disappearance of bulk-billing right across the State. At the Rockingham-Kwinana District Hospital, 70 per cent of cases that went to the emergency department could have been dealt with by a GP. Such costs should not be borne by Western Australia, but by the federal Government.

Dr LLOYD: At this point in time we have not costed the change in the Medicare bulk-billing rate. That will be difficult to do because we cannot be certain how many people who are not bulk-billed will come into the system, rather than agree to a type of co-payment. It is a difficult area to cost. We do not have the measurements; however, data has indicated that people would prefer to have a free service than a co-payment arrangement, particularly for after-hour consultations. Therefore, people are favouring coming into our system. The monitoring and database will be an important part of the formal arrangements for the up-coming negotiations. From a budgetary point of view, we have started a trial in four hospitals that involves an arrangement with the Commonwealth, and that will provide us with access to commonwealth funds for prescriptions. The Commonwealth will provide us with the money for some of the high-cost drugs, such as those used in the treatment of cancer. It may well be that if we find our pharmaceutical costs increasing, and if the trial looks beneficial from a budgetary point of view, we would benefit by rapidly moving the project forward and expanding the trial.

Mr D'ORAZIO: Is Dr Lloyd aware that Victoria has signed a $40 million PBS agreement with the federal Government that will provide all pharmaceuticals for the public hospital system?

Dr LLOYD: Yes. Our agreement, which began last year, is part of the same agreement signed by Victoria. However, a few requirements in the agreement must be met. One of the problems we face is trying to staff the number of pharmacists who are needed in the public system.

Mr D'ORAZIO: Two members of the committee are pharmacists; perhaps we could do the work!

Mr KUCERA: I may take the member for Ballajura up on his suggestion!

Mr BOARD: The issue of commonwealth-state funding is critical, and cost shifting is critical for all the States. The States have not been too bad at doing their own cost shifting! I will totally support every dollar the Minister for Health can get out of the Commonwealth!

I draw the minister's attention to page 157 of the *Economic and Fiscal Outlook*, which refers to current grants and subsidies. It appears that a number of statements made about the Commonwealth's assistance are not reflected in the budget papers. Under the Australian Health Care Agreement, there has been a massive 12 per cent increase in revenue. The actual figure for 2001-02 is $585.7 million, and the estimated actual is $660.8 million. The budget estimate for 2002-03 is $680 million, which is a record increase. Therefore, the statements that have been made about the Commonwealth's support are not reflected in the figures. The Government is saying that the figure are declining, but they are increasing significantly. It is my understanding -

I do not have the figures here indicating that the Commonwealth's contribution to the overall health budget in Western Australia is higher than it was 10 years ago. Also, the cost for the State's contribution is lower than it was, in real terms, 10 years ago. In other words, the comments that the Commonwealth is not playing its role are not justified.

Mr KUCERA: I do not agree with member for Murdoch. The increase in the federal Government's contribution is usually governed by the rules that are already in place. I assure the member for Murdoch that the Commonwealth does not give the States anything for which they do not fight. It certainly does not give much away.

The issue is not about what the Commonwealth provides; it is about what it does not provide, and that is the difficulty. It is my understanding that people in Western Australia, particularly country people, access $38 a head less than anybody else in Australia. That is because of the lack of GPs, programs and health services. In that regard, the commonwealth agreement did not fully acknowledge Western Australia's unique position. There are no private facilities outside the metropolitan area, apart from Bunbury, and to a lesser degree Geraldton. Regardless of the fact that the commonwealth contribution to public hospitals has increased in Western Australia, that does not take into account the fact that very few people in Rockingham can see their GP at 4.30 in the afternoon and make a claim against the federal Government through whatever arrangements have been made. That cost shifting is causing many difficulties. The issue is not about knocking the federal Government because of what it has given Western Australia. It is about trying to make it realise that because of the way the Medicare agreement was last arranged, and because Western Australia did not lock into the types of agreements that Victoria and New South Wales signed, it is missing out on a slab of money that it would have otherwise received.

[10.30 am]

MR CHUK: In recent years, and probably also into the future, not knowing the outcome of the new Medicare agreement, the increases in funding from the Commonwealth have been at a rate that is far less than what the State is contributing to the Western Australian health system. The Commonwealth has had an increase in its overall health funding of in excess of seven per cent, but what I see coming through on the line that the member referred to is an increase in the order of three per cent. The gap between the amount of money that is going into our health system from state funds versus the amount of money that is going in from commonwealth funds is growing, and that is a matter we intend to address in renegotiating the new Australian Health Care Agreement.

Mr KUCERA: One issue which was raised by the member for Ballajura and which was not picked up on was the Health Care Agreement. I again defer to Mr Daube.

Mr DAUBE: The renegotiation of the Australian Health Care Agreement is one of the most important matters facing us over the coming 18 months. At the recent Australian health ministers meeting, the health ministers decided that rather than take the traditional approach, which is to start the brawl early and end up in a fist fight very quickly, they would review the way in which the States work with the Commonwealth on some of the common issues that we have to address. They have established a process, which will be fairly speedy, that will be overseen by four health ministers. It will be chaired by the Victorian health minister, and the other three ministers will be the commonwealth, New South Wales and Western Australian health ministers. They have established nine reference groups to deal with different aspects of the Health Care Agreement. Each of those groups will be co-chaired by a government and a non-government person. One of those reference groups is on the continuum between preventive, primary, chronic and acute models of care and the implications for the future of the Health Care Agreements. I have the somewhat doubtful privilege of co-chairing that reference group, which is just about to commence work. That will provide the benefit that someone from Western Australia will be on one of these national groups, and it will also mean that we can seriously address the concerns that have been raised. The process of renegotiation of the Health Care Agreement will be fundamentally important. For example, there is a reference group on rural health, and we have ensured that there will be Western Australian representation on that group. While we need to address the national issues, we also need to be parochial and address some of our own concerns.

Dr WOOLLARD: I believe the Government is considering installing a non-licensed magnetic resonance imaging scanner at Royal Perth and Sir Charles Gairdner Hospitals, which will facilitate cost shifting, when there is a greater clinical need for an MRI scanner at Fremantle Hospital.

Mr KUCERA: We will simply be replacing the existing licensed machines at Royal Perth and Sir Charles Gairdner Hospitals. The Royal Perth machine has reached the end of its life. Therefore, I have asked the department to include in the tender process for the MRI at Princess Margaret Hospital the procurement plans for replacement of the MRI machines at Royal Perth and Sir Charles Gairdner Hospitals and to leave an open-ended

tender for Fremantle Hospital in the event that we are granted a licence, as we should have been granted the year before last as a result of the Blandford report. We are tendering for four MRI machines, but the fourth tender is open ended because as yet we do not know whether we will get any additional licences from the federal Government. This Government cannot allow the situation at Princess Margaret Hospital to continue. An MRI machine must be put into that hospital, and we have made arrangements to fund that machine. I have also asked the director general to look at the needs of the south of this State generally, because there is nothing south of the river. We are not necessarily looking just at Fremantle. We need to look at the whole of the south of this State; and that is what the Blandford committee did. These machines are not unlicensed. The licences are already in place. We are simply replacing old machines. In the case of Royal Perth, the MRI machine is getting to the end of its operational life.

Dr WOOLLARD: The Sir Charles Gairdner machine is three years younger than the Royal Perth machine. Is the minister saying that when he gets the new machines the old machines will not be used?

Mr KUCERA: I do not know the technicalities, but my understanding is that the machines are due for replacement. It is not simply a matter of the machines being old. The technology has moved on. The member should not forget that this State has not had a new MRI machine in a public hospital and has not had a new licence to operate an MRI machine in a public hospital for nearly 10 years. As I have said repeatedly in the House, the way these machines have been allocated is a scandal. The State can no longer wait for a machine to be allocated. However, at the end of the day, the member has heard already how tight our health budget is and how precious our health dollars are, and I cannot lead the State down a path of pushing us back into a blow-out in health simply because those kinds of planning arrangements have not been made. It would be misinformation if the member were to put out that these machines are not licensed; they are licensed. They are simply being replaced.

Mr TRENORDEN: What the previous question is referring to is critical. The minister needs to tell us whether those two machines will be in use, because my information is that the Health Department intends to use those machines for hospital in-patients, and with an income of about $1 million for each of those machines, that will put the health budget into a positive situation. The minister needs to explain to the people of this State why he is giving Royal Perth and Sir Charles Gairdner Hospitals preference over Fremantle Hospital, when those two hospitals already have operational MRI machines. He also needs to tell the people of this State what profit he expects to make out of that arrangement, because the people who talk to me are saying that he will make a substantial profit from putting in two new machines under the licensing arrangement and operating the two old machines for hospital in-patients, and that he is putting profits in front of the people in the south west of this State.

Mr KUCERA: The machines will be removed.

Mr TRENORDEN: Scrapped?

Mr KUCERA: The machines will not be serviceable once they are removed. We will be putting in new machines. I remind the member for Avon that Fremantle Hospital is not licensed. These machines cost an enormous amount of money to run. It is as simple as that. However, it is not simply about the cost. Let me go back to the positron emission tomography machine that we had the argument about in the House. There was no whole-of-life planning for that machine in the form of what it would cost this State to run. It is the same with the MRI machine at Fremantle Hospital. This is what got the State into trouble in the past in health planning. There has to be a whole-of-life approach. The member for Avon is a businessman. He runs things in his other life outside this House. If we do not have a whole-of-life plan these days for the procurement of machines that cost millions of dollars to install and run, I as the minister, and the health management team, would be remiss for not giving that advice. We went back to the federal Government on the PET machine, and we got a very good deal.

[10.40 am]

We now have the PET machine; and the federal Government has recognised and acknowledged that we could not meet the tender process. I would not enter into a process that was dishonest. It is the same with these machines. They use old, outdated technology. It would be a backward step to pull the machine out of that hospital and stick into another hospital like Fremantle Hospital. I would rather that we as a State - in a bipartisan way - approached the federal Government and pointed out the desperate needs this State has for this technology.

This shemozzle over the issue of the licences must stop. There must be proper, set criteria for the treatment of people in this State and their access to these machines. I do not think anyone in this committee denies that. The practice of giving these machines to the profit area must stop. We need to move on.

The simple answer is no; we do not intend to use those machines. A long changeover process is involved. We cannot simply go down to Woolworths and buy an MRI machine off the shelf. We will be lucky to have the first

one in place by late this year. That will be installed at Princess Margaret Hospital for Children, and I will not resile from that decision. We will then progressively install the machines as they are needed. My real worry is about the lack of planning. The Royal Perth Hospital machine is just about at the end of its life, and it must often be serviced. My real concern is that it will soon stop being serviceable.

Mr TRENORDEN: As the member for Alfred Cove outlined, one of the machines is three years younger than the other. The information I have is that it is still a serviceable machine. It is not modern technology, but it is much better than nothing. Why can the minister not take that machine and either use it for in-patients in the same hospital, which I do not advocate, or give it to Fremantle Hospital?

Dr LLOYD: The Royal Perth Hospital machine is essentially nearing the end of its life and should be replaced promptly. The member is correct in saying that the machine at Sir Charles Gairdner Hospital has some life left in it. One of the problems we have in Western Australia is that we tend to run machines for too long, and we reach the point at which we pay enormous amounts to keep them serviceable. The machine at Royal Perth Hospital is often closed for days because it must be serviced. Special engineers and so on must be brought in. There is a fine line between removing something and driving it into the ground. Our view is that we should learn the trade-in prices on this machine before finalising how it will be deployed. It is old technology. It contains a huge magnet. Not too many people would want to pick it up and reinstall it somewhere else.

Mr TRENORDEN: It probably weighs five tonnes.

Dr LLOYD: It is a big machine. It would require in excess of $500 000 to install. That amount of money may well be out of proportion to how long the machine will last. The feeling is that we should not run a second machine which will cost huge amounts to service and maintain and which has a very limited life span. I also suspect that Fremantle Hospital would not be particularly enthused about installing it.

Dr WOOLLARD: Why can Fremantle Hospital not have the new machine so that there is one MRI machine each north and south of the river, rather than patients having to be transferred north of the river, where there are two machines?

Mr KUCERA: Fremantle Hospital does not have a licence to operate that machine. I am not prepared to transfer the licence or to take from the health budget the additional money that would be required to run it when there is a machine just a few kilometres away. The lack of planning that went into buying these machines in the first instance is a scandal. We are now unfortunately having to live with that legacy. Our precious health dollars are stretched. They will be stretched even more when we move the machine into the children's hospital. This is not about a preference between Fremantle and other hospitals. It is about time that that sort of silly nonsense in our hospitals stopped. This business of "we got this but we did not get that" is like the behaviour of children in the schoolyard.

Dr WOOLLARD: Patients south of the river -

Mr KUCERA: I am talking about the management of hospitals. That sort of behaviour needs to stop. This State runs a single, uniform health system that benefits everybody. The key issue is that people can get treatment. It is not about the egos of people in different hospitals or the particular clinicians who want to push certain political agendas in their areas. This is about a good health service for this State. I will not be railroaded by the kinds of egos that have hindered health ministers in this State in the past. It is about time that we had a proper procurement plan for this kind of medical imaging machinery and that we settled down to make sure it is properly used and financed with a whole-of-life planning system. I do not think anybody in the committee would disagree with that. I would like everyone on both sides to make it clear to the federal Government that we have some specific needs. Fremantle Hospital is one of those. I have spoken to Minister Patterson about that. I am equally as keen as the member to get a machine in that place. However, I will not do it at the expense of other parts of the health system.

Mr BOARD: I refer to the output performance measures on pages 1219 and 1220. These provide a significant indication of the trends and performance in and the cost effectiveness of the delivery of services. I find three sets of figures disturbing, and I will ask the minister to explain them. The first is under "Quality". It appears that 32 per cent of our public hospitals are not accredited by the Australian Council on Healthcare Standards. I do not understand that, and ask why there is no target to improve that figure. It remains constant over the out years. Given the impending creation of the office of safety and quality, I would have thought the minister would have projected a higher level of health care standards among our public hospitals. The second is the cost of weighted separations at public hospitals, which is a major cost driver in our tertiary hospitals. The minister is indicating a 12 per cent increase on what he budgeted for last year, which is significant. As I understand it, the cost of weighted separations in Western Australia is the highest in Australia. I do not think that a 12 per cent increase is

in the interests of the budget. The third issue I need the minister to explain is the waiting list weighted hospital separations. The estimated actual for 2001-02 is half of what was budgeted for, but the target for 2002-03 rises to 7 800, which is similar to last year's budget estimate. The table indicates that the decline is due to a resource shift during the year. Can the minister explain those three fairly dramatic indicators of where the budget is going?

[10.50 am]

Mr KUCERA: There are clear explanations for them. The separations equations are very complex. I refer first to the wait list separations. Management decided last year that the Central Wait List Bureau would, rather than simply hold the money, concentrate more on the way it does its work. It has done very well this year. I will defer to the other advisers in a moment, but my advice is that our waiting lists are now at the lowest level since 1993. The way we do it is important from a management perspective, but from the government and community perspective, the outcome is the most important issue. If our waiting list trends are downward, as far as I am concerned, that is working. The role of the Central Wait List Bureau will be extended this year. It will take on board dental waiting lists, and provision is being made for that to occur. I pay tribute in the House today to Michelle Wilkie and her team at the wait list bureau for the work they are doing. For a specific answer to your question on quality I will defer to Dr Lloyd, and then the director general will instruct another of his advisers to answer your questions on the other two items.

Dr LLOYD: Quality has been a longstanding concern. Although we have not explored it in detail I believe the concern is about small peripheral institutions that are probably not of a size to deal with quality issues.

Mr BOARD: Can the minister provide, by way of supplementary information, a list of the hospitals that are not accredited?

Mr KUCERA: The member seeks supplementary information on those public hospitals that are not accredited by the Australian Council of Healthcare Standards. I undertake to supply that information.

[*Supplementary Information No B53*]

Mr KUCERA: That accreditation process does not in any way interfere with the operations of the current hospitals.

Dr LLOYD: Accreditation is one of the processes of quality assurance in a hospital; others are available. To answer the member's question, the office of safety and quality will be established very shortly. We see that as an exciting concept for the development of policy. The office will take over management of the set of policies that ensure quality.

Mr BOARD: That is why I would have expected the target figure for the budget year to be predicted to improve.

Mr DAUBE: As a former hospital executive who has been through the accreditation process, I can say that it is long and complex, and hospitals take a great deal of time to prepare for it. We will supply the member with information about which of the hospitals are not accredited. If it is simply a matter of some of the smaller hospitals not being appropriate for that accreditation process; it may not be appropriate to make any specific change. I must emphasise again that quality is one of the most important themes we will be trying to drive over the coming years. As Dr Lloyd said, the office of quality and the quality council will be established. A couple of other issues were raised.

Mr KUCERA: The main issue I am concerned about in the area of quality is that I do not want the community to think, from the question of the member for Murdoch, that there was any concern about the accreditation process, because there is not.

Mr BOARD: The figures just surprise me.

Mr KUCERA: The figures may surprise the member, but quality is a continuous process of improvement. With 631 facilities in this State, we must be realistic. Some of them will not necessarily meet the standards. Health facilities in some remote communities may not necessarily meet an accreditation standard that we might consider appropriate, but in many instances they are culturally appropriate, and it is a matter of working through that process. I can assure the member that all of our metropolitan hospitals have been awarded accreditation processes. I do not want to alarm anybody in the community into thinking that suddenly our hospitals did not quite meet the stringent standards set by the director general.

Mr BOARD: I do not want to be alarmist either, but my point was that I would have thought that, considering the establishment of the office of quality, there would be a projected improvement in the target figure.

Mr KUCERA: As that is Dr Lloyd's principal function, I would like him to comment further.

Dr LLOYD: That is an important point. One of the issues about accreditation is that, having made a decision to set up the office of safety and quality, there is a fair lag time. Hospitals will need to apply for accreditation and then go through the lengthy process that leads up to it. Part of the point of the accreditation process is the gains made from going through it, rather than the ticket, as the member is well aware. That process often requires many things to be instituted in the hospital, leading up to accreditation. It is unlikely that the process would be completed in many institutions during this financial year.

Mr KUCERA: I will now ask the director general to deal with the other two points raised by the member.

Mr DAUBE: The two issues raised were those of weighted separation and the 12 per cent increase in the budget. I ask Mr Chuk to cover those.

Mr CHUK: Reference was made to a 12 per cent increase, which I believe is being calculated on the basis of the target for 2002-03 compared with the budget for the prior year. Looking at this line raises questions in my mind about the budget figure for 2001-02, as reported. The actuals tell a story here. The increase between 2000-01 and 2001-02 is six per cent, and the forecast for the coming budget year 2002-03 over the estimate for the current year shows an increase of less than one per cent. The 12 per cent, being the comparison between the budget and the target, is fair, but I draw the attention of the member to the comparison of the target to the actuals, which tell a different story.

Mr BOARD: Given that that is one of the major cost drivers in tertiary hospitals, the figures are going in the wrong direction for what the minister is trying to achieve. Considering costs are already high in that area, I would have thought that a reduction in those costs was being targeted.

Mr KUCERA: As I said at the outset, when we were talking about a construct of the budget, I have asked the management team to be absolutely realistic about where we are going, particularly with the cost drivers. If they are stating drivers that are there, that is an open and accountable way to go, and we need to do it. If the target conflicts with where we eventually want to be, that is stating reality. I will pass this question back to Mr Chuk.

Mr BOARD: While he is answering that question, perhaps he could also explain why the figures are exactly the same for medical and surgical procedures whether they be in metropolitan or rural areas. It seems that we do not have a handle on those figures at all, and that they are guesstimates. The suggestion that a medical procedure in a rural area costs exactly the same as a surgical procedure in the metropolitan area suggests that either they have been aggregated across the system or that we do not really know what they cost.

[11.00 am]

Mr KUCERA: That is a good question, and an astute observation by the member for Murdoch. The issue concerned me when I read the original papers.

Mr CHUK: The one per cent increase between the expected out-turn for the current year and the new budget year augurs well in the context of holding costs, particularly when we look at the factors behind those costs. Managing these costs is a really important part of our system. Salaries and wages take up 60 or 70 per cent of these costs. In an environment in which there is a three per cent wages policy, the one per cent increase must be looked at favourably - that is, three per cent on wages; yet one per cent of the total cost.

Ms McKECHNIE: A standard methodology is used for calculating the cost. For the purposes of presentation of these figures, that methodology has been applied to the whole activity sample rather than to the separate components of the information. It is done in that way to provide a comparison with the model in which we are required to present figures to the Commonwealth. Although the methodology is different, the pool of both activity data and total costs is managed similarly.

Mr BOARD: We are referring to the output performance measures. Anyone who wants to compare the cost performance of regional hospitals with the cost of separations can work only on that figure. Aggregated amounts in that way do not provide comparisons between surgical and medical, and rural and country services.

Mr KUCERA: I agree; that is the difficulty with a global budget, and this is a global budget. Those breakdowns are available for the various areas. However, as the member for Murdoch correctly pointed out, it is an aggregation. I am not an accountant, but the size and complexities of the health budget demand that we present a global budget. Given that we deal with 631 centres, we would be here for much longer than five hours if we examined the issues on a micro-management basis.

Mr BOARD: I will respect what Mr Chuk says. We are often told that part of the cost of running our tertiary teaching hospitals is the inherent delivery of the teaching process; whereas surely a smaller, more efficient country hospital would run at a much lower cost. We are trying to get a handle on what it costs to deliver these services through the metropolitan teaching hospitals.

Mr CHUK: I am unable to respond to the latter part of the question. However, if it is useful I can respond to an earlier part on the comparison of the Western Australian health system with other jurisdictions. This is a complex area and has caused much debate. In our budget submission to the expenditure review committee we did our very best to make genuine comparisons between this State's services and those in other States. We referred to the recent fulsome report by the Productivity Commission entitled "Report on Government Services", which compares funding of health services in Australian jurisdictions.

The Australian average funding for acute services in public hospitals is $2 832. Members do not have this data in front of them because I am referring to the Productivity Commission report. The figure for Western Australia is $2 726, which is less than the Australian average. I acknowledge that many sets of data are available and many comparisons are made. However, the Department of Health is not necessarily convinced that the Western Australian health service is any more or less efficient than any other Australian health service. Our advice to the Government was that the Western Australian service is in the pack. Our assessment of cost comparisons is that it is not leading the pack.

Mr KUCERA: It is a global budget. I am not sure what the member is seeking in terms of the division between an individual country hospital or an individual country health service versus a tertiary hospital or whether he requires specific information about the separation between country hospital costs. These figures raised an issue in my mind and I suspect that costs are higher in some country areas than in the tertiary hospitals. In some cases the situation might be the reverse.

Mr BOARD: Mike Daube was involved in the Health Administrative Review Committee report, which was proposed under the previous Government. In assessing the delivery of services and some of the changes from tertiary hospitals to secondary hospitals, the department must get a handle on when it can deliver some of those services more cost effectively. It is therefore necessary to compare the costs between secondary and tertiary hospitals.

Mr KUCERA: We can do that now. Given the global construct of the health budget, that information is not included in this set of papers. However, the information is available; we have a handle on it. We know the costs of the individual health centres right down to the small nursing posts scattered around the State. How much information should we include in a budget? We can provide the member with a breakdown of those figures.

Mr BOARD: I therefore request that information.

Mr KUCERA: As I recall, either the member for Murdoch or the member for Roe requested the breakdown of costs for individual hospitals last year. I am not sure whether we can provide an overall comparison of country versus metropolitan hospitals.

Mr TRENORDEN: It would be appreciated if the minister could do that.

Mr KUCERA: As Mr Daube said earlier, last year we drew a line in the sand for budgets generally. This year we will dig that line a little deeper. Mr Daube has already indicated that we are on target at this stage. I understand that is the intention for the forthcoming year, and I have no reason to doubt that. A very different rigour is being applied for the sake of accountability generally, which was perhaps not the case in previous years. We will wait and see.

The CHAIRMAN: Does the minister agree to provide the supplementary information? If so, will he please state exactly what information he will provide?

Mr KUCERA: I am not sure what the member wants.

Mr BOARD: I do not expect details of costs for every hospital. However, we would like in a general sense the cost of a weighted separation. Perhaps we could have a breakdown of an average for the country region, compared with secondary hospitals, compared with metropolitan hospitals.

Mr TRENORDEN: The minister indicated that he might be able to provide a breakdown of country versus city hospital costs.

Mr KUCERA: I am advised by the director general that we can provide those figures. Would it be helpful if a couple of areas were selected, such as Kalgoorlie and Albany, and compared with the Kimberley?

[11.10 am]

Mr BOARD: If they were averaged.

The CHAIRMAN: Members are not being helpful in assisting Hansard and the Chair. Members need to be succinct. We need to know exactly what supplementary information is being sought and what the minister will agree to present. Once that has been determined, I will allocate a supplementary information number.

Mr KUCERA: The members for Murdoch and Avon have requested a comparison of the weighted separation cost between a number of selected country areas and the metropolitan area and tertiary institutions. They also want to know the cost of weighted separations between the tertiary and secondary hospitals in the metropolitan area.

Mr BOARD: That is correct.

Mr TRENORDEN: I would like to clarify a point. I want to make sure that a couple of smaller country hospitals will be used in that comparison, and not just hospitals in Albany, Geraldton and other major centres.

Mr KUCERA: A number of small country hospitals will be included in that comparison.

[*Supplementary Information No B54*]

Mr BOARD: There was one other part to that question. The minister was going to deal with the issue of the waiting list weighted hospital separations.

Mr KUCERA: I will refer that question to Dr Lloyd.

Dr LLOYD: We are currently anticipating that, with improvements in management structures and the regional system, we should be able to get back to a normal system of allocating wait list work. The figure was derived based on previous allocations and forward allocations.

Mr BOARD: I do not understand this. We are told that the waiting list is improving. The web site states that there are fewer patients on the waiting list but that waiting time has gone up by 20 per cent. However, the budget papers state that the number of weighted hospital separations for those on the waiting list is half of what was projected.

Mr KUCERA: Again, I will refer that question to Dr Lloyd.

Dr LLOYD: I will try to explain that. The member for Murdoch has raised a good point. It is difficult to understand some of these numbers. We need to understand that the wait list weighted separations cover only about five per cent of the surgical work done in metropolitan hospitals. We are talking about a very small proportion of the total work. The other 95 per cent of work is determined by emergency admissions or work that comes off the wait list but is not funded by the wait list. The wait list weighted separations are that five per cent funded through the wait list. Of course, 100 per cent of surgical work is still dealt with and managed through the wait list databases and processes, but at least 95 per cent of that work is funded through hospital allocations.

Mr BOARD: Would I be correct in saying that the low figure is a direct result of the policy decision late last year to take some money out of the Central Wait List Bureau and allocate it to tertiary hospitals?

Mr KUCERA: A management process was carried out. I will again refer the question to Dr Lloyd.

Dr LLOYD: That is correct. A decision was made late last year or early this year. The department felt that given the heavy pressures that the teaching hospitals and some secondary hospitals were under, both from a budgetary and work point of view, they needed to be a little innovative in how they dealt with things in difficult circumstances. Late last year Vancomycin-resistant enterococci were active and there were nursing shortages, so there was a reduced bed capacity in hospitals. The hospitals needed to develop some innovations. A decision was made to directly apply to hospitals about half the money that the Central Wait List Bureau normally applied to help with the 95 per cent of work that the hospitals normally do. There was concern among some management people that it was inappropriate in those difficult circumstances to provide an incentive pool that allowed what could almost be called competition between hospitals, in which hospitals sought to free up some capacity in order to get access to some wait list work and money while others battled to push through the work that needed to be done on a category one or urgent basis. Although it is always the department's intention to give highest priority to urgent and category one cases, much of that work would not have been dealt with through the allocation of Central Wait List Bureau money. About 2.5 per cent of the surgical work done this year was not funded through the wait list, compared with the five per cent that is normally funded in that way.

Mr KUCERA: The wait list process has not changed at all; in fact, it has been strengthened. We intend to move the dental waiting list into the same process this year. At the end of the day, the key issue is that people receive treatment. The wait lists are down. One area has moved out slightly in terms of the times people are waiting, but by and large the system is working well. I compliment the previous Government on putting that system in place. As far as we are concerned, that system will continue to work well.

Mr BOARD: If the figure has gone back to what was previously projected, I assume that the same level of funding will be re-established to the Central Wait List Bureau.

Mr CHUK: This is probably an appropriate general comment in that it is fair to say that the internal allocation processes for the aggregate budget within our major budget holders have not yet been completed. At this stage, we have not finalised the funding that will be managed through the wait list as opposed to the money that will be directed largely to metropolitan hospitals. As Dr Lloyd indicated, the bulk of the money goes directly to the hospitals to undertake this work. The split between what goes to the wait list for funding purposes as opposed to administrative purposes is yet to be determined.

Sitting suspended from 11.20 to 11.29 am

Mrs MARTIN: I refer to the works in progress listed on page 1236. There is an allocation for various north west plan developments. Apparently that is where the funds for the dialysis unit in the Kimberley can be found. About $1 million has been allocated for those developments, but a figure of $568 000 has been mentioned. Where is that figure located in the budget papers? Secondly, is there an allocation for accommodation for people who come to Perth? I understand that the Elizabeth Henson Autumn Centre is available for accommodation. However, a lot of concerns have been raised by family members about that centre. Has the department given any thought to the future of the autumn centre?

Mr KUCERA: As a result of my trip north, during which I spoke with families in the area, I visited the autumn centre. I will defer to Mr Buckley to provide information on the overall capital works in the Kimberley. Then I will defer to Mr Xanthis from the Office of Aboriginal Health to comment on the autumn centre. We are putting together a new tender process and a contract for the autumn centre, and he will refer to that.

Mr BUCKLEY: Further to my earlier comments, the Broome Regional Aboriginal Medical Service renal project has a total budget of $1.568 million, of which $500 000 is from the Commonwealth, and we have received that money. The balance of the funds sits in the capital works program on page 1236 and can be found in the line item for north west plan developments under works in progress. The rest of that allocation was used for other north west projects such as the Port Hedland renal dialysis project, which has been operating for some time.

Mrs MARTIN: That has made it clear, because I thought we had $500 000 extra.

Mr XANTHIS: The Office of Aboriginal Health currently funds the Derbarl Yerrigan Health Service on a contract basis to run a residential facility at the Elizabeth Hansen Autumn Centre on Guildford Road in Bayswater. The premise of that contract is to provide a culturally secure and appropriate residential facility. The term "culturally secure and appropriate" is used a lot, but many people do not understand what it means. In our terms, it means that it influences Aboriginal people's decisions about accessing health services, their acceptance or rejection of treatment and the likelihood of compliance and follow-up. As the minister has indicated, the contract will be advertised in the next two weeks. We have constructed a new tender document that allows for a culturally secure and appropriate residential facility. A new manager is in place at the Elizabeth Henson Autumn Centre. It has 10 Aboriginal staff representing all the regions. The services provided are appropriate. The clients resident at the autumn centre are predominantly from the Kimberley, and the attendance is by both males and females. Renal disease has the top hospitalisation rate for males in the Kimberley and the third top hospitalisation rate for females. A number of people will no doubt tender for this process, and that will ensure there is an appropriate proponent.

Mrs MARTIN: Have specific funds been allocated?

Mr XANTHIS: The allocation for the tender cost is in the budget of the Office of Aboriginal Health. It is not a separate line item.

Mr KUCERA: The value of the tender is in the vicinity of $668 000 and is contained within the overall budget of the Office of Aboriginal Health. As a result of the concerns that the member has raised with me, I also arranged for the Minister for Housing and Works to inspect the premises. My understanding is that the Department of Housing and Works has now settled the title deed from the previous owner and has taken back ownership of the autumn centre. Its maintenance etc will be carried out by the Department of Housing and Works. We have taken back ownership of that hostel to guarantee its future maintenance.

Mr BRADSHAW: My question relates to a significant issue and trend on page 1205 about the obstetric and gynaecology services at King Edward Memorial Hospital for Women. What is the precise reason that the minister did not make public two important sections of the report that provide non-identifying summaries of clinical cases in which problems occurred? The minister may be concerned about being sued for damages by patients, but this is a lesser issue than the need for staff at the hospital to learn from their mistakes in order to reduce the likelihood of problems occurring for women and babies in the future. They cannot do this fully unless they are given adequate clinical information. There is interest in this report, not only in Western Australia but also around Australia.

Mr KUCERA: What precisely is the member asking?

Mr BRADSHAW: I am asking why certain parts of the report were not made public.

Mr KUCERA: I will defer that to the Director General of Health, but I think the issues were well canvassed when the report was released. In relation to that, I was at King Edward Memorial Hospital for Women this week. I met with Professor Karen Simmer, one of the hospital's new professors. The feeling in the hospital from a morale point of view is palpable. There has been a definite change in the past year since the report came out and we have started to move on the recommendations. Mr Daube will talk about what we are moving on. The key issue which the Government needs to address urgently and which is in the works program is the emergency department. I understand from Mr Buckley that the redevelopment of that area is included in this year's capital works budget. In relation to the overall implementation of that report, I will defer to the director general who will touch on the two issues that the member raised.

Mr BRADSHAW: The main issue is that if those reports are not made available to the people involved, they cannot learn from their mistakes.

Mr DAUBE: I will make some comments and then ask Dr Lloyd to continue. Dr Lloyd is chairing the implementation group that we established. This was a frustration for us in that we were keen to publish the whole report as it stood. However, there were some pages in the report that, if published, would have put us at risk of identifying patients. The advice we received was that it would not be appropriate to print the report in full. We must work on the basis of Government's best legal advice, and that is the advice that we took. There was certainly no intent on our part to not publish. It was a little frustrating, but we have to work on the basis of the report as we were given it and to publish what we can with legal advice.

It would be hard to think of anything that we have taken more seriously than the Douglas report. We are very keen to ensure that we learn lessons from the report, not only for King Edward Memorial Hospital for Women but for other hospitals across the State and for the health system; indeed, the minister has raised the issues nationally at the Australian Health Ministers Conference to ensure that people nationally are learning the lessons from here. The process that we have adopted is to establish an implementation committee, which Dr Lloyd chairs, and we have been very keen to ensure that that committee has strong external representation on it, including Professor Jeffrey Robinson, who was the medical member of the Douglas panel and who has kindly agreed to be on that committee. Professor Robinson is also on the selection panel for the appointment of our chief executive. We are making sure that there is a consistency throughout and a real transparency in the way this whole thing works. We want to ensure that we learn every possible lesson from that report and the recommendations. As I said, with Professor Robinson on that implementation committee, we are pretty sure that nothing will go past that we should not be taking account of across the system as a whole. May I suggest, through the minister, that given the importance of this issue and given that Dr Lloyd is chairing the implementation group, it will be helpful if he addresses the processes through which that group is working.

[11.40 am]

Dr LLOYD: This is an extremely important issue, and the issues raised by the member are also important to the Department of Health. The question we must ask is: do we learn by reviewing the cases that occurred over a 10-year period, or do we go forward by developing better processes and a culture based on quality, openness and the like? Since late January or early February, a distinguished group of people have met regularly. This group includes the chair of the Health Consumers' Council of Western Australia, the local president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the president of the Western Australian branch of the College of Midwives, and Professor Ian Constable from the Lions Eye Institute, who is a distinguished clinician and scientist. We are fortunate that Professor Jeffrey Robinson joins us for each meeting by telephone. His contributions have been very useful. The group has set up a database and a matrix to analyse the severity of the issues and the likelihood that they will be repeated. We have been working through high-risk and other issues. Rather than apportion blame, from my experience it is more beneficial to have the hospital staff work through the recommendations with us. Obviously, we were not able to do this because the cases had not been published. The group has signed off on a reasonable number of recommendations, and the processes involved in implementing the recommendations are appropriate. The other recommendations are well under way. A huge amount of work is taking place at King Edward Memorial Hospital for Women. Different types of groups and subcommittees are working on various issues. Guidelines are being developed, and the first of two courses that were recommended is now being held; indeed, it has been well attended. We are also developing programs for the Collaborative Training and Education Centre at the University of Western Australia. Cardiotocography interpretations are important to the group, because they record the electrical impulses from the baby, and programs are being developed in that area. Methods have been put in place to ensure that only those with the necessary credentials are allowed to work in certain areas. Therefore, we have

put in place many changes that were recommended. I agree with the minister; the culture at King Edward Memorial Hospital for Women has markedly changed. More staff are now on board, and there is more staff participation. Processes have been put in place to help grieving mothers and to review any adverse incidents, especially deaths. Extra ward rounds have been established on nights and weekends. Senior staff do two ward rounds in the labour wards after hours. There are also new criteria for the management of sick patients.

Mr BOARD: All the initiatives are first-class, and I commend the Department of Health. However, as Dr Lloyd knows, only some of the objectives have been fulfilled. The objective for a number of individuals was closure. We must determine how to deal with the sensitive and difficult issue of closure. I agree with moving forward and with the structures that have been put in place, because they are important. However, the issue of closure remains unresolved.

Mr Daube mentioned legal advice, and that is fine. However, what is the legal advice based on? Is it based on exposure to the State? If so, is that the reason parts of the report were not published?

Mr KUCERA: The legal advice came from the Crown Solicitor's Office. It was based on a number of factors, including the State's exposure and the protection of patients. Essentially, we could not release individual cases without clearly identifying the families and the patients involved. That was the basis of the legal advice.

The point raised by the member for Murdoch about closure is important. Some people will never have closure, because of the very nature of what has occurred. Closure would be difficult even if there were no legal impediments. A number of people who have lost their children come to my office on a regular basis, and they are still coming to terms with their loss, regardless of the fact that all the legal niceties have been dealt with. Wherever possible, we will assist people with their closure, either through the legal process or by simply being human about such matters. We must have a culture of compassion in health - it seems to have disappeared. That is one of the problems we have with the argument about liability.

I now refer to the point made by the member for Murray-Wellington. The lessons that came out of the individual cases are clearly contained in the report's recommendations. I have had an opportunity to read the entire report, and I have consulted with those who put the recommendations together. That, together with the inclusion of Professor Robinson in the implementation group, will ensure that all the lessons that have come out of the individual cases will be dealt with - in fact, as minister, I insist that that be the case - as the change in culture is implemented at King Edward. The lesson we have learned from the situations at King Edward and at Bristol is that there must be a change in the culture. That is what this is all about.

The issue about publishing individual cases that may harm the confidentiality of patients is important. However, a more important point was made by the member for Murdoch; that is, the lessons we have learned must be included in the measures we take. Having read the report, and given the assurances that I have received, I am comfortable that Jeffrey Robinson has been included in the group. As the director general pointed out, the key change in culture will be the appointment of an officer who will be in charge of King Edward. That is why Professor Robinson will sit on the board that chooses the chief executive officer who will manage women's and children's health in Western Australia. That process is well under way. It sits comfortably with the Public Sector Management Act 1994, as the matter rests entirely with those in the public sector and with the director general. As minister, I do not take any part in the process. I have already presented one report to Parliament. I will continue to present reports until Parliament decides that the issue at King Edward Memorial Hospital for Women can be put to rest. We are trying to make the papers available to those who are trying to gain legal closure. A number of freedom of information requests have been lodged, and wherever we can facilitate the release of such information in a legal framework, that will occur.

[11.50 am]

Mr BOARD: Is the minister saying - because this is new information - that even though that part of the report is not public, it is available to those individuals?

Mr KUCERA: No. I am saying that the issue is being tested at the moment. My advice is there are a number of FOI applications. I do not know whether that refers specifically to some of those closed portions of the report; I am surmising that. However, constantly across my desk I get requests for information from the Douglas report. I surmise that that includes some of those areas. That has to be tested, obviously. In all fairness, we have to be guided by the Crown Solicitor, and we have taken his advice. We also conferred with the member's party and with the National Party before we issued the report, and we made it clear that that was the advice that we were given and that was the advice that we would adhere to.

Mr BRADSHAW: In view of the fact that the minister will not release those deleted sections, will he arrange for the Opposition to have a briefing by the Solicitor General on the deletion of those two sections?

Mr KUCERA: My understanding is that members Foss and Criddle were briefed.

Mr BOARD: I think that was a personal invitation rather than an opposition briefing.

Mr KUCERA: I am happy to talk with the Crown Solicitor about that matter and see whether he is prepared to brief the Opposition on the current situation, but I would have to take that on advice.

Mr BOARD: Things may have moved on since then.

Mr KUCERA: They very well may have. I would have to take that on advice and talk to the Attorney General to see whether that is appropriate. I do not know. I would be flying blind if I were to say yes at this stage.

Mr TRENORDEN: I agree with the minister that this is a very delicate matter. I want to make it clear that I am not interested in apportioning blame. However, I am very concerned about the procedures in those two hospitals, and I am unconvinced about change. The reason is that I am in a vacuum. One of the problems in a democracy is that people can deal only with the information that they have. People from those hospitals are ringing me and telling me a different story. I would like both those hospitals, particularly King Edward, to be well regarded in this State, and the sooner we can get there, the better. On that issue the minister and I are as one. However, until I am in that position, I will be a critic; and I would prefer to be a critic on fact than a critic on assumption. A request was made earlier that the Leader of the Opposition and my office be given some guarantee that we will be supplied with a full copy of this report so that we can know what those issues are rather than assume or hear about them third hand.

Mr KUCERA: The legal advice as I recall it was that, regardless of whether we were briefing the Opposition, any release of those sections of the report would be akin to publishing them. I am not sure of the technicalities. I am not a lawyer. I have already said through the Chair that I am prepared to seek that advice and let the member know whether it is possible for that briefing to occur. There is no reason that the Government would stand in the way of that, other than the legal advice given by the Crown Solicitor. There is no attempt to hide anything from the public. As I said, the issue is that the lessons that came out of the individual cases that were not published have been included by Professor Robinson and the entire team in the recommendations, and it is clearly evident from some of the changes that I have seen at that hospital that those recommendations are starting to bite. Obviously until the new director is appointed at that hospital and until the full gamut of what those recommendations indicate to government is in place, it will be an ongoing process. I understand the concern, but I can only seek advice from the Solicitor General and I can only abide by the advice that I have been given.

Mr DAUBE: As I said earlier, it has been a frustration to us; even the delay in publication was a frustration to us. We would have liked to have had the report published instantly. However, we can deal only with the report as it was written and then act on the best legal advice that we have. In terms of the change in culture, the impact on King Edward Hospital has been profound. I have been in this role since only fairly recently. I visited that hospital a number of times before the report came out. I also went there on the day after the report had been published and addressed staff, and we set a number of processes in train. The changes have been profound, whether in terms of new people coming in, new procedures or whatever else. It is also very clear that change in any institution takes time and we cannot turn things around just with the turn of a dial. We are trying to move that cultural change through as quickly as we can. This is an opportunity to pay tribute to the many people who have supported the hospital through thick and thin, staff as well as volunteers, and to recognise that they are playing a positive role in working through the problems that the hospital has had and in making those changes. There is a recognition in hospitals around the country that when we talk about the problems at a hospital such as King Edward, there but for the grace of God go they, and they are all keen to learn lessons from us too.

Mr KUCERA: My understanding is that I will supply advice from the Crown Solicitor's Office on whether the Crown Solicitor can brief the Leader of the Opposition and the Leader of the National Party on why those sections of the King Edward report were not released.

Mr BOARD: Am I right to assume that when the minister says the Leader of the Opposition and the Leader of the National Party, it may include members other than just those two people?

Mr KUCERA: My understanding was that the request was for the Leader of the Opposition and the Leader of the National Party. Let me first seek advice on whether that briefing can be given. I undertake to supply that advice as supplementary information.

[*Supplementary Information No B55*]

Dr WOOLLARD: I refer to the bottom of page 1218, home and community care, and also to page 1229, community-based services. I have spoken with the minister previously about measures to help people to be cared for at home, whether that be their family home or a nursing home. What percentage of the budget last year and this year has been allocated to Silver Chain Nursing Association; and how many patients, either daily or

weekly, take up hospital beds either after having been transferred from nursing homes or while awaiting placement in nursing homes?

[12 noon]

Mr KUCERA: I do not have the current figures. As I recall, last year about 130 people a day were occupying our emergency departments or acute care entry areas. Last year there were 424 300 episodes of in-patient care. I do not know what percentage of those were related to aged-care issues.

There were 3 662 700 occasions of service for non-admitted patients, and 105 000 nursing home-type bed days. I suspect that some of that includes those relating to the Silver Chain Nursing Association. There were 3 696 000 hours of home care, and 682 200 attendances at our state-funded hospital emergency departments. I suspect that, again, a large number of those relate to the people the member asked about. I have a host of other statistics relating to that, but I think they are the important ones. Sue McKechnie will explain the specific funding for Silver Chain.

Ms McKECHNIE: The total allocation to the Silver Chain Nursing Association in 2001-02 was $48 166 508. Supplementary project funds were also made available for mental health funding and other small programs, such as the home oxygen program.

Mr KUCERA: In addition to Silver Chain, most of the major hospitals supply home care programs of one sort or another. I think I said during last year's estimates hearings that we are trying to move out some of the programs, such as the unit at Carinya of Bicton, which now provides home services for people who live in the East Fremantle area. We are looking towards expansion of the capacity to deal with particularly aged care patients in the community or in the aged care homes rather than in the hospitals. I refer to Dr Lloyd.

Dr LLOYD: There are two issues of relevance to the member's question. First, home and community care funds will increase in the coming year from about $98 million to about $108 million, which will help provide for people who need assistance out of hospital. Second, we have begun working with general practitioner groups and divisions to see how we can better support the care of people in nursing homes or out of the teaching or other hospitals and help maintain those people in their homes. We are considering the sort of support systems that we can provide, and how we can better coordinate and use the current system to provide for a patient who, for example, has mild pneumonia but who the doctor does not think needs to be in hospital. We are questioning the support we can give the general practitioner in that regard, and whether a nurse practitioner or one of our post-acute care nurses from the teaching hospitals could visit the patient. The general practitioner groups and divisions are very keen to work with us to that end. I am hopeful that in the next month or two, we will bring on board a very good project officer to lead the task and to see what we can coordinate better in that regard.

Dr WOOLLARD: I am very pleased with what is happening with the divisions. Will the minister consider making geriatric nurse practitioners available to assist and re-skill nurses in aged care nursing homes? Often patients are transferred from aged care nursing homes to public hospitals simply because the nurse is new or has not been required to perform a particular skill for several years. It is very upsetting for those patients to be moved into a general hospital. They often become confused and disorientated, and they do not know the staff.

Mr KUCERA: That is our intention. I will defer to Dr Lloyd.

Dr LLOYD: That is a very pivotal point. WAGPAC, the Western Australian General Practice Advisory Council, which comprises all the peak general practitioners bodies, was two weeks ago addressed by Pauline Iles, a senior person in the nursing home industry. WAGPAC is discussing these very issues. It wants to know how we can help a nurse who has a patient with a problem that is outside her scope or current experience so that the patient does not need to be sent to hospital in an ambulance, which the patient or family do not want. That is part of this issue. The group is asking whether help can be provided by access through the front door. If a catheter falls out of a patient or a patient has a pressure sore that requires specialist nursing, and the attending nurse is either too busy or does not have recent skills to deal with it, it might be possible for one of our nurses on the road to roll in, assist with that procedure and try to maintain the patient in much more comfortable surrounds. That will be the scope of this project. I am very dedicated to achieving that sort of program.

Dr WOOLLARD: Does the budget contain funding for those services?

Mr KUCERA: The budget has general funding for hospital services. There is always leeway within the hospital budget to look at those kinds of programs. I will defer to Michael Jackson, but my understanding is that there is funding for an increase in the number of community nurses. I am not quite sure of the scope of those nurses' tasks.

Mr JACKSON: Part of the health improvement fund last year went to putting on 15 additional community nurses in both metropolitan and country districts. We have only just received our budget for this year, so we

have not yet made those allocations. The most significant point is that the population health division has a new branch of child and community health. That will be dedicated to improving community health service delivery throughout the State.

Mr BOARD: That issue of nurse practitioners is critical for the delivery of many services. I notice that the scope of the working group has extended from rural and remote areas to cover the whole State. That is important.

Mr KUCERA: It is to cover areas of need.

Mr BOARD: I think there are areas of need everywhere. When will we see the nurse practitioner legislation? Has the minister widened the scope for the application of nurse practitioners in this State? He would get great support from the Opposition if he were prepared to take on some of these issues.

Mr KUCERA: Yes. The legislation originated under the member's Government, and we picked it up. The member has rightly pointed out that I have extended the drafting instructions to apply to areas of need. The legislation will have a much broader application. The member has raised a good point. The nurse practitioner legislation will be introduced in the next session of Parliament. I welcome the member's support, as it is a very important piece of legislation. I will defer to Phillip Della, the principal nursing adviser.

[12.10 pm]

Dr DELLA: The nurse practitioner in Western Australia legislation is based on the report of the original steering committee. We have prepared the drafting instructions, and parliamentary counsel is drafting the legislation. Six pieces of legislation need to be changed to allow the implementation of the nurse practitioner. We have also called for tenders to run the educational course for nurse practitioners, which will be at postgraduate diploma level. There will be four units of core advanced nursing skills and four areas of speciality, such as aged care, community care or remote and rural care. The nurse practitioner tenders will also include the advanced skills in prescribing a range of medications and a range of investigation tests from a clinical protocol. The education program is envisaged to start in the 2003 academic year. It is proposed that the legislation include a grandfather clause for nurses who feel they are already practising at that level and can demonstrate the necessary competence and skills to allow them to demonstrate their skills and be registered. We are protecting the title in Western Australia by registering nurse practitioners with the Nurses Board of Western Australia, which will give us the level of quality and safety required.

Mr KUCERA: I do not believe, as was said by a clinician last year, that this is second-hand doctoring. This is top-class nursing. I would welcome the introduction of this legislation into Parliament, and note the desire of the member for Murdoch to treat it in a bipartisan manner.

Mr BOARD: If anything, the Opposition would take it further.

Mr KUCERA: I will always entertain amendments.

Mr BOARD: The minister raised in Parliament the issue of professional development for nurses. I am not sure if he is aware that, under Senator Alston's regional development fund, there are two finalists for Western Australia. The minister's colleague, the Minister for Education, has submitted a bid for educational requirements, and there is an Optus-Curtin University bid for the professional development of nurses through the use of satellites. The Opposition is supporting this on health grounds. I am not sure what the Department of Health position is, but it would be an excellent development that would help in this very area.

Mr KUCERA: The representative from Optus was at the presentation of the country scholarships at Wesfarmers Ltd the other evening, and I discussed the issue briefly with him. The Government certainly is very interested in the question of tele-education, but I will refer that back to Dr Della.

Dr DELLA: The Optus contract that is being sought would enhance our ability to provide clinical education from Curtin University to remote and rural areas. It is supported by the department. We have indicated our support to the Commonwealth Government and Curtin University. We have already worked with Curtin in distance education for nurses, and we would see this as a definite improvement and enhancement.

Mr KUCERA: I am very heartened by the response to the Nurse-Link program, which has been resounding. I would be happy for Dr Della to expand on that, now that we are talking about nurse training in generally. Last year, 181 additional nurses came into the system, and so far this year there have been in excess of 160 inquiries. Another 60 nurses from overseas have indicated some degree of interest. The Nurse-Link program is the first phase of bringing those 400 nurses into the system.

Dr DELLA: Since its launch only three weeks ago, the Nurse-Link program has attracted 160 inquiries from the metropolitan area. It has been rolled out to country areas with advertising, and calls are now coming from the

country. Many of the nurses wishing to re-enter the profession need re-entry programs, either through refresher courses or renewal of registration. We have successfully negotiated with the education provider to externalise that program so that people in country areas can be provided with support from Fremantle Hospital and the education program and then get the clinical experience they need in the regional hospitals. In addition to that, 60 migrant nurses will require a migrant bridging course, including learning English to a professional level, and clinical and theoretical components on the Australian health system. That course will be run in the second half of this year. Last night we began to receive calls from nurses on the eastern seaboard wanting to rejoin the government health system in Western Australia. We were planning to advertise in the eastern States in June.

Mr BOARD: Bringing new nurses into the system is very important, but there is also a question of how many will go out the other end. We do not have any figures about the retention rate of nurses. Is there a figure on the number of nurses leaving the system? That is very relevant overall. How will some of the agency nurses be brought back into the public health system? This is critical for not only cost reasons, but also the long-term security of the public health system.

Mr KUCERA: The rate of loss of nurses from the system has declined, and the retention rates are rising. I will ask Dr Della to talk about that. I have had discussions on a number of occasions with our Victorian counterparts. Until the recent changes in Victoria, 40 per cent of the work force in the eastern States were agency nurses. In this State the figure is six to eight per cent. In country areas that impacts very strongly, because much of the agency nursing is done in country areas. We intend eventually to establish pools of relief nurses in both the metropolitan area and the country, which will be run in a similar way to the Victorian pools, and we intend to roll out this plan with remuneration and flexibility. The other thing that needs to be done is to change the culture within hospitals. I have put the directors of nursing in some of the smaller hospitals on notice that they will need to be a little more flexible with their work force. We intend to phase out agency nursing in this State early next year, wherever possible. It must be a long-term program and Dr Della has it mapped out. I do not particularly want to talk about the whole program at the moment, because I do not want other States to think -

Mr BOARD: Does the flexibility refer to shifts?

Mr KUCERA: Flexibility is about shifts, child care and a whole range of issues identified in the new vision, new direction program. It also means getting some realisation between the various sectors of nursing about the flexibility required at crossover points, as is being seen in the scope of nursing studies being carried out. I will ask Dr Della to speak further on this point. At the moment we are positioning ourselves to move down that track and overcome the whole work force issue, particularly for the country.

[12.20 pm]

Dr DELLA: The first phase of Nurse-Link is to increase the number of nurses working in the government health industry in both the metropolitan area and the country. The rationale for doing that is that, if the supply of nurses can be increased, the issue of agency nurses can then be tackled. Agency nurses who have expressed interest in coming back into the system - and this is a similar experience to that of Victoria - are requesting part-time work, casual shifts and greater flexibility. The establishment of Nurse-Link will meet that need by giving them the shifts they want on the days they want, while not detracting from permanent nursing positions within hospitals.

The first phase of increasing the supply of nurses is very much tied in with the refresher courses and the re-entry courses of renewal and registration. We are also working with the aged-care industry by bringing many of the nurses from the aged-care nursing homes into the refresher courses to upskill them, so that they can return to the nursing home. That will prevent some of the transfer of patients from the nursing homes into hospital aged care.

The second phase will be the establishment of a coordinated supply system called nurse bank, which will be the second phase of Nurse-Link. We will seek nurses in country areas who are willing to move from country town to town. They are usually needed for a week, a month or up to three months. We have identified that a number of agency nurses are doing that in an ad hoc way and often their skills are not matched with the needs at the country hospital, or they move on before time. The advantages of working for the Government's nurse bank will be that we can plan their movements, give them access to professional development, provide the skills they need to work in country areas and give them access to professional development, superannuation, annual leave, holidays and sick leave, which are not available when they work through an agency. That is an attraction. Once again, based on the success of the nurse banks established by Victoria and the United Kingdom, this will attract them back into the government health system. We are also working very closely with our health service providers to ensure that their needs are being met in this program.

We are continuing to market nursing to school leavers to ensure that the future supply of nurses will increase. This year an additional 111 nursing places were taken up in our universities. The tertiary entrance score has increased, which has resulted in the attrition rate from the programs decreasing from the national average of 30

per cent to 10 per cent, which will result in more nurses coming through the system. We will continue the "are you good enough to be a nurse" marketing campaign to encourage school leavers to take up nursing and we will establish Nurse-Link to attract nurses back into the centres. To address the problems identified in the new vision, new direction study about the work environment, we are working through the recommendations to improve the work environment through child care, family-friendly initiatives, professional development, professional standards and focus on nursing leadership. The whole package should come together to produce a much more viable work force for us in the future.

Mr TRENORDEN: Is the minister considering providing further resources? From hard experience in country areas, few nurses are sitting at home wondering what they will do. Most are working in other occupations, many of which are not chosen occupations. The requirement to drop their current job, whatever it may be, to undergo training in the metropolitan area creates a serious problem. Those restrictions mean that people who want to be nurses are not returning to the nursing system.

Mr KUCERA: That is an excellent point. A group of nurses I met in a wheatbelt town earlier this year, expressed that point. Nurse-Link is designed to help with that. Nurse-Link is about paying people to return to nursing.

Mr TRENORDEN: I commend the minister on an excellent program. I hope those people can be released.

Dr DELLA: As part of Nurse-Link, we will pay for the educational course and we will be able to deliver it in both the country and the metropolitan area. In the new vision, new direction study, we identified the payment they will receive while they are on the course. As the member for Avon correctly identified, people will not leave a job if they cannot receive an income during training. If registered nurses do a refresher course because they want to upskill or have been away for three or four years, they will be paid a nurse's salary. If they are renewing their registration, under the Nurses Act we cannot pay a nursing salary; we will therefore pay a re-entry allowance that will be equivalent to a salary.

Mr KUCERA: The discussion with the group of women in the town, to which I referred earlier, prompted the discussions that initiated this program. We acknowledge the member's concern and the concern of people missing out on re-entry to the profession. Women want to use this program. Many mature women have taken their family break and want to return to nursing. If we can retrain them in this way, whether it be in Merredin or Southern Cross, we know they will stay there because they live there and their partners are involved in the towns.

Mr TRENORDEN: They have a commitment to the hospital.

Mr KUCERA: That is what it is about. At the outset today, I referred to reintroducing the idea of family and community into hospitals.

Dr WOOLLARD: I congratulate the Government on this move and thank Dr Della for the work he has done on the new vision, new direction program. If this program is fully implemented, it will help improve health care delivery in both metropolitan and rural areas.

Mr KUCERA: I thank the member for Alfred Cover for that. It is in all our interests that it succeed. The Department of Health will put maximum effort into it. As I said, our main priority is nursing and after that emergency departments and the bypass issue, which I prefer to call emergency management because it is tied into all the issues.

Mr TRENORDEN: I refer to dot points six and eight on page 1204. Dot point six refers to current service delivery. I would like some details on the measures that have been implemented since the last financial year, following the minister's health reform program. I would also like details on the new management team and which staff are the new employees within the process. I am happy for that to be taken on notice.

Mr KUCERA: In relation to country issues, we are fairly close to releasing the next phase of the HARC report, which will answer most of the member's questions.

[12.30 pm]

Mr DAUBE: It always seems to me that when something like the HARC report is produced we cannot expect everything to happen overnight. I am aware that fundamental change takes some time. It will take about a year for all the processes and recommendations to roll through. Clearly, the administrative changes were important to implement fairly speedily. I took up my position on 12 November last year and I think it was 28 or 29 November when we sent out information to implement the new structure. We were delayed slightly by Christmas in making the new senior appointments because it is not possible to advertise and appoint people over that period. We have moved as fast as we can consistent with the various processes that are necessary to work through. We were very fortunate to appoint Andrew Chuk and Dr Brian Lloyd, two outstanding deputy directors

general, and Michael Jackson, the executive director of population health. The appointment of the executive director of country services will shortly be announced, and the appointment of the area chief executives will be announced within the next two or three weeks. Once that state health management team is fundamentally in place, we anticipate following through with the rest of the structure as quickly as possible. Getting that team in place is crucial. The department is also moving ahead with a host of other recommendations from the Health Administrative Review Committee report. I am not willing to implement the new metropolitan area structures until the substantive chief executives are in place. A number of changes have already been made to bring things together, particularly in the corporate and finance areas. If I were being appointed as chief executive of an area, I would want some say in the structure thereafter. As the minister has said, the department is working pretty speedily on country services and hopes to have that process in place and announced by the minister shortly. Overall, the department is moving reasonably well through this process. I could sit here for another three hours and explain the progress in each area, but my rough count is that the department has either implemented or is implementing about 22 out of 24 recommendations. The department is trying to move through the HARC recommendation process as quickly as it can. However, time moves on. Even since we met and received various submissions and so on, new things have had to be done, so not everything can be set in concrete. The department is trying to develop the philosophy behind it and implement the administrative structures and so on as quickly as possible.

Mr TRENORDEN: Could we be provided with documentation on what the minister believes has been done up to 30 May and the positions that are in place? I know it is an ongoing process and I make no criticism of that. However, I have some concerns. I have no idea what were the criteria for the executive director of country services. I hope that a country person or a person with country experience will be appointed to that position; however, I do not know if that formed part of the criteria for that position. I have an interest in what procedures the department had in place and what people were in place to the end of May. I agree that the minister cannot tell me what has not been done; that is fair enough.

Mr KUCERA: I do not have any problem with providing the information sought by the member. My understanding is that the member for Avon would essentially like a progress report on the implementation of the HARC recommendations to this stage.

Mr DAUBE: The department would be glad to supply that information.

Mr TRENORDEN: I would be a bit more enthusiastic if I knew what was happening.

Mr KUCERA: I think it was clearly stated in the advertisement for the director of country services. We can provide the member with copies of the advertisements for that position .

Mr DAUBE: I would be glad to make information on selection criteria and the selection panel available to the member.

Mr TRENORDEN: I would like to receive that information.

Mr DAUBE: It is very transparent. Clear criteria were included for knowledge and experience of country issues.

Mr KUCERA: I do not know who was on that panel.

Mr DAUBE: We do not normally talk about panels, but as the interviews have been held I will provide that information. Dr Lloyd chaired the panel. The other members where Heather D'Antoine, Manager of Indigenous Research at the Institute for Child Health Research; a country board chair, whose name escapes me at the moment; and the former Leader of the National Party, Hendy Cowan.

Mr KUCERA: I will provide to the member a progress report on the implementation of the HARC report to date, and information on the appointments or proposed appointments that are enumerated in the structure of the HARC report.

[*Supplementary Information No B56*]

Mr KUCERA: Would the member for Avon be happy if job descriptions were provided?

Mr TRENORDEN: Yes.

Mr BOARD: One area in which I feel the minister has dallied, or about which I could be critical, is the establishment of the clinical senate. A lot was said about the clinical input in this process. I would have thought that, notwithstanding the appointments that needed to be made, this area could have been progressed. This is the Government's second budget. The reason I make this point is that the Government has made some fairly specific allocations within its second budget, which means that while the clinical senate might look at what is

happening within the current hospital system, it will not play a role until the third budget, at least in budget deliberations. Was that the minister's intention? Why has the Government waited to start that process?

Mr KUCERA: From a ministerial and Government perspective, it was not out of choice. I remind the member for Murdoch that I went through a fairly torrid time last year in dealing with clinicians generally in the settlement of an enterprise bargaining agreement. The environment at that time was not always conducive to constructive dialogue with certain parts of the clinical areas that were to make up the clinical senate. I thought it important that a chief medical officer came on board who would be around for at least the next three to five years, because at the end of the day that person needs to be able to put together a group of clinicians who will lead the direction of health in this State not just for the next three or four years of this Government but also into the future. It was not a matter of dalliance, but of circumstances falling into place. There has been a great deal of discussion within the department and clinical circles about what should be the nature and direction of that senate.

Dr LLOYD: The senate has been a priority. As the member for Murdoch is aware, it will take over from the Western Australian Medical Council. There was a problem in undertaking full consultation with clinicians. Despite the department's enthusiasm to get this up and running, we felt that it would be inappropriate to just force it through without consultation in a form that suited us. Indeed, the department has been advised informally by many clinicians that cooperation would require input. I am pleased to say that in the last month we have been able to have a range of enthusiastic input. Members may recall that before the Metropolitan Health Service Board was disbanded, a clinical advisory committee was established. Many people felt that the senate should have a similar structure to that committee. The HARC did not intend the senate to be structured in a way that would make it a committee of review that would look across the system. It is reasonable to say that we have pretty well finalised the input to that committee through consultations. I am probably at a penultimate draft of that, which I will give to the director general for his and, hopefully, the minister's agreement. I anticipate that within a month we will call for nominations for that senate. I anticipate that in July we will have our first senate meeting about a couple of issues that have arisen pending the formation of the senate.

[12.40 pm]

Mr BOARD: Does the minister see the senate playing a critical role in some of the major issues in the devolution or sharing of services?

Mr KUCERA: Absolutely. I was a little brusque with the member for Alfred Cove earlier about the differences between hospitals. One of the key issues in this State is the delineation of our major tertiary hospitals. That is one of the principal reasons that the establishment of a senate is vital to any change or reform process. I do not want to answer on Dr Lloyd's behalf, but I suspect that he would agree with me in that regard. The senate will give some clear direction. Without clinicians taking part in the overall reform process, there can be no reform. Their input and role in any reform process is the key. The climate has not been particularly conducive for that in the past eight or nine months.

Mr DAUBE: I will link two issues. As the minister indicated, in the current climate we will get some very strong support for the clinical senate and we will have good senatorial discussion as opposed to people representing their interest too much. The other innovative recommendation that came out of the Health Administrative Review Committee, which we will be in a position to run with shortly, is that a health standards surveillance council called health watch be established. A lot of work has been done on that already, particularly with the strong support of Professor D'Arcy Holman, who has been invaluable in advising on this area. I am advised that the final draft and recommendations for health watch will be with me within two weeks. We should be in a position to announce that and have it up and running very quickly. It will not be resource heavy; it will be very small. However, it will have an important role in dealing with the population as a whole, as well as with vulnerable populations.

The CHAIRMAN: After the member for Murray-Wellington asks a further question, I will give the call to the member for Albany. Then I will ask members whether they have one-sentence questions that require one-sentence answers. After that we can come back to the longer questions and answers. I would like to get through a lot more questions.

Mr BRADSHAW: Item 7 of the HARC report relates to the complex nature of non-metropolitan country health services. It recommended that a review be carried out over a six-month period to develop the optimal approach to the administration and coordination of non-metropolitan boards and services. Has that review started? If so, who is on the review panel, when is the review expected to finish and why has it taken so long?

Mr KUCERA: I do not believe the program mapped out by the director general has taken too long. Major changes cannot be made within the system until the senior management team is in place. That is why I have been appointing boards -

Mr BRADSHAW: A review has nothing to do with putting senior management in place.

Mr KUCERA: The Government needs to give a clear direction about what the area health authorities will be. A process is in place and shortly I will announce what those country areas are. Once those country areas have been established, and the member would be aware that the review has already been advertised -

Mr BRADSHAW: Only about a week ago.

Mr KUCERA: That probably gives the member a clear indication of how close we are to announcing what those areas will be. The review will be about the administration of those areas and the continued involvement of the community in choosing the configuration of its services within those areas. The review is not about chopping the State into five, 10 or 12 pieces. Once those areas are locked in place - some fairly clear guidelines can be applied to that -

Mr BRADSHAW: How can that be done without a review?

Mr KUCERA: That part of it can be done without the review. The country areas of the State have been reviewed to death. Everyone knows what the affinities are. We will announce those areas in due course. I expect the review process to tell us clearly what should be the configuration of services in those areas. There has been one slight variation, which will affect the member's electorate; that is, both the Peel and Pinjarra campuses have been included in the southern corridor that links with Fremantle. Some of the reasons for that relate to the supply of services. By and large, that is the program. A process of consultation is under way already. In fact, Mrs O'Farrell has been carrying out that across the State, so I will defer to her to provide information about the process from here on in.

Mrs O'FARRELL: The country health review started in April and was widely advertised. We have a web site. We are well over halfway through a program of visiting major regional centres and smaller outlying towns. This is the interactive process of engagement in consultation. We intend to have the review completed by the end of July. The consultative process will be completed by the end of June. It is open to people to make submissions to the review until the end of June.

Mr BRADSHAW: Why does the department concentrate on regional centres, as does every other government agency? There are other towns in the country besides the regional centres.

Mr KUCERA: It is the nature of the supply of health services. I have talked at great length in the past 18 months about the hub and complementary hospitals, or the hub and spoke hospitals. It is just a fact of life that all the services cannot be put into one regional hospital. The reality is that most of the smaller hospitals across the State supply only about 40 per cent of the total health care needs of those communities. Oncology and cardiology services etc will never be provided outside of the big tertiary hospitals. Some of those services will be able to be delivered in Albany, Bunbury, Port Hedland and Geraldton, and to a lesser extent in Karratha and Broome. Depending on the size of the hospital, the supply of services can be expanded to suit that hospital. We will never get that level of service in Harvey, Yarloop, Mukinbudin or Dwellingup.

Mr BRADSHAW: The minister should be talking to those communities if he is doing a review of country health services.

Mr KUCERA: Exactly. That is what the review is about. There is an area to which we will supply a total package of health services. For example, there is a hub and spoke hospital both north and south of the city. We will ask those country communities what level of service needs to apply in their areas. There needs to be flexibility in that. People must realise that we will never be able to supply all health services to every one of those 651 different facilities in our State. I assure the member that the community will continue to have input in this process.

The other issue is that whatever the final structure, which has been the problem with bureaucracies since people arrived on the First Fleet, as soon as we establish those little boxes, someone comes along with a cement mixer and sets them in concrete. That will not happen with this. This whole process needs to evolve as our communities change. Chris O'Farrell could provide the member with specifics, but I think we have pretty well covered the matter.

[12.50 pm]

Mr BRADSHAW: The minister talks about consultation, but he sacked our health boards without consultation.

Mr KUCERA: I will not argue with the member. The member will find that we will have a much better health system. I applaud the coalition Government for starting that process. I think that John Day, as the previous Minister for Health, showed some vision in this regard. I will pat him on the back for that. It was the start of a process of change, which the member for Murray-Wellington has acknowledged in the Parliament needs to happen. We need to change. We cannot keep doing things in the same way.

Dr WOOLLARD: In relation to the restructuring process and the focus on nursing this year, will the minister be appointing someone to the position of chief nursing officer, and, if not, why not? Will there be equal representation of the nursing and medical profession on the senate and on any other health body?

Mr KUCERA: The director general will answer the first part of the question. The simple answer is that we will be appointing a chief nurse and that process is under way.

Mr DAUBE: If I can very briefly say that the consultation process in the country has entailed, and does entail, smaller as well as larger places. We are not just concentrating on the larger centres. In relation to the chief nursing officer position, as soon as we get the top tier in place we shall be moving into the other senior positions. The recommendation in the report of the Health Administrative Review Committee was that there be a chief nursing officer, and we will be proceeding with that appointment. In relation to the clinical senate, through the minister, I seek Dr Lloyd's response.

Dr LLOYD: The number of representational groups on the senate is not allocated in that way. For example, representatives are nominated by regions but with the recommendation that there be a mix of people to select from for appointment to the senate. There should be a mix of nurses, doctors, allied health and other clinicians, rather than just traditionally doctors and nurses. There will be community nursing representatives, specifically, and one other group of nurses, the name of which has slipped my mind for the moment. The actual count will depend on how they are nominated from the various groups.

Mrs MARTIN: I refer to the review of country services, which is a contentious issue, and the rationalisation of services to population centres. I refer specifically to the regional hospital in the Kimberley, which is located in Derby, which has a population of 4 000. I compare that with another centre just down the road with a population of 14 000. Will the review look at the logic of that, the service delivery aspects and the fact that 30 000 people in the Kimberley need a service that is accessible. When I have spoken to people in the Kimberley about the review, no matter where I was, they raised the matter of the Derby Regional Hospital being inaccessible; it is not serviced by domestic air transport. Will the review investigate those sorts of things?

Mr KUCERA: The review is looking more at the affinities between hospitals than necessarily determining what is a regional hospital. For instance, Port Hedland links in with a raft of the smaller hospitals; Karratha with a raft of different smaller hospitals etc; and Derby and Broome are the same. The review will take into account the kinds of affinities that need to be in place. I will pass that to Chris O'Farrell.

Mrs O'FARRELL: There is a service planning process in place in the Kimberley that will go into much greater depth than the current country services review, although the two processes will complement one another. Associated with the capital grant available for various Kimberley projects is this detailed and much deeper service planning exercise, which will have to inevitably address that issue. The review will come into contact with that process to ensure that they are complementary to one another and we will, probably through the review process, see a general direction expressed in relation to that.

Mrs MARTIN: Will that review examine bettering the good of the whole 30 000 people in the Kimberley rather than a small group? I hate to say this but we are dealing with realities: we live with them up there every day. I am sorry to have to push the minister on this issue.

Mr KUCERA: It is a good point and the review must deal with realities; it cannot deal only with philosophies. Individual hospitals and individual towns have different needs; however, this is about the supply of services. If, for instance, we have a full dialysis service at Broome, we must balance that with what we have at Fitzroy. Broome, for instance, may supply all of the dialysis services for the Kimberley, whereas Derby may supply the same general medical services but a different specialist service compared with Broome. That is essentially what we have been looking at. It is part of the review process and partly what must be figured out. If we were to decide that there should be a health service in the Kimberley, the review will take into account the services that must be supplied and the way in which those services would be best supplied by the people in Broome and Derby.

Mrs MARTIN: Will regional autonomy play a role in local decision making? By "local" I mean Kimberley decision making for Kimberley resources and services.

Mr KUCERA: It already does in the Kimberley because the Kimberley already has a model.

Mrs MARTIN: That is what I thought.

Mr KUCERA: If it ain't broke, don't fix it.

Mrs MARTIN: That service will therefore become overt.

Mr KUCERA: Exactly.

Mrs MARTIN: It has been there but it has never been stated.

Mr KUCERA: Yes.

Mr LOGAN: I refer to page 1205. Has the Government considered asking obstetricians who want to drop out of the profession, due to the current uncertainty surrounding indemnity insurance, to work on a salary basis in the public system for which their skills are desperately needed and their insurance costs would be met by the Government? There are doctors working in small hospitals in Denmark and Mt Barker who just cannot afford the indemnity insurance premiums.

Mr KUCERA: We would be delighted to have any doctor who wants to opt out of the private service in the public service on salary. Currently in many instances we subsidise country general practitioners and obstetricians who carry out obstetric services. From a ministerial perspective, I would be delighted to negotiate with any doctor who cannot operate in the private hospital system because of the liability issue. Liability, as was clearly stated in *The West Australian* this morning, is a national issue. The liability side of the issue must be kept to one side to allow a national solution to this problem. We will support country doctors wherever possible to keep them working. However, if they feel ultimately that they cannot practise in the private arena, we would be delighted to have them back in the public arena and we look forward to talking to them about that. I ask Dr Lloyd to comment on that.

Dr LLOYD: The point raised by the member is a good one. In each of the difficult areas in which I have been involved we have sat down and examined the best option for hospitals and the best option for individuals. Often when doctors come into the public service on either a sessional or salary basis their life becomes a lot better. For example, I believe a good case could be made for the Albany surgeons to have the opportunity to practise full-time or part-time in the public arena. That would be a good thing for them in many respects, including for their professional development and to give them links to enable them to perform surgery in the city or in another town. For instance, they could leave Albany and go to Esperance for a day to perform surgery in a salaried role. We are keen to look at those options, not just on the issue of insurance but also on the issues of continuity, being on call, quality of life and professional development.

[1.00 pm]

Mr BOARD: Indemnity insurance is not mentioned in the budget papers as a trend or a significant issue, and I thought it would have been. There is certainly no budget allocation for the State to play a role in this area. If the indemnity insurance issue did have a financial implication for the State, from what part of the budget would the money come?

Mr KUCERA: It is not quite correct that it is not mentioned in the budget papers. There is an allocation under general services for subsidies that are paid in country areas. I cannot give the specific line item. Secondly, any doctor who comes into the public hospital system is covered by Risk Cover. The allocations are in the normal costings for running a budget.

Mr BOARD: I am talking about the broader issue of indemnity insurance.

Mr KUCERA: The broader issue is one that we do not budget for, because all those doctors who are concerned about this matter at the moment are essentially private operators, and they carry their own insurance. That is why it is a national issue, and that is why it has been raised at the national level. The Prime Minister has acknowledged there needs to be major change. We will cross that bridge as we come to it. There is provision in the normal costings of the budget for our existing subsidy. Those costs are recognised. It is not an issue in the public hospital system in the city, for instance, because all our doctors are on salary.

Mr BOARD: It is an issue for the delivery of health in the State, because if we have a significant reduction in specialists in the private sector as a result of the indemnity insurance problem, it will have a significant effect on what the Department of Health can deliver.

Mr KUCERA: If I can give an example, we were able to bring a number of the midwives in this State under Risk Cover. Obviously we cannot bring in those midwives who choose to stay in private practice. However, we say to the women who use that service that there is an alternative service within the public hospital system that we invite them to use. We fund for that. No States are funding specifically for the private sector in medicine.

Mr BOARD: I suspect that within the next 12 months there will be a requirement of some kind to do that.

Mr KUCERA: It is not just this State. It is a national issue, and it is something the Prime Minister has taken up, almost as a personal crusade, it would seem, in the past couple of days.

Mr TRENORDEN: In the general area of assistance for public liability insurance, what was paid in the previous budget and what is allocated in this budget?

Mr CHUK: As a result of the great deal of focus on our Risk Cover insurance issues that the departmental staff have undertaken in the past few years, our Risk Cover premium will reduce in the coming year. That is due to a lot of effort to clean up the tail and a lot of the old claims from years gone by. It is a fair point. It is certainly an issue for us.

Mrs O'FARRELL: From a country perspective, we have for some time been providing assistance to procedural dental practitioners in the country. Last year our contribution towards that was marginally more than $400 000, in addition to approximately $100 000 in the form of a first-time one-off offer of some very modest financial assistance to rural specialist obstetricians. By my calculations, if we provide assistance again to general practitioners in the forthcoming financial year based on the same application formula, and taking into account the significant price hike in the premium, it would cost about $800 000. It would cost an additional $500 000 to provide the same sort of assistance again to specialist obstetricians this year. Moreover, if other specialist proceduralists such as country surgeons want to be part of the scheme it would cost an additional $500 000. The best way to look at this problem is in conjunction with the other problems that we are having with the stability, or lack thereof, of regionally based specialist services. We must consider whether we want to be exposed by putting those amounts of money into assisting practitioners meet their insurance costs or whether we should revisit how we engage our medical suppliers in the country. This raises the issue of whether we should look at the option of some practitioners moving to salaried or sessional arrangements and perhaps linking them with metropolitan bases in order that they have access to greater support systems for their professional and ongoing needs.

Mr TRENORDEN: I understand the problem but it is also a problem for the doctors; there is a great deal of uncertainty. The minister needs to give an indication to people of what will happen. I agree there has been a substantial increase in responsibility.

Mr KUCERA: We would make savings from other provisions in the system if more doctors moved to salaries.

Mr TRENORDEN: I ask the minister to not keep the "if" out there for too long.

Mr KUCERA: There is room for the federal Government and the State Government to play a role. I acknowledge that. We are playing our role with the subsidies we pay and those we are prepared to pay. If it affects country delivery of services, it will be of real concern to me. We offer the lifeline of discussing changes in the arrangements between hospitals, doctors and out services in the country. The Government is more than happy to do that. We must ensure that services are maintained. I give the certainty that current arrangements with country doctors will continue and that we are more than prepared to enter into discussions if doctors find the liability issue too onerous. We are more than happy to discuss changes in working arrangements.

Mr D'ORAZIO: We have spent more than two hours and 50 minutes -

The CHAIRMAN: Ask a question! I do not want to hear speeches. Give a page number and a program number.

Mr D'ORAZIO: I refer to the hospital bypass system. It is now seen politically as an inefficiency in the health system. The Public Accounts Committee has recently returned from New South Wales. In that State, the hospital bypass system is seen as a management tool. It was pointed out to the committee that some hospitals use the bypass system to manage resources, but not in a political sense; it is taken out of the political context. I suggest we look at using different terminology. Rather than call it bypass, we could call it an emergency management system. When the bypass system is applied to one of the State's teaching hospitals it is not always because the hospital is full. It is often due to the resources available and the requirement to share resources. It is very important that, as we have an integrated health system, the bypass system is removed from the political framework as it creates the impression that there is an endemic problem in the health system. It is a great management tool that should be used more often. The senior management should have a centralised point so that the overall management of emergencies is not done in a political system, as is the situation currently. First, is the minister considering that? Secondly, can we try, at least in the public forum, to get away from creating the impression that bypass is a political stunt? I make no reference to the member for Murdoch.

[1.10 pm]

Mr BOARD: Where was the member before the state election when we were in crisis because of bypass?

The CHAIRMAN: Order! I cannot begin to tell members how many hours I have chaired the Estimates Committees this week, and I am tired. Members should not push their luck. Will the minister please respond to the questions?

Mr D'ORAZIO: I have not quite finished yet.

The CHAIRMAN: The member has finished. Trust me.

Mr KUCERA: Bypass is a form of management of admissions to hospitals. It has grown and taken on a political context; there is no doubt about that. I would prefer that that was not the case, because it is a way of managing the flow of admissions to hospitals. There is a total program on dealing with emergency management generally. I refer to Dr Lloyd on that.

Dr LLOYD: As the committee is well aware, a task force has been reviewing emergency department issues and trying to figure out how to deal with the pressure. Wherever one goes in Australia, this issue is a problem. For some reason we took a little while to develop it. We got it in 2000. The working group released an interim report in December, I think, and that group's final report is being prepared just now. It will continue the theme of the original report; that is, that we must improve capacity and facilities in the structure of some of the emergency departments in places such as Sir Charles Gairdner Hospital and Rockingham. In addition, we need to even up the resourcing in our emergency departments so that staffing profiles are appropriate. We also need to change the way in which we manage our beds and have better bed capacity because, at the end of the day, bypass is a symptom of another problem. Bypass is a symptom of there being too many patients in the emergency department at a particular time and a need for the department to lower its workload. That can be because too many people arrive very quickly or because they cannot get through in an appropriate time. However, I agree with the member totally. It is about managing all those processes.

We have begun regular discussions with the ambulance officers to try to even up the workload so that Royal Perth Hospital does not, for example, get 15 cases an hour for two or three hours. A large amount of capital work is under way to improve the hospitals' structures. We are attempting to increase the retention of patients at secondary hospitals, so that they are not assessed in, say, Armadale and then sent to another hospital. When the final report is released, we will recommend that a project group work with the hospitals on both emergency services and bed management to continue improvements to allow greater bed capacity.

As to the short-term problem, the committee will be aware that 65 beds were authorised to be opened about a month ago, and a further 27 will be opened in the near future to relieve some of that capacity problem.

Mr BOARD: The Government has found the management system in bypass. It was a crisis before the state election.

The CHAIRMAN: Not a speech, member, a question.

Mr BOARD: It is amazing how people change when they go to the other side of the Chamber.

Mr KUCERA: We have noticed.

Mr BOARD: Exactly. The issue of bypass is critical. We are critical of the Department of Health because the incidence of bypass has increased. It is now a regular occurrence. According to the figures, there has been a 1 000 per cent increase in the use of bypass. That is symptomatic of the clog in the system. The funds in the budget for the emergency management system need to be spent very quickly. That situation must be worked through, because we are heading towards a crucial point.

Mr KUCERA: Bypass is symptomatic of the neglect in some of those hospitals. Sir Charles Gairdner Hospital is a classic example. We need to rebuild its emergency department. Rockingham-Kwinana District Hospital is a disgrace. It is probably the worst campus we have. We need to rebuild its emergency department. Royal Perth Hospital also needs a new emergency section. We recognise those things. We know the pressures we face. The upgrade of those departments is occurring, and money is in the budget for that. The tenders have been called. However, we cannot build them overnight. As Dr Lloyd said, we are starting to deal with a range of the short-term issues, and we will expand on that as time goes on. Money is in the budget for these things. This is a good-news budget. The emergency management system is one of the key priorities. We have three key priorities. Nurses affect the flowthrough of the hospital system. If there are no nurses to open beds, the system clogs up. The budget contains money for the emergency departments, and I will not go into that in great detail. We have the will to do this. The processes are in place; the whole system is in place. As we have said from day one, these are our priorities, and we will work towards them.

Mr TRENORDEN: Does the budget provide money to resolve the situation in which people coming into the emergency departments from country areas bounce across two or three hospitals? It is an issue for not only the patient but also the people trying to follow the patient. I heard of one recent case in which the patient was taken to three hospitals before he was admitted. There should be a system that allows the ambulance to communicate with someone about where it should go.

Mr KUCERA: I am not the emergency specialist, so I will pass that on to Dr Lloyd. My understanding of the emergency system is that the emergency departments in our small country hospitals are essentially triage centres that simply stabilise people. People cannot be stabilised unless a clinician is available -

Mr TRENORDEN: The minister has misunderstood me. Once patients have been to the triage centre and transferred to the city, they are rejected by metropolitan hospitals.

Mr KUCERA: None of our patients gets rejected. I would hate for the member to call our patients rejects.

Mr TRENORDEN: I will use the word "bypass".

Mr KUCERA: We should stick with the terminology we all understand. No person in our health system is rejected. I will refer that to Dr Lloyd. Everyone coming into the metropolitan system is subject to the same rules.

Dr LLOYD: I have not been confronted with that problem before. Clearly, we need to deal with that. I have taken the question on notice, and will deal with it. The severity of the condition of people arriving at hospitals varies. Someone with an urgent condition will be admitted regardless of whether the hospital is strictly on bypass -

Mr TRENORDEN: Not everyone who comes by ambulance is in a critical situation.

Dr LLOYD: A patient may be shifted under that circumstance. We need to, and will, tackle that as a direct problem.

Mr TRENORDEN: The adviser can understand that it causes great angst.

Dr LLOYD: Yes.

Mr D'ORAZIO: The member for Murdoch referred to the health system as being in crisis because of the bypass issue. I suggest that it is not about crisis but about managing the emergency departments. There is a helluva difference. Building a new emergency department might help the end product. We all seem to see bypass as a symptom of the problem. Bypass could be a positive. The New South Wales system has a central -

The CHAIRMAN: What is the member's question?

Mr D'ORAZIO: Will the department consider a process whereby the emergency departments integrate at one point? Under such a system, an ambulance coming from Timbuktu would be told that the resources at Royal Perth Hospital were stressed, and would instead go to Sir Charles Gairdner Hospital. Bypass is not about crisis but about using the best resources available. It can be positive, not negative.

[1.20 pm]

Mr KUCERA: The member is making a good point; it is the spin that is put on it. I defer that question to Dr Lloyd.

Dr LLOYD: We are actually doing that. At the moment we have people in the ambulance control room who are specifically there to coordinate the ambulances. We have put our EDIS system - emergency department information system; the computer triage system - in St John Ambulance and they can see on the screen how busy each of the departments is at a particular time. We have funded control people in the ambulance headquarters, we have put a screen in front of them showing exactly the status of each department, and the aim of those procedures and our negotiations to this stage has been to balance up the workload so that these problems do not occur. With long-haul ambulances we may need to begin some better coordination, so the country one is not sub-diverted. I am sure that can be built in once the problem has been identified, as it just has.

Mr KUCERA: We had 682 200 attendances at state-funded emergency departments last year. It would be pretty pointless having a queue of 15 ambulances sitting at Royal Perth Hospital if there was an empty emergency department down at Fremantle. I think that is the point the member for Ballajura is trying to make. It is a centralised program. I remind the member for Murdoch that this program was introduced by his Government; we are using it as a management tool. It is not about crisis; it is about managing our hospitals properly so that those 682 200 people get the level of treatment they deserve.

Mrs MARTIN: I refer to the fourth dot point on page 1232 under residential aged care services. Will the minister elaborate on the department's plan for aged care services in the Kimberley? The issue of long-term care and high-care beds really concerns the community.

Ms McKECHNIE: Currently there is a concentration of 50 high-care places located in Derby at the Numbala Nunga Nursing Home, which represents an inequitable distribution of high-care residential aged care places in the Kimberley. There is a need to redevelop that service so that by 2008 it meets commonwealth residential aged care standards; as a result, some extensive planning has been done for residential aged care in the Kimberley. The other issue concerning the provision of aged care services in the Kimberley is that there are no private providers of high-care aged residential care in the Kimberley, and to date that has meant that the State has had to invest in the provision of a state-funded nursing home for high-care patients. The plan for aged care

recognises that there needs to be a redistribution of the high-care places. The plan is that approximately 26 places will remain in Derby, 14 in Broome and 10 in Kununurra, and there is also provision for some other high-care places that have been sourced from the metropolitan area, which are likely to be located in Fitzroy Crossing and Halls Creek.

Mrs MARTIN: How many would that be?

Ms McKECHNIE: That is another six. The capital commitment associated with those redevelopments is incorporated into the Kimberley developments. Overall aged care planning in the Kimberley also is being considered in the total Kimberley service plan referred to earlier by Ms O'Farrell.

Mr BUCKLEY: Listed in the capital works program on page 1326 is $34.1 million for the Kimberley, of which $10 million is for aged care programs, as described by Ms McKechnie.

Mr KUCERA: This highlights one of our great difficulties at the moment with the division between the federal Government's views on aged care and those of the State Government. The federal Government took over the responsibility for aged care in this country a number of years ago, but since then the lack of capitalisation has been a real problem. Now the State Government must use its precious health dollars to pick up capitalisation of aged care facilities. Much is made of all the beds that have been created, but trying to capitalise them is another thing.

Mr BOARD: I refer to page 1230, under the heading "Timeliness". In the metropolitan area it takes only four days to carry out an aged care assessment. The time in the country has been 6.5 days, but the budget targets a blow-out of that figure to eight days next year, which seems to fly in the face of what the minister is trying to achieve with bed places. Why is this blow-out occurring?

Mr KUCERA: I would not call it a blow-out. It may be taking into account the reality of the availability of the assessment teams. I will defer that to Ms McKechnie.

Ms McKECHNIE: As the minister has indicated, assessing people for eligibility for aged care is the responsibility of aged care assessment teams. It requires an assessment not only of the individual, which may occur while that person is hospitalised, but also of the person's home and other support circumstances. Necessarily, in the country, that may require some degree of travel, both to access the services, and for family members and others to attend the interview. A range of conditions may result in that timing blowing out. There are also more older people in the community, so the workload of those assessment teams is increasing.

Mr KUCERA: The key issue here is that the budget remains the same. It is not as if anything is being cut back. Far more people now require assessment. It is difficult, particularly in remote communities, to get that interaction between the community and the assessors. We are faced with a reality. An aging population will cost more and become harder to service. That is part and parcel of getting that balance I spoke about before.

[1.30 pm]

Mr TRENORDEN: I would like some detail on that, because, living in a country area, that 20 per cent blow-out in assessment time makes me nervous. I agree it is only a statistic, but the matters being raised were no different yesterday from what they will be tomorrow. Even the numbers situation does not go vertically tomorrow to 20 days. I want to know why it goes from 6.5 days to eight days. I am happy for that to be provided as supplementary information.

Mr KUCERA: The actual country average waiting time for aged care was 6.5 days and it was budgeted for eight days. I am happy to provide details. We need to explain the reason for the increase and the expected increase of one and a half days. We need to get that into perspective in the assessment for country average waiting times for aged care.

[*Supplementary Information No B57*]

Mr BRADSHAW: I refer to stage 1205 and prevention and promotion. Country police officers cannot believe the minister's intention to decriminalise the use of marijuana. They know that it will lead to more widespread use and more health and social problems in country towns.

Mr KUCERA: I fail to see how that has any relevance to this item. We are not decriminalising the use of marijuana; it will remain illegal in this State. This Government is increasing the penalties. I would love to speak to those officers. The Community Drug Summit proposed that police officers retain the discretion to lay a criminal charge.

Mr BRADSHAW: They can impose a $100 fine.

Mr KUCERA: It is up to the court to set the fine.

The CHAIRMAN: We are dealing with page 1205 and the last dot point from a health perspective. I would like members to address themselves to that. If a legal question has arisen, it should have been dealt with in another division - not this division!

Mr KUCERA: I agree with the Chair. We have plenty of prevention programs. The use of cannabis will not be decriminalised in this State. Police officers will retain discretion to charge people with a criminal offence. It will be up to the court to decide whether a penalty is applied.

Mr BOARD: I refer to page 1203 and the total appropriations for purchase. The doctors' salary package process has not been transparent. The press releases were in line with the Government's general wages policy. Apparently adjustments were made to keep the salaries of members of the senior medical fraternity in line with those in the eastern States. We know that some increases are as much as 20 per cent. How much has the doctors' three-year salary package cost the State?

Mr KUCERA: Firstly, the enterprise bargain agreement sought parity of salaries between Western Australia and the eastern States. Much was made during negotiations of doctors suggesting they would leave this State and go elsewhere. That did not occur in most instances. Secondly, it was about equity and ensuring level adjustment across the whole clinical spectrum. Thirdly, it was about eliminating tax devices that were used by the previous Government to increase doctors' salaries. It was about getting things onto a level footing and drawing a line in the sand, as did all other States, regarding fringe benefits tax arrangements, and putting our doctors' salaries on a par with those of their eastern States counterparts, although perhaps not to the same extent as those in Sydney. Most importantly, it got rid of tax schemes and devices that this Government does not consider to be appropriate for increasing people's remuneration, particularly in the vital area of health. Doctors should not have to resort to that. They should be paid proper salaries within the hospital system.

Mr CHUK: It is a two-year agreement, which ends on 1 January 2004. In the first instance, as the minister indicated, the increase was a parity adjustment to ensure that we fared equally with other States in attracting and retaining medical practitioners so that our resources were not drained by the eastern States.

One of the complexities with the EBA was the transition from the FBT salary packaging arrangements - the amount in the salary and the benefit outside the salary - which greatly affected the consideration of parity. Through this process at least, we have moved beyond that somewhat complex and difficult tax arrangement to bolster clinicians' salaries to a point that their salaries compare favourably with those of their colleagues in other jurisdictions.

The up-front increase the practitioners received depended on the extent to which they took advantage of the salary packaging arrangements. It is fair to say that some doctors received a six per cent, up-front increase - I cannot recollect the figure the member used - and some may have received as much as 20 per cent; for example, a doctor who, for some reason or other, did not use the salary packaging arrangements. That most likely applied only to practitioners who had recently joined the public health system when the transition from this arrangement was public knowledge. In the past six to 12 months there was a very limited uptake of that arrangement as we changed to the new arrangements.

The member referred to the total cost over two years. The total additional cost of the agreement is slightly more than $80 million. Of that, around $20 million relates to the transition from the FBT arrangement. I think the figure previously used in media releases was an additional $60 million over two years.

Mr BOARD: Is that $80 million over the two years an additional amount?

Mr CHUK: In the order of 2 500 medical practitioners are in the public system. I am referring only to the additional cost spread over two years. I said it was an additional cost of $80 million. If the current arrangements had prevailed, we would have incurred between $20 million and $25 million of that in any case. The best description is that over the two years, the additional cost for medical practitioners is $30 million a year.

[1.40 pm]

Mr TRENORDEN: On page 1205 the third dot point of significant issues and trends relates to multipurpose services in the budget. I am aware that no multipurpose services were established last year. I presume that part of the reason is that capital was not available from the Commonwealth. Is that a correct assumption? What funding is in the budget for multipurpose services? How many more multipurpose service delivery sites will be established? Is the minister a fan of multipurpose services? I ask because I created them.

Mr KUCERA: If the member did create them, I pat him on the back. It is the one way in which we will keep country hospitals viable and have groups of towns realising that a synergy will be achieved by bringing facilities together. There must be a degree of understanding and cooperation between the small towns. As for the number established last year, I recall opening a number of facilities.

Mr TRENORDEN: I am not picking on the minister, but I understand that they were a flow over from the previous year.

Mr KUCERA: I do not know where they came from, but I do recall going to Katanning, Mt Barker and Goomalling.

Mr TRENORDEN: Goomalling was established only recently.

Mr KUCERA: That is right. I remember meeting the member for Moore there. There are some others down the track.

Mrs O'FARRELL: There is a strong future commitment to the multipurpose service program. A couple of issues have arisen over the past 12 months which have held up the progression of re-signing existing MPSs bringing new MPSs into the program. There has been a little concern about the exposure of the State to the capital costs of all the aged care infrastructure that we are inheriting. It is a relatively minor problem, which we think is quite manageable. The most significant issue that has been holding things up has not been entirely of the State's making. It has been to do with the making of a new form of agreement that has emanated from the Commonwealth. The Commonwealth has not been happy to sign up any existing MPSs or new MPSs onto the previous agreement. It has steadfastly held to getting this new agreement up and agreed between the State and the Commonwealth. That has now been done. Both the State and the commonwealth departments at official level, including appropriate legal advice, have worked through that process. That agreement is now with us and ready for sign off at our level. We anticipate with some enthusiasm signing up the MPSs that are to be renewed and also bringing our waiting MPSs on stream as quickly as possible.

Mr TRENORDEN: I am pleased to hear that. As the minister will be aware, I have been sweating on a few myself. They are excellent.

Mr KUCERA: I agree. I thank the member for Avon for his support. If the member could use his influence in some of the towns that still see a difficulty in coming together, I would be most grateful.

Mr TRENORDEN: I have lost some blood in a couple of those communities, Beverley being one.

Mr KUCERA: I was not going to mention any names.

Mr TRENORDEN: I am happy to, because it raises some important issues.

Mr KUCERA: It does. The days have gone when towns can go down that line without coming together to ensure they have the best supply of services. I hope the member will push it as hard as he can.

Mr TRENORDEN: I will be talking about Pingelly and Brookton.

Mr WATSON: I refer to the first dot point under Aboriginal health on page 1212 of the *Budget Statements*. Has the say no to smokes program been evaluated; and, if so, has it been successful?

Mr KUCERA: I will refer that question to the director general. He may wish to defer to Mr Xanthis from Aboriginal health, or to Mr Jackson or Mr Stephenson from public health.

Mr DAUBE: My enthusiasm in this area will come as no surprise. It is important to recognise that smoking is a significantly greater problem in indigenous communities than it is in the wider community and makes a huge contribution to the gap in life expectancy. I read Dr Alex Wodak's estimate a little while ago that tobacco, excessive alcohol and other drug use was responsible for about half of the gap in life expectancy. It is a serious problem. It is also one that is difficult to address. We are dealing with some severely disadvantaged communities and communities that are often hard to reach. The say no to smokes program is primarily a Healthway funded program to which the department makes a contribution. I ask Colin Xanthis to address the specific details.

Mr XANTHIS: The say no to smokes program is a new initiative that was signed and commenced this year. The outcomes will be reported next year. A recent report by Dr Rowena Ivers identified that 54 per cent of Aboriginal and Torres Strait Islander people smoke compared with 22 per cent of the general population. In some regional and remote communities, 83 per cent of Aboriginal and Torres Strait Islander men and 73 per cent of women smoke. This program will provide some new directions to address the rate and consequences of smoking in these communities, such as circulatory, stroke and respiratory disease. As the director general has indicated, this is a joint initiative. The department is working in conjunction with the Derbarl Yerrigan Health Service, Healthway and the Australian Council on Smoking and Health on this program. The outcomes will be reported next year.

Mr BOARD: I refer to page 1210 of the *Budget Statements*. The cost of Health Direct calls seems to be extraordinary. It cost $29 per call in 2000-01. It was obvious that the Government was trying to bring down that cost. However, it went the other way. It appears that the Government has capitulated and has targeted a cost of

$36 per call, which I find extraordinary. The minister has said that there is a greater range of indirect costs. What goes into that cost? A person could see a general practitioner for that amount. It is a lot of money per call. Is there any way to make it more cost effective?

[1.50 pm]

Mr KUCERA: I agree with the member for Murdoch. When I received the budget papers, this was one of the issues I raised with the director general. I am concerned about the increasing cost in that area. As late as yesterday we discussed the efficacy of this program. I remind the member for Murdoch that his Government locked the State into a contractual arrangement on this process. I am concerned about the costs. I have asked the director general to look at it and see whether there is a need to renew it. Health Direct is important to country people. None of us will argue about the efficacy of the system. Although I agree with the member and I am concerned about it, we are locked into a contractual arrangement. This week I raised the matter with the director general and he has assured me that we will examine the average cost and what is being done. I cannot say any more than that at this stage. An attempt has been made to keep costs down. When a telephone call is on a par with the cost of a visit to a general practitioner these days, the situation must be examined. However, when we consider the arrangements, we might find that we have no option but to continue the service. Medical services to the general public, particularly to country people, have been very well evaluated. The rising costs concern me as much as they concern the member for Murdoch. Last year Health Direct received about 180 000 queries. I do not know whether the member has heard me on a radio program in the evenings, but a lady who regularly rings me from Serpentine has used Health Direct rather than a GP because we cannot get GPs out to her suburb. I have asked the director general to consider the matter and come back to me with the costs.

Mr BOARD: One would think that more calls would create better efficiency in this area; however, it is going the other way.

Mr KUCERA: It is also because of the nature of the people Health Direct employs. It employs clinicians and nurses, whose pay has substantially increased this year. That is of concern to me and it must be taken into account. I will defer to Andrew Chuk in that regard.

Mr CHUK: There is an error on page 1210 of the *Budget Statements*. The estimated budget for 2002-03 at line item "Health Direct calls from public" reads $179 564. I believe that two figures have been transposed and it should read $197 564, which would bring it more into line with what we would expect. A note on page 1210 about the costing methodology shows that the reason for significant variation between the 2001-02 estimated budget and the 2002-03 target is largely driven by the inclusion of the indirect costs, capital user charges and superannuation depreciation. As the minister mentioned, we must look into that matter.

Mr KUCERA: There is no doubt that it is a high-cost service, which must be taken into consideration when considering the pressures on the health budget. However, as I say, we may be locked into that arrangement through a contractual agreement. I have asked the director general to consider that matter. I thank the member for mentioning that issue because it shows that we are both on the ball.

Mr D'ORAZIO: I refer to the purchase of outputs listed on page 1201 of the *Budget Statements*. The federal pharmaceutical benefits scheme has reduced some of the benefits available to general patients. Some of the newer drugs have not been made available through that scheme. Has the Department of Health quantified the cost of those extra benefits to the state system? Outpatients or patients who go thorough the emergency departments get the drugs for free through the state system and have far better access to drugs than they do on the PBS. One tablet to treat a high cholesterol level could either cost $200 under one system or be free under another. What else can public patients who are taken off the PBS list do other than get the drugs from the state public system? Has the minister quantified the cost to the State? The cost is being passed from the federal Government to the State Government. If the minister has quantified those costs, what are they? It will only get worse because the rules will change from 1 August and even more pharmaceutical costs will be transferred to the state system.

Mr KUCERA: I will address that in a number of ways. I will refer the matter of the cost to the State to Mr Chuk and Dr Lloyd. As the Minister for Health, I have some other concerns. My main concern is about the cost shifting. The latest survey, which was reported in *The West Australian* this week, indicates that one in five people in this country are likely to stop using long-term medicines because of the current increase in federal prescription charges. That is of real concern to me for two reasons: first, as the member rightly pointed out, those people will front up at public hospitals, as they are entitled to do, and take advantage of the schemes within those hospitals. Secondly, those people who traditionally take medicines will simply stop using the medicines, and they will get a lot sicker. I am concerned that within 12 months, the people who go to the emergency departments in hospitals will be far sicker than is currently the case. That will apply particularly in the outer country areas. It is an imposition on the State by the federal Government. My understanding is that we are

already examining some pilots in the pharmaceutical benefits scheme within public hospitals. Again, that is an extra cost borne by us. I will defer to Dr Lloyd and Mr Chuk.

Mr CHUK: The research done during the budget process indicated that pharmaceuticals are likely to increase by more than 10 per cent. It is the largest single line item in forecasted percentage increases. That is on a base of about $100 million. We are looking at an increase in pharmaceuticals of about $10 million in the coming year's budget.

Mr D'ORAZIO: If we add to that $10 million the $50 million for the doctors, it means $60 million is being added to the health system by the federal Government.

Mr KUCERA: Exactly. There will be no increase in service; it simply means that the service will cost more and will be under more pressure. The member raised a good point.

Dr LLOYD: No, we have not done that costing at this point, but we should. We will do so when some of our staff are freed up after this process. At the moment, there are competing demands for some of these technical analyses, some of which we cannot influence. It is true to say that in general, drugs are not given out routinely in the teaching hospitals to which people will front for a lot of these medicines. We try to get patients to go back to their general practitioners so that they are prescribed their medication under the normal commonwealth system.

Mr D'ORAZIO: As a practising pharmacist, this is an area with which I am very familiar. Some of the really expensive drugs, which cost up to $700 or $800, are not available on the PBS. Some doctors are telling their patients to go to public hospitals because they will get them for nothing. That is a real problem and it needs to be identified and costed. It puts a huge cost on us when that cost should be pushed back onto the federal Government, because it was the federal Government's decision not to put those medicines on the PBS that created the problem.

Dr LLOYD: The member has made a good point. About two or three months ago, we created an overarching committee. Most hospitals have a drug committee that determines what drugs are in its formulary, what the dispensing practices will be and so on. An element of competition has arisen from that. If a degree of lobbying in hospital A results in that hospital getting a cancer drug a bit earlier, there is pressure on the other hospitals to match it. We have created an overarching group of the top people to determine what should be the overall policy under which the hospital committees will act. We are hopeful that there will be some control of that within a unified system.

Mr BOARD: We think we get our heads around the whole issue of capital contribution and the capital user charge, but there are times when I find it very difficult. I refer to page 1203 and the dramatic decrease in the capital contribution for this coming year. The objective for 2002-03 indicates that $67 million has been parked in some sort of holding account, which I gather is a new account. Will the minister explain exactly what is that for, what is its intention and how does it work?

Mr KUCERA: I would be delighted to explain that. As I said at the outset, our capital contribution this year is made up of two streams: a holding account, as correctly pointed out by the member for Murdoch, and essentially the new contribution of $38.389 million. I would be delighted for Mr Kirkwood to further explain that.

The CHAIRMAN: I am sorry, but the time has expired.

Mr BOARD: Will the minister provide it as supplementary information?

The CHAIRMAN: I am sure the member for Murdoch is aware of the protocols of the committee and his ability to ask that question in another arena.

The appropriation was recommended.

Committee adjourned at 2.00 pm