Division 33: Health, $3 450 428 000 -

Mrs D.J. Guise, Chairman.

Mr J.A. McGinty, Minister for Health.

Dr N. Fong, Director General.

Dr J. De Campo, Chief Executive Officer, North Metropolitan Area Health Service.

Mrs L.C. Smith, Chief Executive Officer, South Metropolitan Area Health Service.

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

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

Dr P. Flett, Chief Executive, PathWest.

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

Dr P.A. Wynn Owen, Acting Executive Director, Office of Mental Health.

Mr C.P. Xanthis, Acting Executive Director, Health System Support.

Mr P.J. King, Acting Chief Finance Officer.

Mr M. Pervan, Director, Health Reform Implementation Taskforce.

Mr R. Keesing, Infrastructure Consultant, Health Reform Implementation Taskforce.

Ms S. Jones, Acting Director, Planning Technology.

Dr S. Bowen, Executive Director, Population Health and Ambulatory Care.

Dr A.G. Robertson, Divisional Director, Health Protection Group.

Mr T. Murphy, Acting Executive Director, Drug and Alcohol Office.

Professor P. Della, Chief Nursing Officer.

Dr D. Neesham, Director, Dental Services, Metropolitan Health Services.

Mr W. Salvage, Acting Director, Budget Strategy.

Ms S. Skevington, Acting Divisional Director, Safety and Quality.

Ms D. Mantell, Acting Director, Organisation Division.

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

The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated fund. This is the prime focus of the committee. While there is scope for members to examine many matters, questions need to be clearly related to a page number, item, program, or amount within the volumes. For example, members are free to pursue performance indicators that are included in the budget statements while there remains a clear link between the questions and the estimates. It is the intention of the Chairman to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point.

The minister may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. For the purpose of following up the provision of this information, I ask the minister to clearly indicate to the committee which supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the committee clerk by 9 June 2006, so that members may read it before the report and third reading stages. If the supplementary information cannot be provided within that time, written advice is required of the day by which the information will be made available. Details in relation to supplementary information have been provided to both members and advisers and accordingly I ask the minister to cooperate with those requirements.

I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office. Only supplementary information that the minister agrees to provide will be sought by 9 June 2006.

Dr K.D. HAMES: My first question relates to page 535, which is one of the capital works pages of the budget. Members also need to have open the "WA Health Clinical Services Framework 2005-2015", page 11D, which is the metropolitan clinical services framework. I want to cross-reference some of the budget items with plans put forward in the clinical services framework, because on this page there is outgoing funding up to 2014-15. Before I specifically get onto that I want to tie down this issue and get some clarification on beds. As members know, there has been some confusion about beds, multi-day beds, same-day beds and dialysis chairs, and I understand that a bed in an emergency department counts also as a same-day bed. I am particularly referring to Sir Charles Gairdner Hospital. I was discussing beds there. I note that under the clinical services framework there is a reference to 645 current beds but that that includes some public mental health beds, public restorative beds at Mercy Hospital, and 18 public palliative-care beds. I assume that the net figure, after reducing the additional beds from Sir Charles Gairdner Hospital, is 591 multi-day and same-day beds. When I ask staff at Sir Charles Gairdner Hospital how many beds are available on any one day, they say they have 630. I ask whether they are fully funded and staffed beds, and they say, no, they have only 590 fully funded and staffed beds. How does Sir Charles Gairdner Hospital get those extra 40 beds, how are they paid for and where is that money allocated in the budget?

[4.10 pm]

The CHAIRMAN: It may be easier if the member asks one question at a time and I will keep coming back to him.

Dr K.D. HAMES: I want to know how many additional beds, above the allocated beds, are funded from other sources at Royal Perth Hospital and Sir Charles Gairdner Hospital?

Mr J.A. McGINTY: The member for Dawesville is as bad as the member for Victoria Park was last night! I will ask the director general to answer the question.

Dr N. Fong: An available bed is immediately available to be used by the patient who is to be admitted. That is a commonwealth definition. The number of beds that are available go up and down on any given day and on any given week. In the clinical services framework, we have the bed capacity. It says in the budget papers that there are 645 beds, and in the clinical services framework it says that bed numbers indicate hospital capacity. It does not necessarily mean they are available, and "available" means funded. There may well be some closures in managing the demand that is required at the time and/or activity issues related to demand.

Dr K.D. HAMES: The director general's answer is opposite to the question I asked. He said they have 591 beds when the other beds are taken out, but not all of them may be available. That indicates the number of fully funded beds they have. I know that they have 591 beds. The Sir Charles Gairdner Hospital emergency department staff will say that on their list of available beds for any day they have 630 beds. That is 40 beds in excess of the fully funded beds of 590.

Dr N. Fong: I am not quite sure what the question is.

Dr K.D. HAMES: The question is: how are the extra beds that are not listed under fully funded and staffed beds funded? Is that the same situation at Royal Perth Hospital?

Dr N. Fong: We allocate money to the area health services and they manage their budgets according to demand. It fluctuates. Bed capacity does not necessarily mean that we have them funded.

Dr K.D. HAMES: If I get the drift, the other 40 beds at Charles Gairdner are available for use on any one day above its fully funding and staffed beds. The capacity to be able to do that is provided from funds from other sources that are part of general hospital funding. If that is the case and they have 40 extra beds that can be used at any one time, how many do Royal Perth have?

Dr J. De Campo: We are allocated money to look after patients and I do not count the beds each day. I never have. It is the patients who count. We look after patients, not beds. Whether one screen says 620 and another says 590 is irrelevant to the staff who manage the hospital. We are interested in looking after those people who come to the front door. In fact, we are even more interested in having the means to ensure that fewer people come through the front door. The focus on beds is not what hospitals are focused on. They are focused on keeping people well and, with the available funds, looking after them when they come into hospital. Our capacity and our available beds will vary from time to time during the year. For example, in winter we will have more beds open than in the middle of summer, and we will have fewer beds open during the school holidays. It is standard good management. The historical capacity figure may be a certain number, but it is not relevant week to week or day to day. It is matching capacity to demand day to day. We are more interested in reducing the length of stay in a hospital and using fewer beds and keeping patients well at home. The staff in the north metropolitan area are not, in an operational sense, driven by the bed number.

Dr K.D. HAMES: How many extras beds are currently available at, for example, Royal Perth?

Dr J. De Campo: Speaking for Sir Charles Gairdner, the number of beds is not the relevant issue.

Dr K.D. HAMES: With respect, it might not be relevant to Mr De Campo, but it is relevant to me, and I am asking the question.

Dr J. De Campo: The number of physical beds in the state will be higher than the number of beds that we are using. The number of beds that we are using is constrained primarily by the staff who are available in the state. The key issue in the number of beds that we may use in any one day is demand and available staff. The underlying issue for the state and the nation, in fact any First World country, is the staff, particularly nursing staff, who are available. That number is relatively fixed and is likely to be fixed for the next decade. Hence, a bed strategy that we are talking about is actually constrained not by funds, but by the number of staff who are available throughout the First World. This applies to not only Sir Charles Gairdner but also other hospitals across the nation.

Dr K.D. HAMES: Currently, the funds and the staff are available to maintain Sir Charles Gairdner at a bed capacity 40 greater than the listed number of beds in the clinical services framework.

Dr J. De Campo: I have funds to link demand.

Dr K.D. HAMES: Is that a yes?

Dr J. De Campo: No, I do not think it is a yes or a no. I am not funded for beds.

Dr K.D. HAMES: If someone is working today in the emergency department at Sir Charles Gairdner Hospital and he has a screen in front of him that says 630 beds are available today -

Dr J. De Campo: I do not know what screen he has.

Dr K.D. HAMES: If the person managing that department is working out how many beds are available in the hospital, he will be under pressure knowing that there are 630 available beds. This is like getting blood out of a stone. The available number of beds is 630. It is not a hard question and there is nothing deceitful in having that number. I know that it is the case and I want Mr De Campo to say that.

Dr J. De Campo: I do not know that that is the case but I will accept that it is the case.

Dr K.D. HAMES: I am interested to find out what extra beds are funded from other sources. The north metropolitan region is funded for a certain number of beds. The reason this is important is that we have been through the total availability of beds as outlined in the Reid review, the clinical services consultation and the clinical services framework. Those reviews went into great detail about the number of beds that are available in hospitals, where they are, where they are going and what amount of money is required to fund beds in hospitals in the future, such as the proposed Fiona Stanley hospital. It is based on bed numbers and, to some extent, that determines funding for hospitals. At the end of the day, there must be a reasonable expectation of the number of available beds in hospitals. We have been through documents that say there are 590 beds at Sir Charles Gairdner and 600-plus beds at Royal Perth Hospital. If that is not the number of available beds on any one day, I would be interested to know the number. Why are there different figures? It is not winter, so the government does not have a winter strategy in place. It has a certain number of beds. I think Dr Fong would like to answer this time.

[4.20 pm]

The CHAIRMAN: Minister, over to you. However, if the member for Dawesville does not get the answer he seeks, he might have to put his question on notice.

Dr N. Fong: I will try to answer the member's question by being more to the point. We know the bed capacity of all our hospitals. It is nice to know the bed capacity of our hospitals, because it means that if we get to extreme points at a given time of the year we can use those beds if we can staff them. However, we do not open all those beds, because we are trying to manage budgets; so there is a constraint in terms of funds. However, we are also trying to improve the length of stay - improve our care - for patients. Therefore, we try to set targets for our clinicians and hospitals to achieve national best practice in terms of benchmarking for how long a patient should be in hospital. We actually do not budget according to beds. We budget according to activity. Through our system we are achieving far more activity through having the same, or a lesser, number of beds from day to day than we have ever done before. That has been achieved as a result of our great staff managing patients out of hospital appropriately and more quickly. The member said that the screen shows that 630 beds are available at Sir Charles Gairdner Hospital. At any given time - the member is quite right - we might have 590 beds open and available, and funded.

Dr K.D. Hames: It is the other way around. It has 590 beds.

The CHAIRMAN: Member for Dawesville, this is not an opportunity for debate across the chamber. I ask the member to let Dr Fong finish.

Dr N. Fong: I do not quite understand what the member is getting at. If the member wants to ask a supplementary question, I would be happy to try to answer it.

The CHAIRMAN: The member for Dawesville can ask a further question, and I will then move on.

Dr K.D. HAMES: I will give it one more try. Sir Charles Gairdner has overall funding, but it is designated as having 590 beds. When we are working out the total number of beds available in the metropolitan area, we look at how many there are at Fremantle Hospital. Dr Fong may say that there are 590 beds. However, when I talk to the staff at the hospital, they say it is not 590; it is 630. They say there are currently 40 extra beds that are funded from elsewhere; that is, from within the total north west metropolitan budget, or within the total hospital budget. Therefore, that hospital is currently funding extra beds within its own capacity. It is good that it can do that. However, that gives that hospital a distorted view of how many beds are available in total, because if that is the practice at that hospital, I suspect the same thing happens at other hospitals.

Dr N. Fong: We do not allocate money to our area health services on a bed number basis. Hospitals do not receive funding on the basis of the number of beds they have. Hospitals are funded to deal with activity. The money that is there for the extra 40 beds - as perceived by the member for Dawesville - is being used to prevent people from having to go to hospital and use those beds so that we do not have to open those beds. That is what we do. The ambulatory care strategies are using money in the overall global allocation to deal with demand, but in a different way; that is, before the patients actually hit the hospitals beds.

Dr K.D. HAMES: They are open and they are being used.

The CHAIRMAN: I will move on. Member for Wagin.

Mr T.K. WALDRON: I refer to page 532. The first dot point under "Healthy Workforce", which is listed under "Significant Issues and Trends", refers to maximising the number of health professionals available to the Western Australian health system with an appropriate distribution of skills between the metropolitan, regional, rural and remote areas. How does the government intend to do this? What sorts of incentives are being offered to attract health professionals? What initiatives will the department use to keep health professionals in rural and regional areas, because, as the minister would be aware, that is a big issue?

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

Mrs C. O'Farrell: I will start with the planning of health services and the appropriate service delivery structures. As the member would be aware, we had a look at that in 2002, and we subsequently embarked on a program of reform of regional health services based on developing a well-networked regional service delivery system. There has been a significant departure from running a large number of hospitals that operate in isolation from, and compete against each other for, health workers. In each of our seven regions we have a networked and dynamic system of service delivery. For the hospital system, that involves a delineation of the role of each hospital so that its role and function, and the level and range of its services, is prescribed. More importantly, the hospital's linkages with other hospitals in the region, and with hospitals that support services from the metropolitan area, is also prescribed. That gives us a fairly rational framework of service delivery in which to then develop a work force plan. Within that, we have subsequently done some reviews of various service areas. For example, we have looked at mental health, aged care, acute and emergency services, and specialist services. Therefore, we have a very well developed specialist services plan that we are in the process of implementing. That resulted in our investing in a significant number of medical specialists and new medical positions in our key hospitals, particularly those that provide procedural services. We have had a very active program of encouraging new graduate allied health staff into our country service domain. We have had remarkable success with that. We have made some progress in reducing the reliance on agency nurses in many hospitals, although obviously from time to time we still need to resort to agency nurses to cover our rosters. However, we have significantly changed the profile of use through some of our work in developing nursing services. We have introduced allied health therapists and therapy assistants, who are supported by the allied health work force. We are well progressed in developing our nurse practitioner strategy. We have a range of strategies.

Mr T.K. WALDRON: How is the nurse practitioner strategy progressing? I am very interested in that area. I know that some nurse practitioners were appointed recently. I have acknowledged that point in the Parliament. Are more nurse practitioners due to come on board?

Mrs C. O'Farrell: We have done a lot of work in the area of nurse practitioners, and we are making progress. The remote area nurses were immediately rolled into the nurse practitioner model on a grandfather clause basis. We have gone through the process of designating a large number of sites. Twenty-three sites have been designated, and another 10 are coming on-stream. We are looking at another 33 possible designations to

introduce nurse practitioners, and the services they provide, into some of the emergency departments in our hospitals. We will be bringing people on-stream into those roles as they come through the training programs. A number of scholarships have been introduced. In the next year or two we anticipate seeing some bodies in jobs and services expanded through that strategy. We have a number of fairly significant work force strategies. One strategy that is very important is structuring the remuneration arrangements with our large number of visiting medical practitioners in the country, whom we largely rely on to supply medical services to our hospitals, both large and small. We have been through another successful round of doing that. As part of our review of the WA Country Health Service framework, which is called "Foundations for Country Health Services", we have commenced a process of getting out to every region and talking to every country doctor, including those doctors in the metropolitan area who are typically the specialists who visit the country. We are starting to pick up some ideas and some thoughts.

[4.30 pm]

Mr T.K. WALDRON: Is that remuneration in some of the centres I am talking about?

Mrs C. O'Farrell: It is certainly not all about remuneration. That is an issue that we have had to get on top of and become comfortable with. Now we are getting into the value issues about the work force and medical services for the future, I think we will pick up a lot of intelligence out of that process.

Mr P.B. WATSON: Are you getting much opposition from the AMA on the nurse practitioners?

Dr N. Fong: The state-based AMA has not voiced opposition to nurse practitioners publicly. The national president of the AMA came out very strongly criticising the push for more nurse practitioners. We want to work collaboratively with the AMA. We understand it wants to maintain standards and quality and all the rest of it, as well as address issues of territory. We have had some very useful informal discussions with the AMA about, for example, medical assistants, and the role of training these people. Given the qualifications of these people, they could assist primary health care practitioners such as GPs, for example. We are looking forward to collaborating rather than fighting over issues about demarcation over various health care workers. There is no greater issue facing health systems in developed countries around the world than a health work force. We need to have different approaches because it is not just about getting more of the same. There are not enough resources or bodies in terms of doctors and/or nurses. We need more doctors and nurses but we need people who will do different jobs assisting people in their particular professions. One of the key planks of our health reform program is designing new jobs and new ways of providing health care in the community using a collaborative approach.

Mr P.B. WATSON: Minister, why is there such a gap in community transitional services between metropolitan and rural areas, and, in particular, in rural areas with fewer other supportive options? Historically, why has there been no growth in nursing in home and community care programs and what funding is in the budget to alleviate the pressure on getting post-acute clients back into the community?

The CHAIRMAN: I think I heard a few questions there. What page are you referring to?

Mr P.B. WATSON: I am mainly concerned about the level of nursing in the community transitional services through HACC programs in regional areas. I can give a couple of instances. There is no transitional care. I am referring to the first dot point under the major initiatives listed on page 571. I can list some of the programs that do not exist. There is no transitional care for patients transferring from hospitals to the community. Funding is available in the metropolitan area for home care or placements but not in the country. There is no funding for hospitals for home care or post-acute services for rural areas, although programs are available in metropolitan areas. Also, there is no choice of providers for rural services, be they capped services or HACC funding, and I refer specifically to nursing in Albany.

Dr S.C.B. Towler: I am responsible for the aged care directorate. I would like to make a few global comments firstly about the forward commitment in the budget for the HACC program. As the member will see in the budget papers, another 8.6 per cent increase in HACC funding has been committed in the forward estimates and the budget for this year.

Mr P.B. WATSON: Is that statewide or just in the metropolitan area?

Dr S.C.B. Towler: That is a statewide figure. The questions the member raised are fundamentally key issues for us and relate to how we deliver some of these more detailed services. There is a commitment around creating capability in the sector to meet the needs of transitional care. HACC funding has been a major initiative in ensuring growth in this sector. There are technical difficulties in the rural sector in creating opportunities of a substantial nature. There is a commitment through the program to make the funding available. I am not aware of specific details concerning the site that the member raised. I am happy to come back with additional

information if the member requires it. There is a very clear commitment to grow the services that underpin better support for this group of patients in the community and the resources being made available through the matched funding arrangements with the commonwealth government.

Mr P.B. WATSON: We have five "bed blockers" in Albany at the moment who cannot be offered a home service. They are holding up beds at the Albany Regional Hospital because there is no facility to get them into their homes. Albany has a very ageing community. It has the regional hub hospital but it does not have this service to provide for the seniors.

Mr J.A. McGINTY: I am not familiar with those five people that the member is referring to so I cannot answer that question.

The CHAIRMAN: The member may want to take that up at another time.

Dr K.D. HAMES: I have a supplementary question on HACC funding. I notice the actual budget for this year was $11 million less than budgeted for. I am referring to page 570 of the *Budget Statements*. In the 2005-06 budget, the net cost of service was $57 346 000. The estimated actual is $11 million less than that. The budget has gone up by $1.5 million but it is actually less. I wrote to the minister two weeks ago about the Mandurah home and community care program, which does a great job. It has not overspent its budget. It has received fewer donations from people getting the service and the service has been provided to more people. It was short $12 000 a month. It has had to reduce some of the services it provides to elderly disabled people. I am raising that money through Rotary and donations so it can keep up that level of service. It is a shame that the minister's letter came back saying that the government could not provide extra funding when home and community care services are $11 million under budget.

Mr J.A. McGINTY: As the member can see on page 570 of the budget papers, the discrepancy arises because of the far higher than budgeted commonwealth contribution to the HACC scheme. The second line under income shows that we budgeted for $83 million in 2005-06. We received $94 million, which is substantially income from the commonwealth. That substantially accounts for the unexpected delivery of -

Dr K.D. HAMES: That makes it even worse. The government received an extra $11 million from the commonwealth, yet it spent $11 million less than it budgeted for. It was going to spend $57 million and get $83 million but it got $11 million more than that and spent $11 million less. That means there is $22 million less in the state government coffers.

Mr J.A. McGINTY: I ask the member to look at the first line relating to the total cost of service, which is what was budgeted. We budgeted to spend $141 million and we estimated that we spent $141 million on HACC services. It does not make it worse. What was received was income above that.

Dr K.D. HAMES: Where is the $140 million?

Mr J.A. McGINTY: On the top line.

Dr K.D. HAMES: I had the wrong page.

Mr J.A. McGINTY: In answer to the general questions raised by the members for Albany and Dawesville, we are aware of the tremendous growth in demand for HACC services, particularly in the south west, if I can call Albany part of that area.

Mr P.B. WATSON: No, the minister cannot; it is the great southern.

[4.40 pm]

Mr J.A. McGINTY: I will refer to it as the south west extending over the boundary of Albany as well. We have seen a tremendous growth in demand for HACC services in a whole range of areas, including the member's area of Mandurah. Again, that was unanticipated. This is the only area that has been brought specifically to my attention. I do not know whether the same is true in the wheatbelt or other parts of the state. I am aware of the situation generally in the south west and parts of the great southern. It is something we will need to look at, because if the example given by the member for Albany of five people occupying expensive beds in hospital because there are no home care packages for them is correct, that would cause me enormous concern, because it is not a good allocation of resources. We will need to look at it, because of the growth in demand.

Dr K.D. HAMES: I understand the budget figures now. The government budgeted for $141 million and spent $141 million. The government got an extra $11 million from the commonwealth, which means the state had to contribute $11 million less to spend the same amount of money.

Mr J.A. McGINTY: There is a funding formula, and I presume this is the case, but I will double check in answer to the question -

Dr K.D. HAMES: It would be nice to help Mandurah. That is the point I am trying to make.

Mr J.A. McGINTY: The HACC program is jointly funded, as the member is aware. Roughly two-thirds comes from the commonwealth, and one-third comes from the state. In fact, 60.69 per cent comes from the Australian government, and 39.31 per cent comes from the state government. Therefore, I do not think the formula would have worked out as the member just indicated. However, assuming those proportions have been maintained -

Dr K.D. HAMES: The state contributed less at the end of the day.

Mr J.A. McGINTY: We contribute our one-third and the commonwealth contributes its two-thirds. That is the normal arrangement. I will investigate whether that is the case in respect of the increased revenue from the commonwealth.

Dr K.D. HAMES: It does not matter. We need to do what the government has already committed to do.

Dr S.C. THOMAS: I refer to the two dot points under "Health Corporate Network" at page 540. The first dot point states that during 2005-06 the transfer of staff to the HCN was substantially completed. Can the minister indicate the total number of staff transferred, and the areas they have come from? I particularly want to know how many have come from the country health services. The dot point states also that the formation of the HCN will result in a reduction of 178 FTEs from corporate support areas. Were any of those 178 FTEs part of the functional review implementation team process that took place during 2005-06? Can the minister give a breakdown of those figures?

Mr J.A. McGINTY: The member's question really relates to those transferred primarily from the country.

Dr S.C. THOMAS: Yes; the metropolitan figures were given previously.

Mr J.A. McGINTY: A total of 102.6 FTEs were transferred from country WA, at a value of $6.1 million. The majority of affected country staff either have elected or will elect not to transfer to the city, but their positions have been transferred. It is anticipated that the transfer of these functions will result in approximately 70 redeployees, initially within the WA Country Health Service. The remainder of the 102.6 FTEs will have transferred to Perth or been immediately absorbed at the time of their functional transfer due to fixed-term contract usage and immediate redeployment.

Dr S.C. THOMAS: Are the 102 FTEs separate from the 70 redeployees?

Mr J.A. McGINTY: We expect that of the 102 positions transferred from the country, there will be 70 redeployees. These are people who will not want to accept that offer to move to the city. It is further anticipated that redeployment within the WA Country Health Service and to other government agencies will result in a residual 30 redeployees by 30 June 2007. In other words, in 12 months we expect that number to have come down to 30. The net effect in the 2006-07 financial year is estimated to be an average of 45 full-year FTEs at a cost of approximately $3 million. That is with the redeployees.

Dr S.C. THOMAS: What does the minister expect will be the total number of FTEs and the budget of the Health Corporate Network when this process is completed?

Mr J.A. McGINTY: The total number of FTEs employed in the Health Corporate Network is 608. That is 178 FTEs fewer than were performing those corporate functions in the individual hospitals. The saving on those 178 FTEs is approximately $12 million in 2008-09 terms, which is in line with government expectations.

Mr P.B. WATSON: Minister, is it true that some staff who have been redeployed have dropped back to 70 per cent of their original salary?

Mr J.A. McGINTY: To the best of my advice, nobody drops back. They are transferred at level as part of the redeployment process. We do not expect anyone will drop back and receive only a percentage of their original salary.

Mr P.B. WATSON: I have information from one of my constituents that he could be offered a job under the redeployment that is 70 per cent of his current salary.

Mr J.A. McGINTY: That does not sound right to me, but if the member has a particular case that he wants us to take up, we are happy to do so. As I have indicated, the transfer as part of the redeployment process is at the level the person was on.

Mr P.B. WATSON: He wants to stay in Albany, naturally, and all the other people who have been transferred also want to stay in Albany. He can take a job only in Albany, because his family is there. However, if he is not

redeployed to Perth and transfers to another government department, he could drop down to 70 per cent of his wage. I have been told that is happening, but I cannot understand how that could happen.

Mr J.A. McGINTY: The only way that could happen is if a schoolteacher applied for a job as a cleaner, to give a hypothetical example, because a cleaner's salary is less than that of a teacher. Whether something like that is involved, I am not sure. People transfer across at level.

Mr P.B. WATSON: I will get the information to the minister.

Mrs C.A. MARTIN: I refer to the capital works program. One of the items listed under "Western Australia Country Health Service" at page 582 is the continuation of stage 1 of the redevelopment of Broome Hospital. Can the minister give an update on the progress of stage 1 of that redevelopment, and what resources will be affected, considering that it will become the regional resource centre?

Mr J.A. McGINTY: In recent times health care in the Kimberley has been a tremendous good news story: a new hospital in Halls Creek, which I will be opening in the next month; -

Mrs C.A. MARTIN: That was my next question!

Mr J.A. McGINTY: - a new hospital in Fitzroy Crossing; -

Mrs C.A. MARTIN: That was my third question!

[4.50 pm]

Mr J.A. McGINTY: I am coming to that - and new aged care facilities in Kununurra; expanded facilities in Derby with the new acute ward; and the upgrading of Broome to become a regional resource centre. I will ask Chris O'Farrell to provide some detail about exactly where the Broome redevelopment is up to. The health reform program for people living in the country has one major element. That element is the establishment of regional resource centres so that in each of the regions that contain the six major regional cities - in the case of the Kimberley, that is Broome - there will be significant upgrading of not only the physical infrastructure but also the nature of services offered at each of those centres. That will enable many more people to be treated in their own region rather than have to be transferred to Perth.

Broome has been chosen as the regional resource centre for the Kimberley for fairly obvious reasons. A new hospital will be built at Port Hedland; its construction is currently under way. A new hospital has just been built in Geraldton and is now complete, and upgrades are being made to the Bunbury, Albany and Kalgoorlie Regional Hospitals as part of the regional resource centre program. They will be the hub of activity in each of the regions. Many more people will be able to be treated in country Western Australia than has traditionally been the case. The Broome regional resource centre stage 1 redevelopment is the redevelopment of the existing hospital to address the urgent needs associated with the move to the regional resource centre. It includes a specialist centre, new theatres, a central sterilising department, and additional acute inpatient beds. The tender will be let in August 2006 and construction will start in October 2006 and be completed in March 2009, which indicates the extent of the program. In total, $42 million is to be spent on the Broome hospital. The expenditure is as follows: $10 million in 2006-07, $11 million in 2007-08, $15 million in 2008-09, and it will then tail off to nearly $5 million in 2009-10. Hopefully we will see a boost to health services in Broome and therefore the whole of the Kimberley. The major risk we run is the need to attract more specialist staff to work in Broome. Hopefully Broome is such an attractive place that that will not be a problem.

Mrs C.A. MARTIN: I appreciate that each hospital in my region is either being replaced or fully refurbished. The shortfalls have been met by the department when requested, which is great, and the advisory councils work very well. The minister is aware that Halls Creek is not in my electorate. However, when will the hospital at Halls Creek be opened? The minister celebrated the closure of the last one that operated for seven years. When will the opening of the new Halls Creek facility be celebrated?

Mr J.A. McGINTY: A range of issues have been raised about Halls Creek. The need for dramatically improved health care facilities in the form of a brand-new hospital was recognised some years ago. Construction of the facility is complete and it will be opened some time in the next month. I can give the member the exact date of when I will travel to Halls Creek. Hopefully, the member for Kimberley will be able to join us, because although it is not in her electorate now, I suspect that by the end of next year it will be because of the one vote, one value redistribution of the electoral boundaries. The opening of the new facility will be cause for celebration in Halls Creek.

Mrs C.A. MARTIN: I will not ask questions for 20 minutes, unlike other members, but I would like to ask a couple of other questions.

The CHAIRMAN: On the same line?

Mrs C.A. MARTIN: Yes. I wonder about the progress of the Derby Regional Hospital. I understand that a new general ward is being built, which is something we have been waiting for since 1995, when the old one was pulled down by the previous government, as were other general wards until this government got in. Will the minister inform me of the progress of the new general ward and the new dental clinic?

Dr K.D. HAMES: That is a different question.

Mrs C.A. MARTIN: It is the same region. We will not have a waffling match. I am actually interested in the answer to the question.

Mr J.A. McGINTY: The new ward facilities in Derby, which will be quite a significant addition to the Derby Regional Hospital, are currently under construction. I do not have a precise completion date for that construction. I was there with the member for Kimberley. It will be a significant addition to the hospital and it will increase the number of beds that will service the people in the west Kimberley region.

Mr T.K. WALDRON: I am interested in the six major regional cities. Although I applaud the minister for what he is doing, what about Katanning, Narrogin and Merredin in the interior? Is the minister applying the same attitude towards them? It is a long way from Kalgoorlie to Perth or from Albany to Perth or from Bunbury to Kalgoorlie. The facility at Narrogin is a good facility and I notice that in the out years it might be completed. Will the same philosophy be applied to Katanning, Narrogin and Merredin as is being applied to the northern part of the state, so that they have the facilities to service the regions?

Mr J.A. McGINTY: Merredin has not achieved the status of a regional resource centre. Only those six major regional cities were designated for the significant multimillion dollar upgrades to their facilities. The government will spend $9 million on the Merredin District Hospital. The existing resources and facilities will be developed to enable the hospital to undertake a more significant subreferral role in the eastern wheatbelt, and some expenditure will go towards satellite multipurpose services as the business case proceeds. The cash flow for planning in the current budget is $100 000, after which expenditure will be ramped up significantly to peak in 2008-09 at $4.5 million, followed by $3.9 million in 2009-10. That is out of a total budget of $9 million for Merredin. Work on the Narrogin Regional Hospital is in the pipeline but has not yet been finalised. The precise scope of that work has not yet been determined, but the hospital has been identified as being in need of some upgrading. None of this equates with the regional resource centres that we propose for the six major regional cities.

Mr T.K. WALDRON: Although the centres I have mentioned are not as big as the six identified regional resource centres, they fulfil a similar role and therefore need attention. I welcome the development of the Merredin District Hospital and also the completion of the work on the Narrogin Regional Hospital.

Dr G.G. JACOBS: I refer to the second paragraph on page 532. I will follow-up the member for Dawesville's question about bed numbers in Sir Charles Gairdner hospital. I bring to the minister's attention the North Metropolitan Area Health Service. I am informed that the North Metropolitan Area Health Service ran an operating deficit in 2005-06. How much was that deficit?

Mr J.A. McGINTY: It was zero dollars. Whoever gave the member that information gave him a bum steer.

Dr K.D. HAMES: I refer to the capital works program on page 535. The metropolitan framework shows that the Fiona Stanley hospital will be provided with 11 mental health beds this year, 610 beds in the year 2010-11 and 1 058 beds by 2015-16. Presumably that will be when it is fully opened. The budget provides an allocation of $741 million in total. I am pleased to say that if we win the next election, $173 million of that will be spent in this government's term and $565 million will be spent in our term of government. The point is that we were given figures that it would cost about $1 million per bed for a new greenfields site for a tertiary hospital. The budget lists the majority of the money up to 2011-12, which covers the first stage of the hospital up to 610 beds. Where is the funding for the increase from 610 beds to 1 058 beds? That is more than a 400-bed increase, yet the forward estimates of the budget show funding only to 2014. If another 400 beds are to be added by 2015, it will have to be funded in the same way it has been for the years 2012-14. Where is the money for the 1 000 new beds, and why is there not enough money to cover the 1 000 extra beds?

[5.00 pm]

Mr J.A. McGINTY: To put it very simply, the budget takes in the forward estimates for the next four years. However, we have departed from that in health because of the longer term investment in implementing the health reform process. The member for Dawesville will notice that page 534 shows the indicative time frames for the capital investment in health. It is not a specific budget commitment outside the four years, but it is an indication to show people the totality of the program involved. The simple reason that we have not made provision for items in 10 years' time is that it is outside what can reasonably be included in budget papers.

Dr K.D. HAMES: What does the $741 million buy? It refers to 610 beds.

Mr J.A. McGINTY: Yes, 610 beds at the new Fiona Stanley hospital. The intention was always to develop this hospital in two stages. There is an express commitment of funding in the budget papers for stage 1. Stage 2 will be funded when we come to it.

Dr K.D. HAMES: Will the 610 beds be multi-day or same-day beds? Does that figure include a dialysis chair and so on? I do not know why I am asking that; I already know the answer.

Mr J.A. McGINTY: Yes.

Dr K.D. HAMES: On the same line as the hospital funding - I guess the question is redundant in a sense -

Mrs C.A. MARTIN: Why ask it then?

Dr K.D. HAMES: Because I would like to. The member for Kimberley is very picky today; she should relax. We observe the Westminster tradition for question time; namely, it is usually for opposition members.

The CHAIRMAN: Excuse me, the discussion should be through the Chair, not with each other. Members on my left should ask questions of government members across the chamber from them.

Dr K.D. HAMES: The Rockingham budget is funded up front. That will be almost completed by the time of the next election. The budget also refers to an increase in the number of beds at Rockingham from 239 to 306. The point is, large amounts of money will be required above the $3.5 billion that has been budgeted for, and which the minister continues to talk about. In effect, it will be much more than that, because although $3.5 billion is listed in the budget, I think I am correct in saying that it will not cover the construction of Fiona Stanley hospital or the upgrade of Rockingham-Kwinana District Hospital.

Mr J.A. McGINTY: In the next decade, beyond the time we are talking about here, there will, of course, be ongoing commitments of a capital nature. The implementation of our health reform plans involves a massive injection of funds. Last year we spent a little over $100 million on health capital works in Western Australia. I can get the exact figure. The member for Dawesville can see from page 536 that $3.7 billion has been allocated for capital works over the period leading up to 2014.

Dr K.D. HAMES: It will be more than that, will it not?

Mr J.A. McGINTY: Yes, sure, once we get beyond that.

Dr K.D. HAMES: Prior to that, the government will have to provide more money in the budget to fund the extra 600 beds at the new Fiona Stanley hospital and the 600 beds at Rockingham, will it not?

Mr J.A. McGINTY: Most probably. That is a long way ahead. All we have sought to do here is indicate how we will spend the $3.7 billion in the years immediately ahead. The South Australian health minister has been in Perth for the past two days. He has gone back to South Australia green with envy at the fact that we have such an ambitious health reform plan and have the money to spend on the capital works involved, courtesy of our booming economy. The stage of this political cycle, and the leadership of all the people here today, is a once-in-a-lifetime opportunity in which that amount of money can be spent on health care. It is phenomenal, and it should not be underestimated. We have sought to provide an indication of the situation through to 2014. Obviously, ongoing commitments to further programs will be made by that time, but they are so far ahead at this stage that it was not worth including them here, even as an indication.

Dr K.D. HAMES: They are within the clinical services framework and the time frame the minister has provided, but they are not funded in the time frame the minister has given.

Mr J.A. McGINTY: The forward figure is an indication of the nature of the works that will occur beyond the four years ahead. As the member knows, we do not budget more than four years ahead.

Dr K.D. HAMES: It would be good if those figures were included in the indicative stage. It would involve even more money. It would be good to know what the total amount will be. It will be $5 billion or $6 billion by the time those other costs are added.

Mr J.A. McGINTY: Sure, by the time the whole program is completed.

Dr K.D. HAMES: In the time frame the minister has shown; not beyond that.

Mr J.A. McGINTY: Yes. I cannot add anything further.

Mr M.P. WHITELY: I refer to the item headed "Child, Community and Primary Health Care" under "Major Achievements For 2005-06" on page 560. The first dot point refers to a new schedule of contacts for child health screening. Can someone elaborate on what the screening incorporates; what is being screened for and how the new schedule is different from the previous schedule?

Dr N. Fong: The community child health universal screen and surveillance program is being developed. All the area health services are now implementing the schedule. It is a universal screening service that has been part of community nurses' work for many years. Obviously, its object is to identify and detect long-term problems early in children. The community child health nurses do it. They obviously form relationships with the families and help promote the wellbeing of the kids. As I said, the new schedule that is being developed is made up of a personal health record. That is similar to what has been used in the past, but it has been totally revamped. It used to be a little yellow book; it is now a much better book that is distributed with each baby. It will provide a good, longitudinal record of all the contacts with the child health nurse, the screening, and any surveillance for particular issues. Part of the overhaul of the child universal contact schedule has been to provide more training for child health nurses so that they are better educated in the detection of the various issues, clinical skill updates and that type of thing. We hope we can continue to refine it as we detect at an earlier stage the issues in young children.

Mr M.P. WHITELY: What is the screening for? Is it to detect problems with eyesight or hearing, or are we talking about mental health screening?

Dr N. Fong: It is to detect the standard issues of organic problems such as those to which the member referred. Scoliosis is one, although that would be detected later on. It will target at an earlier stage issues of eyesight, hearing and that type of thing. I am not aware that mental health screening is a particular component of the new schedule.

Mr M.P. WHITELY: My personal preference is that it not be part of it.

Mr G. Palmer: It covers the area of speech and social development. It is a comprehensive screening.

Dr N. Fong: But not mental health.

Mr M.P. WHITELY: What ages would the screening target?

Dr N. Fong: From birth to school age.

Mr M.P. WHITELY: Is it universal?

Dr N. Fong: Yes.

[5.10 pm]

Mr M.P. WHITELY: Could I have details of how the past system compares with the changes, by way of supplementary information?

Dr N. Fong: We could make that available. I can answer that qualitatively. I think the member was asking for the booklet, which we could make available to him.

Mr M.P. WHITELY: It refers to a new schedule. How does the current schedule compare with the old one?

Mr J.A. McGINTY: We will undertake to provide the member with a copy of that booklet, not as supplementary information.

Mr T.K. WALDRON: The fourth dot point on page 537 under "Clinical Service Reform Initiatives" refers to the move to address chronic diseases such as diabetes, heart failure and chronic respiratory diseases. I congratulate the department for that, particularly for establishing the eight chronic disease management teams to lessen the burden on hospitals, and I am aware that there will be another three next year. Once again, these are proposed only for the metropolitan area. Why can we not establish a couple of these teams in rural and regional areas? Are there any plans to expand that program beyond the metropolitan area?

Mr J.A. McGINTY: The chronic disease management teams have been, I think, in their relatively short life, tremendously successful. Given the discussion we have just had about the capital works in health, I hope that when we all look back in five or 10 years at the health system, there will be two big things that we will be able to say were dramatic changes from what was the situation at the turn of the century. They will be the distribution of the hospitals, all of the capital works going into the new Fiona Stanley hospital, the new children's hospital, the new Midland hospital, the major resources centres in the country and things of that nature. The second will be the tremendous emphasis away from hospitals as the way in which people are treated to more ambulatory care in the community. The chronic disease management teams are very much part of that - keeping people healthy in the community. We are making a very big investment as a means of shifting resources away from hospital-based care. I think we are too hospital-centric in the way in which we approach health care. We could speak for however long the member wants us to on the question of the chronic disease management teams and the ambulatory care approach, Hospital in the Home - all of those sorts of initiatives - but I will not take up the committee's time unless the member wants -

Mr T.K. WALDRON: I agree with you and I support that. I want to know why this cannot be extended to the country, and will it be?

Mr J.A. McGINTY: We have started in the city because the most pressing problems in this regard are in the city, because it is of great benefit to not only the patient, but also the system by stopping people from occupying an acute hospital bed by treating them in the community. That way the pressure on beds is relieved and the pressure on emergency departments is relieved, and so there is the biggest bang for your buck for the system and the patient by starting it in the city. It is our intention to then extend this concept to regional areas. The member for Albany raised the question of why there is no Hospital in the Home in Albany. I intend to extend this approach to country areas. Obviously, when there are population centres it is easy to do. Earlier this year the director general and I went to Europe to look at models of care and what was the current state of thinking on these sorts of issues in Europe. We came across a hospital in Paris that had a thousand beds, but there were no walls, because the beds were in people's homes. The staff went from this notional hospital to offer the same care in a person's home as the person would receive in a hospital setting. It is cheaper, it is more efficient for people who have home support and it is better for the patient. Many things will be seen as the second area of change, apart from the reconfiguration of the hospitals, in community-based care, which we have done something of in the past but expect that to boom in the years ahead and hopefully extend to the country.

Mr T.K. WALDRON: And not just in those strategic cities around the edge.

Mr J.A. McGINTY: Again, it is a product of population as to where the benefits are realised.

Mr T.K. WALDRON: I understand the pressure on the city hospitals and why this will start in the city. However, the pressure on city hospitals still comes from country areas.

Mr J.A. McGINTY: Yes, exactly. We have started doing this already in the country in respect of mental health. Therefore, there is no reason why it cannot be extended to the other chronic diseases, because mental health is a chronic disease.

Mr P.B. WATSON: I refer to the sixth dot point on page 550. We have a real issue in Albany with a gynaecologist obstetrician. The money has been put aside but we have a fly in, fly out doctor. He is telling the community that he cannot get enough space in the hospital. What is the situation there? Is he making unreasonable demands?

Mr J.A. McGINTY: This has been a contentious issue in Albany for some time. Funding was made available to employ a salaried obstetrician gynaecologist at the hospital. My understanding is that we were not able to fill that or a person accepted and then declined. I will ask Ms O'Farrell to provide some detailed answers about the Albany hospital.

Mrs C. O'Farrell: Albany is a regional resource centre and its obstetrics and gynaecology is a core speciality service that we aim to have in every one of our regional resource centres and we have not had one in Albany for some years. It is becoming important that we establish a position in that centre and we have designated funds for a salaried position. It has been difficult to fill the position, but we have somebody in the pipeline at the moment. There is a visiting gynaecology specialty service to Albany and I believe that is the centre of the little bit of controversy at the moment. We have a requirement for a small amount of additional gynaecology services and we are very prepared to sit down and negotiate that. An alternative proposition has been put to us that we ditch the commitment to a specialist obstetrician gynaecologist and expand the visiting gynaecology service and leave obstetric services to the GPs. We get a very good obstetric service from the GPs in Albany, but as a regional resource centre, I do not think there is any argument to support not having a specialist obstetrician in the town of Albany and for the broader region. We remain committed to that. We would be prepared to provide some additional access to operating lists to clear some backlog on the gynaecology waiting list, and even beyond getting a salaried obstetrician in place, we would not be averse to having some additional visiting gynaecology services. However, the service that we would want to commit to would be based on service requirements rather than the aspirations of an individual clinician.

Mr P.B. WATSON: I agree that there are tremendous doctors in Albany. However, I think the women of Albany with whom I have spoken want someone there all the time. I think the doctors would also like to have someone there, even though there are people to deliver the babies at the moment. However, instead of having to fly someone who is having a difficult birth to Perth, they would love to have a resident person at the hospital. If there is someone in the pipeline, that is great.

Mr J.A. McGINTY: I assure the member that our priority is to have a resident specialist obstetrician gynaecologist employed on a salary basis at the Albany hospital. That is what we are aiming at. We have had difficulties in recruitment, but I am heartened as well to hear that there is a strong likelihood of a successful

application emerging in the not too distant future. I know that is what the people of Albany want. The member for Albany has raised that with me on several occasions. If we advertise and do not get a qualified applicant, all we can do is advertise again. However, it sounds very promising and I hope that something will come through on that in the not too distant future.

[5.20 pm]

Dr S.C. THOMAS: I come back to King Edward Memorial Hospital for Women. What is the minister's understanding about the number of beds that could be made available on the King Edward Memorial Hospital site? It is the opposition's understanding that 1 200 beds could be made available on that site. Can the minister either confirm that or advise what the position will be? Is it the government's intention to relocate either Princess Margaret Hospital for Children or King Edward Memorial Hospital - or both - to that site in the future; and, if so, what impact will that have on the number of beds that will be available on that site?

Mr J.A. McGINTY: It is our intention under our health reform plan that King Edward Memorial Hospital will cease to function on its current site and that it will be rebuilt on the Sir Charles Gairdner Hospital site. To the best of my knowledge, unless someone in the health department has done something that I am not aware of - I do not think that will be the case - no exercise has ever been undertaken to ascertain how many beds could be made available on the existing site.

Dr S.C. THOMAS: Can the minister check?

Mr J.A. McGINTY: I am referring to the King Edward site.

Dr S.C. THOMAS: I was asking about the Sir Charles Gairdner site.

Mr J.A. McGINTY: Our intention is to vacate the King Edward site. The member's question was about how many beds could be made available on the King Edward site.

Dr S.C. THOMAS: No, on the Sir Charles Gairdner Hospital site.

Mr J.A. McGINTY: Sorry; the member must have transposed the hospitals in his question.

Dr S.C. THOMAS: Possibly, but I will ask a further question.

Mr J.A. McGINTY: I assure members that the intention and the plan is to vacate the King Edward site and to move the obstetrics and gynaecology services from King Edward to the Sir Charles Gairdner Hospital site.

Dr S.C. THOMAS: Does the minister have any figures on the number of beds that could be made available on the Sir Charles Gairdner Hospital site?

Mr J.A. McGINTY: Yes. That work has been done. In fact, two things have been done. The "WA Health Clinical Services Framework 2005-2015" refers to redeveloping the Sir Charles Gairdner Hospital site, and I will get the precise number of beds for the member.

Dr S.C. THOMAS: As supplementary information, or does the minister have the information now?

Mr J.A. McGINTY: I will provide it now.

Dr K.D. HAMES: It is 1 200.

Mr J.A. McGINTY: It is in that order. That is the ballpark figure. The member may have the exact figure at his fingertips. The one part of all the health reform recommendations to which we tentatively said no at the beginning was the relocation of Princess Margaret Hospital. Following the clinical services framework, we said that Princess Margaret Hospital needs to be rebuilt. Its building fabric has reached its use-by date. The initial view was that it should go to the North Block at Royal Perth Hospital, which is a relatively new piece of infrastructure. The Australian Medical Association, and others, including the clinicians at PMH, said that they would like the government to revisit that one recommendation, but they were happy with everything else, subject to arguing the finer detail, of course. We have undertaken to do that. Some site master planning work has been done at Sir Charles Gairdner Hospital. However, it has not been completed. Therefore, I am not in a position to provide members with the outcome of that now. I expect that within the next two months that work will be completed. We have given an undertaking to the AMA and the doctors at PMH that we would approach this with an open mind to ascertain whether it is possible to co-locate both the women's and the children's hospitals on the Sir Charles Gairdner Hospital site. I am reluctant to call them King Edward and Princess Margaret. As I understand it, King Edward was a womanising philanderer. Therefore, it is a most inappropriate name for a maternity hospital - or maybe it is an appropriate name; I do not know. Princess Margaret was an alcoholic chain smoker, which is, again, not a very good example to name a children's hospital after.

Dr K.D. HAMES: Fiona Stanley would prefer that the paediatric hospital, rather than the proposed hospital, be named after her.

Mr J.A. McGINTY: She could well do. I will not call the two hospitals I referred to by their names, because it might be time to move on from those names.

Our intention will be to give attention over the next few months - the work has been progressing for some time now - to whether to co-locate the women's and children's hospitals on the Sir Charles Gairdner Hospital site. I think that would meet the desires of the doctors employed at those two hospitals. King Edward is going there anyway. It is a question of whether PMH joins it. There is an obvious synergy with the neonatal units at the two hospitals. We should be in a position to resolve that within the next couple of months. That would lock in the last piece of the jigsaw, and hopefully we will then have complete support throughout the entire medical and health community for the health reform plan that we will be putting in place. I hope that support will also come from the opposition. The health plan will then be taken away from the day-to-day opportunities that politics present and we will be able to say that both sides of politics are committed to this plan because everyone in the system wants that plan to be implemented.

Dr K.D. HAMES: As the minister knows from the document I gave him, our preferred option is to have King Edward and PMH located on the same site. The issue that concerns me is that only 1 200 beds are available on the site. The proposed combined number of beds for King Edward and PMH is just under 500. The government's proposal states that for PMH there will be 256 beds and for King Edward, 229. With that number of beds on a site that will take only 1 200, it leaves, in effect, only a further 700 beds that can be made available on that site. The government's proposal is for Sir Charles Gairdner to go to 1 000 beds to cater for the closure of Royal Perth. If that happens, the emergency department at Sir Charles Gairdner will have to cater for about 80 000 patients a year. To cope with that demand, it will require more beds than it has at present, as the minister knows. How will the government deal with those conflicting figures?

Mr J.A. McGINTY: An inevitable consequence of altering the plans for the women's and children's hospitals to be rebuilt on the Sir Charles Gairdner Hospital site will be that fewer general beds will be available. That is an issue that we need to work through. The option that presents itself is that the King Edward Hospital caters for about 5 000 births a year. It is regarded necessary to have that number of births to maintain a viable teaching facility and to provide the level of expertise to deal with the more difficult births. In the past 12 months there has been an increase in the number of births in Western Australia. I do not know whether that is attributable to financial incentives that have been offered by the federal government.

Dr K.D. HAMES: It did not affect me!

Mr J.A. McGINTY: However, it is happening, and that is the important point. We do not know whether people having more babies is a short-term peak or a long-term trend. We need to look at the nature of the maternity services that we will be providing in addition to the King Edward Memorial Hospital, wherever that will be relocated. We will be looking at offering women greater choice. Within the next few months we will be putting out the maternity services plan, which will outline the way in which we hope to be able to achieve that outcome. Some women in the member for Capel's electorate have spoken to me in recent months about the need for a birthing centre at Busselton. We will consider alternatives to the straight obstetrics model. The issues under consideration include whether we can have more diverse facilities so that King Edward does not need to expand and the obstetrics section can be taken up by the general hospitals.

More importantly, everyone takes their kids to PMH if they are running a temperature at night. Perhaps there will be greater capacity, with the upgrading of the general hospitals, and certainly with the proposed Fiona Stanley hospital coming on stream, to have a greater paediatric presence outside the major children's hospital to allow that hospital to cater for the more acute cases. All of those variables are constantly being remodelled to find the best way to deliver services and to determine their impact - this has been mentioned by the member for Dawesville - on the emergency department at Sir Charles Gairdner Hospital. How big will it have to be in those circumstances? We are constantly considering all those issues. We do not have an answer as yet.

[5.30 pm]

Dr K.D. HAMES: Keep Royal Perth Hospital open - that is the answer.

Mr J.A. McGINTY: No, it is not. This is the key element: if everybody signs up to a certain plan - and that plan includes the closure of Royal Perth Hospital - I hope that the Liberal Party comes on board and places the implementation of that plan above politics. I think the member for Dawesville will find that that is what people in health care want to see as well.

I will add one last thing: the other option that has been put to us by a range of people is to bring forward the completion of the Fiona Stanley hospital and to have more beds at that hospital and at Joondalup Health Campus to compensate for a reduction in general beds at Sir Charles Gairdner Hospital should that occur. The modelling extends beyond the Sir Charles Gairdner Hospital campus site. Sir Charles Gairdner Hospital is constrained by the fact that it is located in the middle of a residential area. It is not the best site for a hospital simply because of its location. The Fiona Stanley site is on South Street, and it is also on the freeway and the railway line. It will be central to the area that it serves. Nonetheless, Sir Charles Gairdner Hospital is located where it is and it is a great institution. It has close proximity to the university, and in some senses that compensates for its less than ideal location. These are all matters that the government is considering at the moment and, hopefully, we will be able to come up with something in the next few months that enjoys broad community support.

Mrs C.A. MARTIN: The second dot point under "Major Initiatives For 2006-07" on page 559 of the *Budget Statements* states that planning for support services has been initiated for Aboriginal patients when they arrive in Perth. Will the minister provide a rundown of what that program is about? Does it include interpretative services?

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

Mrs C. O'Farrell: Initially the service was a 12-month pilot program. It came about as a result of the transport review and was an attempt to improve our capacity to look after north western Aboriginal patients who come to Perth and to ensure that they are met when they arrive, that they get to their intended destination and that they are given assistance. We will be continuing that program. I am sorry, but I did not catch the last question.

Mrs C.A. MARTIN: Does that program include interpretative services?

Mrs C. O'Farrell: Yes, if they are needed.

Dr K.D. HAMES: I will refer back to my previous question relating to the Sir Charles Gairdner site. I will particularly refer to - I do not have a relevant page number in the *Budget Statements* - to the maternity section at Osborne Park Hospital. The minister referred to a maternity services review. I presume that is referred to on a page in the *Budget Statements*.

The CHAIRMAN: The standard procedure is that members must state a line item and page number from the *Budget Statements* when they ask questions. That was clearly broadcast at the beginning of this division. I am sure that what the member for Dawesville has referred to is in the *Budget Statements.* The member for Dawesville must be more resourceful.

Dr K.D. HAMES: I refer to pages 581 and 584 of the *Budget Statements*. Will the minister indicate when the King Edward Memorial Hospital for Women will be closed, because that timetable is not in the budget? The minister has noted in the clinical services framework that the beds at that hospital are listed as 276 and that that number will decrease to 229 in 2010 and then to 212. The minister is going to close the maternity section at Osborne Park Hospital even though there were up to 1 500 deliveries at that hospital last year.

Mr J.A. McGINTY: That is the figure I have seen.

Dr K.D. HAMES: Someone told me that there were 1 700 deliveries at that hospital last year. I do not know whether anyone here can confirm that figure. Births at that hospital are increasing. I used to deliver babies at that hospital. It is a remodelled and redeveloped old unit that has been turned into a magnificent facility, and yet the minister is going to close that service. There were 1 500 deliveries at that facility last year. It is used by people who come from Stirling, Dianella, Yokine and that general area. The people who would normally use that facility will have to go somewhere else. They will have to travel all the way to Swan District Hospital. I live in the area; it takes a long time to get to Swan District Hospital, particularly for a woman in labour. The other alternative is to travel to Joondalup. The same thing applies, however, as it is a half an hour's drive. People will tend to use King Edward Memorial Hospital for Women. A significant number of people who would normally use Osborne Park Hospital will have to use a private facility. Indeed, some will use Glengarry Hospital.

The CHAIRMAN: Member, what is your question?

Dr K.D. HAMES: My question is: what is the minister going to do about King Edward Memorial Hospital for Women? Is keeping the Osborne Park Hospital maternity section open an option?

Mr J.A. McGINTY: No. Both the Reid report and the earlier report prepared by Dr Harry Cohen stated that there needed to be a rationalisation of the number of hospitals offering obstetric services in the metropolitan area.

Dr K.D. HAMES: He referred to 1 100 or 1 500-plus births.

Mr J.A. McGINTY: It was a significant number of births a year. We have already implemented the shift of obstetric services at Kalamunda District Community Hospital to Swan District Hospital, which is at the bottom of the hill. The benefit of that is that we now have 24-hour, seven-day-a-week coverage of salaried obstetric staff at Swan District Hospital, which is something that Kalamunda never enjoyed. Obviously the new Midland hospital - it will be completed in 2010-11 - will have a new maternity facility. When the new maternity services plan is released, it might refer to a family birthing centre not unlike the one at King Edward hospital or other alternative services that might be available in that region.

Dr K.D. HAMES: It is asking a lot to spread those 1 500 births elsewhere.

Mr J.A. McGINTY: There were only 300 at Kalamunda. That change has been effected.

Dr K.D. HAMES: I am talking about Osborne Park Hospital.

Mr J.A. McGINTY: I am outlining the big picture. I will come back to the member's issue. Woodside Maternity Hospital was also earmarked for closure. We have moved Woodside Maternity Hospital to a significantly better and more modern facility. The feedback that we are getting from the women who are using it is fantastic. It was an interesting attachment to a heritage building, but its services were not up to the standard of what people expect these days. The future of the maternity services at Kaleeya Hospital is something that we will need to deal with some years down the track, especially in the context of the new maternity services plan. What has been recommended, but has not been done, is to cease the obstetric function at Osborne Park Hospital and Bentley Hospital. We do not want to increase the number of births at King Edward Memorial Hospital for Women beyond the 5 000 births that take place at that hospital each year. That means that there would be more births at Swan District Hospital, Joondalup Health Campus and Fiona Stanley hospital, even though it is five years away.

Dr K.D. HAMES: The many people who live in the northern suburbs will have to travel a long way to access obstetric services. Realistically, they will have nowhere else to go other than King Edward.

Mr J.A. McGINTY: The advice that we received from part of the clinical services framework and the Reid and Cohen reports has earmarked those two hospitals to cease obstetrics. Osborne Park Hospital is perfectly located - it has the facilities - to become a major surgery centre to attack the elective surgery waiting list. It is a question of making tough decisions to change the nature of the services provided. Provided that they are made on a rational basis and that other better services are available, that is what we will continue to do.

Dr K.D. HAMES: I am happy that extra surgery will be done there. That is good. It is a perfect hospital to do that because it does not have an emergency department. However, the government does not need to remove the obstetrics unit to do that.

Mr J.A. McGINTY: We have a plan. We have properly and rigorously assessed the demand issues, the availability of a medical work force and all of those sorts of issues. We intend to stick to our plan. Do not expect the government to depart from its plan, with the exception of Princess Margaret Hospital for Children - for which we have both indicated our support - which will revert back to the original Reid recommendation, which was that women's and children's services should be co-located on the Sir Charles Gairdner Hospital site. With the exception of that, we do not intend to revisit the model. We will stick to it, otherwise we will come under political pressure every second day of the week with people saying, "Oh, let's keep doing this here, and let's depart from it here", and then the whole plan will dissolve. That is the history of the way health planning has taken place in the state. We will not go down that path.

[5.40 pm]

The CHAIRMAN: I ask members to keep their questions and answers to the point, otherwise we will not get through the list.

Dr G.G. JACOBS: I refer to the key effectiveness indicators on page 543 of the budget papers. Paragraph (c) refers to the proportion of patients discharged home after they have been admitted for hospital treatment. It states this is an indirect measure of the extent to which people have been restored to health after an acute illness. However, because it says that people are discharged home over time, this key performance indicator is meaningless. Rather than indicate that a certain number of people are discharged home - because in a First World country we would, hopefully, expect someone who goes into hospital to go home; the only alternative is that they leave in a box - a better key performance indicator of how well our health system is doing would be to talk about people being restored to health in a time frame of, say, three days, a week, two weeks or a month. It is meaningless to indicate just the number of people restored to health "over time" and use that as a measure of how well the health system and the hospitals are doing in delivering health. The government should not fill our heads with gobbledegook. I do not want to see that in the budget papers next year. As a practising doctor, that is

just meaningless gobbledegook. The budget documents should either say something else or leave it out. Can I get an indication from the minister that there will be no gobbledegook in this document next year? It should be taken out. If we want a real measure of the effectiveness of the health system, we should talk about how well we restore people to health in a time frame - not just say "over time".

Mr J.A. McGINTY: I agree with the member. It was an attempt to develop new performance indicators. This one has certainly fallen well short of having any meaning. We will certainly review it to make sure that the member will not be troubled by it next year.

Mr M.P. WHITELY: The first item listed under "Major Achievements For 2005-06" is "Child, Community and Primary Health Care". The second and third dot points under this item on page 561 relate to children's health services. The third dot point states that a memorandum of understanding has been signed between the Department of Health and the Department of Education and Training for the delivery of school health services. What will those services provide, and how will they work? I would like some detail on those two dot points.

Mr J.A. McGINTY: The school health service is generally staffed by a school health nurse. In addition, other people sometimes form part of the team. That might include other allied health professionals to provide health services to schools. The backbone of the service is the school health nurse.

Mr M.P. WHITELY: What are they doing? In my previous question, I asked about screening. What is their role in identifying problems with children? What is the point of having the service? What will be different as result of that MOU?

Mr J.A. McGINTY: The memorandum of understanding ensures that the health department will establish a school health service headed up by nurses. That health service can include checking on the health status of students at the school. For instance, one of the issues that has been raised in recent days is how to deal with obesity. It has been proposed that a measurement be taken at both the entry to and the exit from primary school - we are told this system operates in Britain - to advise parents if there is a problem with obesity. I think members are broadly familiar with the work that is done by school health staff. They will play an increasing role in health promotion matters in the years ahead. That will be critically important. We are all aware of chronic diseases that affect an enormous proportion of the population. The one public health issue that will swamp our capacity to handle it is how to deal with people who are overweight or obese. The member for Dawesville and I have had a disagreement on this issue. I think we need to be doing more and more, and anything and everything possible, to tackle the issue of children who are overweight or obese. There is a role there for the school health nurse and other allied health professionals who might be part of that team undertaking that work.

Mr M.P. WHITELY: The second dot point on page 561 states that additional therapists have been allocated to child development services. What types of therapists are those people? For example, are they paediatricians, occupational therapists or speech therapists?

Mr J.A. McGINTY: There is a range of therapists. In the other place in recent days Hon Barbara Scott has raised the problem of waiting times for therapists to treat children with health problems or disabilities. We recognise that is a shortcoming in the services that are currently provided.

Mr M.P. WHITELY: These are occupational therapists and speech therapists?

Mr J.A. McGINTY: Yes, particularly speech therapists. The current waiting times are far too long. The Health Reform Implementation Task Force has looked at this issue, because therapies are provided under completely different models in the north metropolitan health area as distinct from the south metropolitan health area. We want to make sure that we can meet the needs of people in need of therapeutic interventions in a better and more timely fashion. I am not convinced that what we are doing at the moment is adequate.

Dr G.G. JACOBS: What are the minister's strategies? How does the minister propose to deal with the significant waiting time to get to see a therapist, and then the significant waiting time to actually get treatment?

Mr J.A. McGINTY: For the past 12 months the Health Reform Implementation Task Force has been addressing this item. I have not yet seen its report. I understand that it contains a significant number of recommendations that are designed to ensure faster access to professional therapy assistance for those children who need it. When I receive the report, I will make it public so that people can see what is proposed. To answer the member's question, until I have seen the report, I cannot advise what the health department is proposing to do to address this shortcoming in service.

Mr T.K. WALDRON: The last dot point under "Clinical Service Reform Initiatives" on page 537 states that $47.3 million has been allocated in 2006-07 to continue the implementation of the mental health strategy, including the provision of additional community supported accommodation. I certainly welcome that figure. Can the minister give us an idea of where that money will go? Considering that rural WA has mental health

issues, particularly youth suicide issues, etc, will part of that money be awarded to country WA? I would also like more detail on the provision of additional community supported accommodation, which is pretty important.

[5.50 pm]

Mr J.A. McGINTY: It was interesting that the Prime Minister said in his recent statement on mental health that he would make more money available through Medicare for people to access psychiatric and psychological services. It did nothing to help Western Australia, because we have a shortage of both and he is not providing the services where they are necessary. In that statement he recognised that community-supported accommodation was one of the services that the state should provide. We intend to do that. In conjunction with Homeswest and the Department of Housing and Works, we have put together a plan that will provide an extra 400 units of accommodation, or beds, to use the phrase that has been bandied about a fair bit today. Two hundred of those will be community-supported residential units in the city and the country for people who have a mental illness and require varying degrees of support, whether of a social nature or whatever. We will hopefully contract non-government organisations such as St Vincent de Paul and others to provide the community supports to these people. The units will be in clusters ranging in size from six beds to 25 beds. They will be built in a range of suburbs; I hope I can get the information fairly quickly on exactly where they are. In Albany, they will be adjacent to the hospital; in Busselton, in West Street; in Bunbury, on the old hospital site; there are some in Geraldton; and there are a number of others, so people can be accommodated in the larger country towns. In the city, they will be spread throughout the suburbs.

In addition, there is a range of specific measures to provide community-based accommodation for people with mental illnesses, adding up to the 400 beds I spoke about. The member will be aware of the dispute we had with the Town of Vincent over the former Hawthorn hospital. Fortunately, Vincent has now come on board and work is due to start any day on refurbishment of the hospital. It will open in October and will provide step-down accommodation for 16 mentally ill people coming out of hospital in preparation for their being placed in community-supported accommodation units or perhaps even at home. My disappointment is that we have not got on with this as quickly as we could have. In an overheated construction market, things have not happened as quickly as I would have liked. Nevertheless, construction will begin this year on most of the projects and most of them will be finished in the next 18 months. Accommodation will then be offered to people with mental illnesses. That will be a very big boost to one of the most fundamental things necessary for people with chronic mental illnesses - secure, supported accommodation.

Mr T.K. WALDRON: Can you tell us what will be provided?

Mr J.A. McGINTY: The nature of the accommodation or where it is?

Mr T.K. WALDRON: Where it will be.

Mr J.A. McGINTY: I can give that to the member now. In Albany, it will be an 11-bed unit on the Albany Hospital site; in Geraldton, a 14-bed unit on the Geraldton Hospital site; in Bunbury, 15 beds on the Bunbury Hospital site; in Busselton, 10 beds; 20 five-bed units on each of the Bentley and Osborne Park Hospital sites; there will be a facility at Armadale; we hope to build a 25-bed community-supported residential accommodation unit at the Kalamunda Hospital site; we hope, although it has not progressed very far yet, to build something in the north-eastern suburb of Stratton; and there will be a 25-bed facility on the Peel Health Campus site. Quite often these are fairly close to hospitals, because we are talking about people who do not need an acute bed but are often not able to cope in the community without some sort of support. Proximity to hospital or health care services is important. Tenders were called in April to build two four-bed group homes in Kelmscott under the Community Options model of care. In addition to that there will be 17 beds in group housing on the old Graylands hospital pharmacy site in Mt Claremont also under the Community Options program. On the Osborne Park Hospital site there will be an additional eight beds under the same program. We are also looking at homeless people with mental illnesses utilising part of the Royal Perth Hospital land fronting Moore Street, East Perth; and three lots in Alma Street, Fremantle. I am delighted to get the support of Homeswest in meeting this need of the most disadvantaged group of people. I just wish we could get on with it and do it quicker.

Mr T.K. WALDRON: When do you expect the Narrogin ones to be built?

Mr J.A. McGINTY: Some time in the future.

The CHAIRMAN: I think the member is looking for a bed!

Mr P.B. WATSON: On page 534 under "Indicative Timeframes for Capital Investment in Health" the figure for the Albany hospital is $26.8 million, going out to 2009-10. The day care centre figure is $820 000. Have the increased costs as a result of the housing boom been built into those figures? For instance, the cost of the entertainment centre on the foreshore has blown out by $10 million.

Mr J.A. McGINTY: The simple answer is yes. I hope the provision is adequate. This was done late last year, but we made our best efforts to estimate what building inflation would be. It is obviously different in different parts of the state.

Mr P.B. WATSON: It was originally $20 million, so it has risen by $6.8 million.

Mr J.A. McGINTY: That was not an increase in the scope of works. That is the building escalation cost we expect over the period of time in question. With regard to the Albany Hospital redevelopment stage 1, the bulk of the expenditure is in 2008-09, but it starts with planning money this year. We have been able to project what we expect building inflation to be and that is now incorporated in all of the Health capital works figures. That will need to be reviewed when we go to tender, and we are finding in some parts of the state, such as Port Hedland, that building inflation seems to be more than we planned on, so we might need to adjust the budget when we get closer to the time. At this stage we think we have got the proper cost of upgrading Albany to regional resource centre status adequately covered for building inflation.

Mr P.B. WATSON: Can the minister give me a guarantee that if it costs any more, he will provide the funding?

Mr J.A. McGINTY: No, much as I would like to. The member will have to speak to the Treasurer about that.

Dr S.C. THOMAS: On page 586, line five deals with accommodation. Are new health department offices being planned or set up at 1 Centro Avenue, Subiaco and, if so, what is the cost of rental and fit-out likely to be?

Dr N. Fong: The Department of Health is rationalising its accommodation across the metropolitan area. We have taken up a lease at 1 Centro. We have done an audit of all our accommodation facilities. The Department of Health and its associated divisions are actually occupying 1 200 square metres less than they were 18 months ago. The bulk of that saving came from getting out of a quite expensive lease in John Septimus Roe building, where our information and IT people were housed. We have now put them into the old Royal Street building. Alvan Street is $200 per square metre per annum and the Centro Avenue site is $240 per square metre. The indicative lease rates for buildings in the CBD are $300 to $350, as the member will know. West Perth is up to $320 and Subiaco is at least $320, so we think we have got a very good deal. We got out of a very expensive option.

Meeting suspended from 6.00 to 7.00 pm

Dr K.D. HAMES: I refer to page 548, which members do not need to look at because I have a question relating to the review of the Peel Health Campus. I know that the review has been conducted and I am told that the report has been sitting on the minister's desk for some time. Can I have a copy of the review? What does it say? The capital works show that the Peel Health Campus development stage 1 will be allocated $7.659 million. That is not the amount allocated for the emergency department, because that is a separate $3 million, and nor is it the amount for the community health unit, which is a separate figure also. I do not know what the $7.659 million is for. Is it related to the results of that review; and, if not, how will the minister fund the recommendations of that review?

Mr J.A. McGINTY: The clinical services framework for the Peel Health Campus has been completed. From memory, it was chaired by Professor Bryant Stokes. Nothing ever sits on my desk, so it has not been on my desk. It might have been sitting on someone else's desk, but I cannot vouch for that. I have not seen it. That probably answers one of the member's later questions.

Dr K.D. HAMES: How long ago was it completed?

Mr J.A. McGINTY: It was completed at the end of last year. I have not received a copy of it. It is currently at the printers and I am told that it will be back from the printers in a matter of days. When I have read it, I intend to release it and I will make sure that the member is given a copy.

Dr K.D. HAMES: The minister's answer concerns me. The review was completed five months ago. We have been talking to the minister for some time about the major problems at the Peel Health Campus. Although surgeons who conduct waitlist surgery are able to perform five or six operations a session, they have been reduced to performing just two operations a session because of the increasing demand. They have seen me and the minister and have kicked up a stink about why they are so restricted in the amount of surgery they can do. The review was completed five months ago, yet there is nothing in this budget for it, unless it is the amount to which I have referred. However, if the minister has not seen it, there is nothing in this budget to address those issues. Why has the minister not read the report when it was ready five months ago and why has the minister not funded its recommendations in this budget?

Mr J.A. McGINTY: I have not read it and I cannot tell the member about something I have not read. It is at the printers. I will read it when it comes back from the printers and then formulate a response to it.

Dr K.D. HAMES: Five months is a long time between the completion of the review and the minister seeing the report.

Mr J.A. McGINTY: It might well be. I cannot change that. A raft of complicated matters must be taken into account regarding the issue of surgery at the Peel Health Campus, including the profitability of the private operator and the level of demand there compared with other hospitals in the south metropolitan region. We have been discussing ways, including going back to the meeting in October or November last year, which the member and I attended with Linda Smith -

Dr K.D. HAMES: I would like the minister to tell me what happened with that.

Mr J.A. McGINTY: I understand that the Peel Health Campus has now agreed on the basis upon which the ambulatory surgery initiative will be extended. For members who are not familiar with that initiative, it is a range of procedures that can be conducted as outpatients using the facilities of the hospital for that purpose. As the member for Dawesville is aware, the surgeons have agreed to bulk-bill Medicare for the surgeons' fee. At that meeting at which the member and I were present, I indicated that there would be no caps on the amount of work to be done under the ASI scheme, which would go a long way towards providing work that would keep up the necessary volume of work and would therefore continue to attract surgeons to live in the Peel region. It is not the total answer, because it is work at the lower end of the complexity scale. Nonetheless, I hope that as a result of that initiative a significant amount of work will be created that involves those procedures that are amenable to day surgery on an outpatient basis. At the end of March, 15 100 people in the metropolitan area were on the surgery waitlist. Half of those cases were day surgery cases. There is quite a lot of scope for work to be done at not only the Peel Health Campus, but also other places as we significantly expand the ambulatory surgery initiative. It seems as though the blockages that have been in place for some months such as the legal issues, the willingness of the hospital to participate and the price at which it would be done, have now been cleared. My understanding is that that is now likely to proceed in the not too distant future, which is a positive step. As soon as I have had a chance to read the clinical services plan for Peel and have formulated a response, I will give the member a copy.

Dr K.D. HAMES: Can the minister tell us about the $7.6 million?

Mr J.A. McGINTY: As the member said, the allocation to the emergency department was $3 million, and that is proceeding.

Dr K.D. HAMES: That is somewhere else.

Mr J.A. McGINTY: Yes, it is.

Dr K.D. HAMES: The $7.6 million is listed under "Peel Health Campus - Development Stage 1" on page 535.

Mr J.A. McGINTY: That is for general work on the hospital to maintain the various services and buildings. It is not an allocation to expand or build new facilities but to maintain the buildings in a fit-for-purpose condition unit 2010-11.

Dr K.D. HAMES: That is a pity. I thought that the minister might be giving us something new.

Mr J.A. McGINTY: It is effectively providing a new hospital and maintaining it in an as-new condition. We gave a commitment at the last election to double the size of the emergency department. A total of $3 million has been allocated to make sure that that is followed through. The bulk of that funding will be spent in 2007-08.

Dr K.D. HAMES: Just before the election.

Mr J.A. McGINTY: The planning will take place in the coming year and construction will commence in the following year.

Dr K.D. HAMES: There are no extra beds in that?

Mr J.A. McGINTY: No. We are currently working through a proposal with Health Solutions (WA), the operator of the Peel Health Campus, which proposed to build a stand-alone private hospital on that site. We have been involved in negotiations with Health Solutions about the excision of land and the contractual obligations that arise from that.

Dr K.D. HAMES: That is good because in a letter the minister wrote to Health Solutions, he suggested that he would not support that proposal because he would not support an extension of the lease. An extension of the lease is needed to give Health Solutions the borrowing capacity to build a new centre. I spoke to the minister about that earlier. I assume that the minister will support that proposal. That is good; I am happy with that.

[7.10 pm]

Mr J.A. McGINTY: All I say is that we are involved in negotiations with Health Solutions in order to achieve that. If Health Solutions wishes to build a private hospital, that is something I would broadly support because it would have the effect of attracting private surgeons and private clinicians to the region and maintain them there.

Dr K.D. HAMES: It would allow them to treat the veterans, of course, because they treat vets in a private hospital.

Mr J.A. McGINTY: That is right. Similarly the proposals for a new private hospital on the campus at Joondalup are proceeding. We are reaching the final stage of negotiations on that and we hope that also will come to fruition in the not too distant future.

Dr G.G. JACOBS: I draw attention to page 586 and want to talk about accommodation. This matter has been touched on previously, but I want to explore the allocation for extra office accommodation at 1 Centro Avenue, Subiaco. We heard about the good rate of $240 a square metre. Can we have a little more information on the fit-out cost and yearly lease or rent for the total area of that new office, which is across the road from the refurbished office at Alvan Street?

Mr J.A. McGINTY: The rental arrangements at 1 Centro Avenue are 682.3 square metres of lettable office space at $240 a square metre. The annual estimate or rent is $163 752. There are then, of course, outgoings and fit-out costs in addition to that.

Dr G.G. JACOBS: Can we have the fit-out costs, please?

Mr J.A. McGINTY: Total fit-out costs are $487 401.

Dr G.G. JACOBS: May I ask a supplementary question?

The CHAIRMAN: A further question on the same subject.

Dr G.G. JACOBS: How many staff does the office house?

Mr J.A. McGINTY: I am told 43 approximately.

Dr K.D. HAMES: Can I ask a supplementary question on what has been asked?

The CHAIRMAN: A further question.

Dr K.D. HAMES: Could we have the detail of all those figures either tabled or provided as a supplementary answer; that is, all the costs relating to items associated with fitting out, developing and planning?

Mr J.A. McGINTY: In terms of the outgoings on an annual basis, the rent in the lease is $163 752.

Dr K.D. HAMES: There is no need to read it to me. Could the minister provide it to us in writing?

The CHAIRMAN: I think the member will find that the minister is about to provide it.

Mr J.A. McGINTY: It is fairly brief; I would rather do it this way. Outgoings are $43 330; parking, $23 040; electricity, $18 000; fibre link, $25 000; cleaning, $15 000; security, $5 000; PABX contract, $8 000; telephone calls and expenses, $45 000 - giving a total of $347 122.

Dr G.G. JACOBS: I have another question, Madam Chair.

The CHAIRMAN: A further question on the same subject.

Dr G.G. JACOBS: I cannot write that fast.

The CHAIRMAN: It will be written down for the member and appear tomorrow in *Hansard*.

Dr G.G. JACOBS: Could I have it tabled so that I can digest it myself?

Mr J.A. McGINTY: Yes, but it would most probably take me longer to get it to the member than it will take for the Hansard reporter to print it.

Dr K.D. HAMES: If she got down everything you said!

Mr J.A. McGINTY: However, I can do that.

The CHAIRMAN: Things are not tabled through the estimates committee; they are supplied either as supplementary information or appear in *Hansard*, which the member can read tomorrow.

Mr J.A. McGINTY: Yes.

Mr P.B. WATSON: I refer to the third dot point on page 565, which reads -

> The 'Mentally Healthy Western Australia' health promotion program will be expanded to Albany, Esperance, Kalgoorlie, Karratha, Geraldton and Northam / York / Toodyay through a collaborative project with universities and non-government organisations.

Could the minister provide me with some information on that please?

Mr J.A. McGINTY: I undertake to provide that by way of supplementary information, as I think the detail that is required would require a bit more -

Mr P.B. WATSON: Is that the Be Active program, because I think it is already set up in Albany?

Mr J.A. McGINTY: It is the Mentally Healthy program. I ask Chris O'Farrell to answer that question, given my inability to do so.

Mrs C. O'Farrell: The Mentally Healthy project is an initiative that we are undertaking in partnership and collaboration with universities and the Australian Institute of Child Health Research. It is an applied research program. It is an early attempt to try to test whether it is possible to take a health promoting approach to the mental health problem and work with people in rural communities to encourage a range of measures that they can take in their work and lives. The research side of it is to test some outcomes in groups in which the projects are not being implemented and in groups in which the project is active. There is therefore a lot of energy behind this program. We have put some contribution and a number of staff towards it, and they have been sourcing funding contributions from other agencies. So, we are fairly proud that it is a good mental health promotion program from which we hope we will get some good outcomes.

Mr P.B. WATSON: I have a supplementary question.

The CHAIRMAN: A further question from the member for Albany.

Mr P.B. WATSON: It has been very successful in Albany and I congratulate Trish Travers and her troop in Albany. They are doing a tremendous job in getting it out into the community and encouraging people to become involved in the community, especially encouraging them to not only join clubs but also become secretary or treasurer of them, or something like that. When I have been doorknocking, I have met a lot of people between 40 and 60 years of age who feel that they have been left on the shelf. This is a great opportunity for them to get out into and be a very important part of the community. I congratulate whoever had this idea, as it has been very successful in Albany.

The CHAIRMAN: Nice feedback, member, but I do not think I heard a question.

Mr P.B. WATSON: It is in the ears of the beholder!

The CHAIRMAN: It will make a damned fine press release tomorrow, I am sure!

Mr T.K. WALDRON: The third dot point from the bottom of page 550 refers to the Western Australian country service specialist services plan. The very last sentence states -

> The next few years will focus on the enhanced regional coordination of non-inpatient services, including population health, mental health and patient transport.

Could the minister expand on what is meant by "population health", if he will excuse my ignorance? I wondered exactly how this statement would manifest itself in real initiatives that are planned to be developed.

Mr J.A. McGINTY: I will ask Chris O'Farrell to comment. However, "population health" is the term used for the face that used to be applied to public health and health promotion and initiatives of that nature.

Mr T.K. WALDRON: That is what Dr Hames said, but I just wanted to clarify it. I am from the country!

Mr J.A. McGINTY: The member for Wagin is in the National Party, not the Liberal Party; I would not trust the member for Dawesville either!

[7.20 pm]

Mrs C. O'Farrell: The regional resource centres and the networking of regional systems is a work in progress. A lot of our attention and investment in the early years of that development has been on the regional hospital element of the regional resource centres and, in fact, the entire hospital system. To make a networked and role-delineated system work, we need to also pay a lot of attention to an increasing profile of non-admitted patient services; that is, services for people in their homes, the community and ambulatory care settings. We need to beef up our capacity to provide good public health services. We need more capability for that in the regions and we need good communication and transport systems. There are a lot of levers and controls and logistics involved in working within a networked system. The next few years will involve our trying to make some of the

linkages and connections work better than they do at the moment, having invested quite a lot in the infrastructure and the hospital system and medical, nursing and specialist services.

Mr T.K. WALDRON: The transport area is important. I would like to couple of those regional resource centres to be established inland.

The CHAIRMAN: You are always good at plugging for the bush, member for Wagin!

Mr T.K. WALDRON: That is what I am paid for.

The CHAIRMAN: Now we will try the metropolitan area, close to my own heart. The member for Joondalup can try to even up the score!

Mr A.P. O'GORMAN: We always even up the score in the northern suburbs. The second dot point on page 551 under "Major Initiatives For 2006-07" refers to planning for development of 15 public beds and 15 private beds in the adult inpatient facility at Joondalup Health campus. An amount of money is set aside for that in the budget. I hope that a bit more than just planning has occurred and that progress is under way towards delivering that. When might it be delivered?

The CHAIRMAN: This might not be looking too good for the northern suburbs.

Mr A.P. O'GORMAN: It is all good, but I want it to be more than just planning.

Mr J.A. McGINTY: We have arranged with the Joondalup Health Campus to contract temporary mental health beds until December this year. An additional 15 beds will then be constructed by June 2007. We expect that to be done in a little over 12 months. The estimated total cost is $5 million. Planning money is allocated for 2006-07 and construction will occur in 2006-07 and conclude in 2007-08. The 15 public beds will be developed in conjunction with the 15 additional private beds on the site. I want to correct one piece of information. Construction will start in February 2007 and will finish in March 2008. It is a little bit later than the earlier indication I gave the member. I gave an indication of the construction period rather than the end of construction. We expect the new mental health beds to be finished in March 2008.

Mr A.P. O'GORMAN: Reference is made in the same dot point to planning for a permanent intermediate care service at Joondalup Health Campus. I assume that is the step-down facility that has been talked about. It is in the planning stages. When will it come on stream? I was not able to find an appropriation for that in the budget.

Mr J.A. McGINTY: As members will be aware, a significant dispute arose with the Town of Vincent over the Hawthorn Hospital. Eventually that was resolved, and 16 beds will be included in the renovated Hawthorn Hospital. That renovation work will be completed in October this year and we expect the first 16 patients to take up residence in October. That will apply for a limited period, until the new permanent step-down facility is constructed at the Joondalup Health Campus. The Joondalup facility will accommodate 22 beds, so it will expand the scope of what will be in existence at Hawthorn. The primary objectives of the intermediate care model are to: relieve pressure on acute mental health services by providing alternative, highly supported, clinically supervised rehabilitation accommodation settings; provide a community alternative to inpatient care; reduce the likelihood of readmission; and promote independent living skills. The construction tender will be let in March 2007, with construction commencing in June 2007. The step-down facility will be completed in August 2008.

Mr A.P. O'GORMAN: Thank you; well done.

Dr K.D. HAMES: I refer to page 586 - the minister need not look. It relates to the total number of health bureaucrats within the system - no offence to all those who are here today. What is the total number of health bureaucrats compared with people who provide a direct service to patients? I do not want to make any negative reference to Dr Fong and his attachment to Royal Perth Hospital for wages; I understand the background to that, so I will not be heard making any critical remarks about it. However, given that Dr Fong was employed by Royal Perth Hospital, I presume that he would not have been listed as a health bureaucrat in the system of health bureaucrats. I am advised that other people who perhaps were once listed as bureaucrats have been attached to hospitals for various reasons and their names have come off the total list of bureaucrats. Is that true? Have people been moved out of that list of bureaucrats and been classified as hospital employees? What is the total number of bureaucrats? I refer to an answer the minister gave previously about salary bands for bureaucrats. Of a $21 million increase in the budget for health staff, $19 million went to those earning $80 000 and over. How many people are at that very high level of pay in the bureaucratic system? How has that changed since 2001? Is it a true reflection of the situation, given the advice that some have been moved into hospital employment?

Mr J.A. McGINTY: The number of FTEs projected for the coming financial year is 27 236.

Dr K.D. HAMES: In the total health system or bureaucrats?

[7.30 pm]

Mr J.A. McGINTY: In the total health system. Steady on! A total staff of 27 200 FTEs are projected for the coming financial year. There has been steady growth in total staff. To translate the FTEs into actual employees, I am told that 36 000, or thereabouts, people are employed in health if we take into account part-time employment in particular. That number reduces to 27 236 FTEs. Nursing numbers have risen from 8 395 in 2000-01 - this will be the comparison I will use throughout - to 10 185. That is nearly 2 000 extra staff during that period. The number of agency nurses has declined marginally from 255 to 214. The number of medical salaried staff has risen from 1 759 to 2 337, medical sessional staff from 223 to 260 and medical support staff from 3 549 to 4 336. I do not know whether they could be called bureaucrats; I do not think I would call them bureaucrats.

Dr K.D. HAMES: What do medical support personnel do?

Dr N. Fong: They are technicians, anaesthetic technicians.

Dr K.D. HAMES: No, I would not call them bureaucrats.

Mr J.A. McGINTY: The number of hotel services staff, which involves cleaning, gardening and cooking, has increased from 3 020 to 3 805. Significantly, that is a result of in-sourcing work that was previously outsourced in the system. The number of site services staff has risen from 484 to 547. Again, that is a fairly modest amount. The number of administrative and clerical staff has increased from 4 739 to 5 416. I do not know that I would classify a number of those people as bureaucrats; for example, a clerical person who is responsible for waiting lists, organising patients to come in for surgery and things of that nature. It is a definitional question. The number of staff in the "other" category - whatever that might be - has increased from 32 to 137.

Dr K.D. HAMES: That is the big jump. Is that the jump in bureaucrats? The figures that I have been provided -

Mr J.A. McGINTY: No; the only group that could possibly fit the description that the member is giving is administrative and clerical staff, the number of which has increased from roughly 4 700 to 5 400, when the total number of employees has increased from 22 400 to 27 200.

Dr K.D. HAMES: What are all the people in the health system who are not involved in direct patient contact classified as - administrative and clerical?

Mr J.A. McGINTY: Administrative -

Dr K.D. HAMES: What are the staff in the "other" category?

Mr J.A. McGINTY: The number of staff in the "other" category is so small that -

Dr G.G. JACOBS: However, it is a significant increase.

Mr J.A. McGINTY: Not really. The number has increased from 32 to 137. In the context of roughly 27 000 employees, it is irrelevant.

Dr K.D. HAMES: The minister was talking about thousands, and then he said 32 to 137; I thought he meant 32 000 to 137 000.

Mr J.A. McGINTY: No, not thousands; 32 actual. The only group that could fit into that category is the administrative and clerical staff, which, according to today's figures, is about 5 400 out of a total of 27 200. There does not appear to have been a proportional growth in that area.

Dr K.D. HAMES: Do the figures that I have cited of the number of staff in the $80 000 and above pay bracket concern the minister? There is an explanation that the pay increases of 3.4 and 3.6 per cent put people into a higher pay bracket. That does not explain the number of personnel in that bracket increasing by 190. The total budget increase in 2004-05 was $21 million and, of that, $19 million was for staff in the $80 000 and above bracket. The rest of the personnel shared $2 million.

Mr J.A. McGINTY: Does that answer refer to all employees receiving more than that amount?

Dr K.D. HAMES: No, it refers to administrative and clerical, administrative support and agency administrative and clerical salaries. The change in the cost of administrative staff over the previous year was $31 million in 2001-02, nothing in 2002-03, $22 million in 2003-04, $21 million in 2004-05 and $20 million in the 2005-06 budget. The figure that I had that was not budgeted was $21 million. If I add together the staff in the $80 000 and above bracket, which increased by 119 personnel, and those in the $90 000 bracket, which increased by 71 personnel - that is 190 extra personnel in those salary ranges - and average it out, that works out to $19 million of the $21 million. The point I am trying to make is that although the minister accepts that there has been an increase in administrative staff, there seem to be a huge number of staff in the top-of-the-range bracket. The

personnel whom the director general and the regional managers are setting up around them worry me. Rather than providing support services to the people on the ground, higher salaries are being paid to a lot of extra people to provide support for the units that have been created.

Mr J.A. McGINTY: That does not sound right to me. I have the answer to the parliamentary question, which is the one provided on Tuesday, 4 April 2006.

Dr K.D. HAMES: No, it was Thursday, 9 March. Sorry, I got the answer on 4 April.

Mr J.A. McGINTY: The answer shows that by far the largest salary bands in which people are located is the $30 000 to $50 000 a year category. There are thousands of people in that category and only hundreds in the other categories.

Dr K.D. HAMES: Sure, but they got hardly any of the money. That is my point. The number of staff in the $80 000 to $89 999 band increased from 60 to 242.

Mr J.A. McGINTY: That is over a period of five years.

Dr K.D. HAMES: Sure. If we look at the period from June 2004 to June 2005, we find that the number has increased from 123 to 242, which is an increase of 119. The number of staff in the $90 000 and above band has increased from 122 to 193. A total of 193 personnel earned $80 000 to $90 000 in 2004-05. They chewed up almost all that increase. The director general is shaking his head.

Mr J.A. McGINTY: The health system employs 27 000 full-time equivalents and the member is talking about 193 individuals -

Dr K.D. HAMES: If the minister looks at the previous page -

Mr J.A. McGINTY: Let me make this point. That number has grown as a result of a range of things, including award salary increases and reclassifications. A series of things result in salary scales moving upwards all the time.

Dr K.D. HAMES: I expect those at the middle and lower end of the scale to get their four, five or six per cent increases, which would chew up much more money. On the previous page, it states that the change over the previous year was $21.07 million. If we multiply that 193 by -

Mrs C.A. MARTIN: If you pay peanuts, you end up with monkeys.

Mr J.A. McGINTY: I will explain it this way.

Dr K.D. HAMES: The point, member for Kimberley, is that -

The CHAIRMAN: Let us not have a debate. Let us wait for the minister's answer, because then I will move on. We have spent too much time on this issue.

Mr J.A. McGINTY: I understand the question.

Dr K.D. HAMES: It is not worth -

The CHAIRMAN: Wait for the answer, and then we will move on.

Mr J.A. McGINTY: There has been significant growth in particular salary bands as classifications or groups of classifications move into the salary band above them; for example, the 3.4 per cent salary increase in January 2004 moved 32 level 11 hospital and salaried officers into the $90 000 and above band. That in itself accounted for 32 of the total increase on the one day. It was a very significant proportion of that movement over those five years, simply as a result of a public sector pay rise.

Dr K.D. HAMES: However, that is the year's increase in salary, and that is 30 out of 71.

Mr J.A. McGINTY: Let me go back. In February 2005 there was a 3.6 per cent public service salary increase, which moved 102 level 7 public service officers into the $80 000 to $89 999 band and 38 level 8 officers into the $90 000 and above band. We can see from those figures that routine salary increases of a modest amount - 3.6 per cent and 3.4 per cent increases on those two occasions - had the effect of putting hundreds of people into a higher salary band. That represents just those two increases. If they have that effect, it seems to me that the issue has really arisen when modest increases granted to public sector people have had the effect of putting them into a higher salary band.

[7.40 pm]

Dr K.D. HAMES: That accounts for about half the numbers.

Mr J.A. McGINTY: The others go back over five years.

Dr K.D. HAMES: I know, but I am talking about half that year's increase for those reasons that the minister has just said. The point is that the department is employing a lot more staff. It seems that it is employing them all in that higher salary band. The member for Kimberley said that if people pay peanuts, they get monkeys, but I would like to see more money and more employment going down to people who are much more involved in direct patient services. I think I have made that point and run out of question. I would rather that we got on.

Mr J.A. McGINTY: I do not think that the member is right. I am happy to stay here and argue this point. In June 2001 there were 768 people in the $40 000 to $50 000 salary range, and in June 2005 there were 1 222. That represents an enormous increase at the modest end of the salary scale. I think the member would agree with that.

Dr K.D. HAMES: Sure, but if one looks at the year before -

The CHAIRMAN: Member, please. Let us just listen to the answer so that we can move on.

Mr J.A. McGINTY: That is one of the salary bands in which there are large numbers of administrative and clerical staff. The member asked the question of how many people are paid $90 000 a year or more at the very top of the administrative and clerical scale. That figure has risen from 88 five years ago to 193. I have already explained that pay rises have put the bulk of those people into higher pay brackets during the course of the year. I think the member is trying to make something out of something that is simply not there.

Dr G.G. JACOBS: I draw the minister's attention to page 544 and ask about some key effectiveness indicators to try to get a measure of how well health services are doing. The first part of my question relates to the low activity, pulse, grimace, appearance and respiration scores for low birth weight babies. It appears in the range of birth weight babies 1 500 grams to 1 999 grams, the state is not performing to national targets. If one compares the target of less than 0.8 per cent, the state is at 1.8 per cent in 2005-06. The second part of the question is to do with emergency department patients seen within recommended times. It would appear that with categories 2, 3 and 4, the state is not up to national benchmarks, nor is it improving. Will the minister or someone else comment on that, please?

Dr N. Fong: The figure the member sees there for birth weight babies of 1 500 to 1 999 grams is as it is. It is higher for the estimated 2005-06 figure than the national target. It is our goal, in making this transparent, to make sure that we hit the targets for next year. We hit the targets in every other category. We are obviously aware that low birth weight babies do have other complications, as the member would be aware. I cannot give the member the details of why, but I would suggest that it would relate to the remoteness of some of the deliveries that would be collected in this statistic for those APGAR scores, particularly in our country areas.

Dr G.G. JACOBS: There was another part of the question to do with emergency departments, but just on that issue, we seem to do better with very low birth weight babies than the national average, but we do not seem to do well with babies in that 1 500 to 1 999 grams range.

Dr N. Fong: We would have to know what the denominator was. I do not know what the denominator is. Clearly, if there are a very low number of babies in that category of weight - there would be - one or two might skew the result quite significantly.

Dr G.G. JACOBS: I asked in my original question about emergency department waiting times.

Dr N. Fong: This target has been around for many years. It is one that we certainly want to try to achieve with national benchmarks. In the triage category 2s, there is clearly room for improvement, but we all know there have been huge increases in the demands on our emergency departments over the past couple of years.

Dr G.G. JACOBS: Although we hear a lot of spin, those figures have basically not shifted; they have not improved from 2004-05 to this year; and in fact the category 2 figures have worsened.

Mr J.A. McGINTY: Marginally, but may I put that in context. The year to date figures show that across the metropolitan area there has been an approximately eight per cent increase in attendances at emergency departments. When one thinks of the hundreds of thousands of people who are seen in emergency departments, an eight per cent increase is a phenomenal increase in the number of patients who need to be seen. I think in the context of that dramatic increase, to be able to hold the position has been a very good achievement. We not only wish to hold it; we want to see it improve. Although the member is right that there has been, I think, a one per cent deterioration in the proportion of category 2 patients being seen within 10 minutes - down from 74 to 73, which is less than one per cent - there have been a couple of percentage points improvement in category 5 patients. There has been a marginal improvement in the proportions of category 4, category 3 and category 1 patients. There has been a very marginal decline in the proportion of category 2 patients seen within 10 minutes, but to put it into context, tens of thousands more patients are fronting to the emergency departments and

requiring treatment. To hold our own in those circumstances is a very good effort, but nonetheless we will continue to make sure that we improve those figures.

Dr K.D. HAMES: Further to that, I have two sets of documents in front of me. I do not have the original forms but these come from government department sources. One relates to eight-hour wait times for hospitals. To mention the three major ones, the Fremantle Hospital eight-hour wait times have risen from 34 per cent to 55 per cent -

Mr J.A. McGINTY: Over what period of time is that?

Dr K.D. HAMES: It was 34 per cent in the year 2000 and 55 per cent now. I am basically agreeing with the minister about the increase in demand, but I am referring to the effect that it has had. Eight-hour wait times at Royal Perth Hospital have gone from 15.73 per cent in the year 2000 to 31 per cent and at Sir Charles Gairdner Hospital they have gone from 11.51 per cent to 28 per cent. That shows a significant increase in all three categories. The other graph I have shows that between the year 2000 and the current year to date there has been a significant increase in overcrowding in every hospital. Given the comment that we do not need extra beds and it is all a matter of working on the amount of time people spend in hospital, and all the other strategies that are put in place, I believe it will take three to four to five years to have a significant effect, whereas now all these statistics are significantly decreasing. What will the minister do about it now rather than having all these plans, such as the Helping the Hospital in the Home program, and all the other programs that will have an effect over the next three to five years?

Mr J.A. McGINTY: Until April of this year, the year to date of 2005-06, the percentage of emergency department presentations waiting longer than eight hours -

Dr K.D. HAMES: In which hospital?

Mr J.A. McGINTY: These are total ED admissions. They were two per cent higher. Sure, there has been a two per cent increase in the number of people waiting longer than eight hours. That is not to be seen but to be admitted to a bed in a hospital, which is a different measure from what we have just been talking about.

[7.50 pm]

Dr K.D. HAMES: I am talking about the eight-hour wait time.

Mr J.A. McGINTY: That is not to be seen.

Dr K.D. HAMES: That was the wait time at Royal Perth Hospital in 2005. In the year to date, according to these figures, the eight-hour wait time at Royal Perth Hospital has increased from 31 per cent to 42 per cent, and the eight-hour wait time at Sir Charles Gairdner Hospital has increased from 28 per cent to 41 per cent.

Mr J.A. McGINTY: That is not to be seen in emergency departments.

Dr K.D. HAMES: It is once people are seen and are waiting for admission.

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

Dr K.D. HAMES: This relates to the report of patients dying in waiting rooms. This is a figure of how long they wait for admission, and a general overcrowding figure.

Mr J.A. McGINTY: It has risen by two per cent in the year to date compared with last year. They are the figures that we have.

Dr K.D. HAMES: These are the minister's figures that I have in front of me.

Mr J.A. McGINTY: I am sorry; I have just given the member my figures. That is, notwithstanding the massive increase in demand, the percentage of people who have had to wait longer than eight hours for admission is up by two per cent to date across the public hospital system.

Dr K.D. HAMES: Madam Chairman, can I supply the minister with a copy of what I have in front of me and ask him to provide, as supplementary information -

Mr J.A. McGINTY: I have already provided the member with our figures. There is nothing more that I can provide him with.

Dr K.D. HAMES: These are the minister's figures. I would like the minister to add them on to these.

The CHAIRMAN: We do not table anything in estimates, so the member can share that with the minister later, and take it up with him elsewhere, I suggest.

Dr K.D. HAMES: Am I not allowed to ask for supplementary information?

The CHAIRMAN: The member can ask for supplementary information, but I think the minister just indicated that he gave the member the information he wanted. The member may request away if he wishes.

Dr K.D. HAMES: I think I did.

The CHAIRMAN: Yes, so do I. I will go back to the member for Kimberley, who has the call.

Mrs C.A. MARTIN: I refer to page 561. One of the items under "Major Achievements For 2005-06" is headed "Cancer Prevention and Detection". It mentions a strategy for breast screening. What mammography screening clinics are available for women in remote areas, specifically the Kimberley?

Mr J.A. McGINTY: The member wants information about the provision of mammography services in country areas.

Mrs C.A. MARTIN: Yes, basically.

Mr J.A. McGINTY: I was hoping to be able to get through this session without the need to provide supplementary information, but I think we have just broken that. I will undertake to provide to the member for Kimberley, by way of supplementary information, the description of mammography services for country areas in Western Australia.

[*Supplementary Information No A53.*]

Mrs C.A. MARTIN: I thank the minister for the supplementary information. I know about the pink truck that visits those areas.

Mr J.A. McGINTY: Yes.

Mrs C.A. MARTIN: I am a bit curious about whether other services will be provided, but that is fine. Can the minister tell me what is happening with the Well Women's Clinic in Broome? I seem to be the only woman on any of these committees at the moment, so I think it is relevant that I ask these questions.

Mr J.A. McGINTY: I will add that information on the Well Women's Clinic in Broome to the supplementary information that I have undertaken to provide.

[*Supplementary Information No A54.*]

The CHAIRMAN: Does the member for Kimberley have a further question on the same issue?

Mrs C.A. MARTIN: No.

The CHAIRMAN: I think the member had better give the minister a rest. The member for Albany can see if he can top that.

Mr P.B. WATSON: I am a bit scared to ask a question! I refer to page 562. One of the other items under "Major Achievements For 2005-06" is headed "Health Promotion". The third dot point under that item states -

> State-wide strategies were implemented to address childhood obesity including the Crunch and Sip school fruit and water policy . . .

A number of other policies are listed. Are there any plans for the Department of Health to work with the Department of Education and Training and the Department of Sport and Recreation in the future on combining their resources to help address child obesity?

Mr J.A. McGINTY: I will ask Dr Simon Towler to comment on this in a minute. However, by way of introduction, I say that today the issue has arisen about the supply in schools of fizzy soft drinks that contain enormous quantities of sugar. I think New South Wales has taken the initiative of banning them. We have not done that yet, but I think it is time that we banned from all our public hospitals the dispensing machines for fizzy drinks and also for other fatty and unhealthy foods. I am thinking particularly of potato chips, chocolates and things of that nature.

Mr P.B. WATSON: This is in hospitals, not in schools.

Mr J.A. McGINTY: This is in hospitals. I cannot speak for schools. I just think it is time for us to do everything we possibly can to fight the issue of people being overweight or obese. I am certainly more than happy to work with the Minister for Education and Training in respect of school canteens. However, I think we should first get our own house in order. It was not all that long ago that to get into Royal Perth Hospital from Victoria Square, people had to fight their way through all the smokers and cancer-causing agents. Then, when they got inside, they would see all the dispensing machines with unhealthy foods in them. We need to do a number of things in that area. However, I will ask Dr Towler to answer the specifics of the member's question.

Dr S.C.B. Towler: I am more than happy to do so. The government is committed to the program through the National Obesity Taskforce that is titled "Healthy Weight 2008". There has been a fundamental focus on school canteens as an example of an environment in which we should appropriately influence children's attitudes to eating and behaviour. As part of the Council of Australian Governments agenda in February, we signed on to the Australian Better Health Initiative. The program, which includes a focus on school canteens, is being developed by the senior officers group for the ABHI, as it is called. We are working on that with the education department in Western Australia at the moment. The health department has for some time been supporting the Western Australian School Canteens Association through its non-government organisation contracting arrangements. In this state, the vast majority of school canteens are provided through voluntary organisations, and we continue to support them. They have been running a program called StarCAP, under which there is an accreditation system for schools. That has been adopted in about 20 per cent of schools. We regard this as a very important initiative. A number of opportunities are coming up, and money will be invested through the education department, and in partnerships, over the next 12 months. There will be further information about that in the next few months.

Mr P.B. WATSON: Victoria has put the three agencies together, and a super minister overrides those three agencies. Victoria is having a large amount of success with child obesity. I wonder whether that is on the horizon for WA.

Mr J.A. McGINTY: It is one of those issues that has been around for a while. It is interesting that other states are now appreciating the need to take very strong action. One of those states is Victoria, which has made the administrative arrangements to which the member has referred. The fact that the Premier is taking responsibility for the Physical Activity Task Force is a step in that direction. There is a growing awareness of the tsunami of obesity that is descending upon us, with all its health implications, and what that will mean for the health condition of obese and overweight kids in the years ahead. That is the reason that I am personally very supportive of a raft of initiatives. One of the things that disappointed me at the last meeting of health ministers, which was held about a month and a half ago, was the refusal of the federal health minister, Tony Abbott, to contemplate a ban on the advertising of junk food on television. We must start with measures like that. We are happy to ban cigarette advertising, because we know about the adverse health effect of cigarettes, yet there is currently a reluctance at the federal level to look at banning junk food, which is having an equally catastrophic health effect on young people in the community. That is something that will emerge, hopefully sooner rather than later.

[8.00 pm]

Mr P.B. WATSON: There was a report in the paper the other day from the AMA about child obesity in England. It was reported that schools are going to start weighing children and sending letters home to the parents. Are there any plans to do that in Western Australia?

Mr J.A. McGINTY: Comments were passed about what the British were doing. I personally support that proposal. We have school health arrangements in place at the moment. School health nurses should be monitoring the health of the students and reporting back. One of the research findings that I read in recent times was that parents of fat kids do not think their kids are fat; they think they are normal. This issue is as much about using exercise, diet and lifestyle information to deal with kids who are overweight or obese as it is about informing their parents and adjusting their parental attitudes to appreciate that their kids are overweight and that will have significant health ramifications in the years ahead. It is about educating parents and bringing the facts home to parents as well. I am personally supportive, but so far we have not given specific consideration to that proposal. It only emerged last week that it is occurring in Britain. However, on the issue of children being overweight or obese, we should always start from the basis that if there is anything positive to be gained from such a proposal, we should be doing it, unless there are strong reasons not to.

The CHAIRMAN: That question was a bit of a stretch in relation to this budget. I ask the member not to try that again. I cannot find the London policy in our budget papers.

Mr T.K. WALDRON: The third dot point under "Major Initiatives For 2006-07" on page 570 states that the new dental clinics at Joondalup, Kununurra and Bunbury will improve access and service provision to eligible patients, which is good to see. Are further new clinics planned over the next four to five years? If so, where will they be located? Can the minister enlarge on the issues concerning the development of dental treatment in rural WA?

Mr J.A. McGINTY: There has been a significant building program for new dental clinics. I visited the dental clinic in Bunbury. It is currently housed in an old 1950s asbestos building. A new dental clinic is planned for construction this year, I think - certainly this coming financial year - on the Bunbury Regional Hospital site.

That is in motion. The Joondalup clinic should be open within a few months. Over the past several years a significant rebuilding program of dental clinics has been undertaken.

I would like to comment on two other issues. The first issue, particularly in regional Western Australia, is attracting qualified dentists. There has been a significant overseas recruitment drive. We have been successful in recruiting dentists, particularly from South Africa. I have met some of those people at both the Albany dental clinic and the Bunbury dental clinic. They are the ones who spring to mind; I am sure there have been others as well. From memory, a young South African couple has gone to work in the Kimberley. That has helped relieve some of the work force shortages that must be met if we are to continue to tackle the waiting lists.

We have also made provision during the life of this government for an extra $1 million a year for dental care. Interestingly, compared with elective surgery, which is relatively expensive, dental care is not. We can significantly slash dental waiting lists by a modest injection of funds. An injection of $1 million a year has caused our dental waiting lists to come down. The member for Albany spoke to me about the waiting times at the dental clinic in Albany, which resulted in the government starting to inject money in its previous term in order to shorten the waiting list. At that stage 26 000 Western Australians - I am talking about health care card holders or those on low incomes - were waiting for dental treatment. The last figure that I saw - I will ask the Director of Dental Services, David Neesham, to comment on this in a moment - was about 13 000. I am told it is now 14 000. It is hovering at half the rate it was three years ago due to that additional injection of funds. David Neesham may be able to provide further information, particularly with respect to country areas.

Mr T.K. WALDRON: And whether any new ones are planned.

Dr D. Neesham: The $1 million wait list initiative will hold the waitlist at about 12 000 to 14 000, with the wait time being between nine and 10 months. This is for routine care. Patients are seen for emergency care on the day they present. We do quite a bit of work on the wait list initiative through the private sector. We have good cooperation with the Australian Dental Association. We have built and redistributed our clinics in the metropolitan area and have been progressively upgrading facilities in country areas. Like all health areas, we have significant manpower issues. They will probably persist during the next three, four or five years until a larger number of local university graduates start to have an impact.

Mr T.K. WALDRON: That is good. People incur an extra cost when they cannot access government dental clinics and have to go through private providers. That is why I asked about extra clinics. I know that the minister cannot do it all, but in some areas people cannot get any access at all. That is something that probably needs to be looked at over time.

Mr A.P. O'GORMAN: One of the items listed under "Major Initiatives For 2006-07" on page 564 is "Genomics". The first dot point under that item refers to a genetics reference document for GPs, including editing by field experts. Is that referring to the Joondalup family health study, or is that the Busselton one? Is there funding in the budget for those family health services?

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

Dr S.C.B. Towler: I am pleased to respond to this. This is part of a package of initiatives that relate to the new health promotion agenda. We have identified the fact that if we provide GPs with a tool that facilitates in profiling a clinical history, it will point to a genetic predisposition. We believe this will be advantageous in identifying at-risk families. We hope to pilot the program in the next 12 months as part of the broad range of initiatives that relate to the Australian better health initiative.

Mr A.P. O'GORMAN: Does that genetics reference document come from the Busselton health study, or is that in general?

Dr S.C.B. Towler: We have developed that in-house through the genomics division of the health department. We are looking for further consultation on actually embedding the document.

Mr A.P. O'GORMAN: Is the department looking at the study that Lyle Palmer has undertaken in the Joondalup family health study? Will that feed into this eventually?

Dr S.C.B. Towler: This is specifically a tool to facilitate for general practice. We are looking at genetic risk profiling in assisting people to identify early those people with the risk of disease. That will help us to provide resources to the patient and their families around early prevention and intervention against chronic disease programs. It is completely separate.

Dr K.D. HAMES: The first dot point under "Major Achievements For 2005-06" on page 547 refers to cancer management. That allows me to ask a question about the breast cancer clinics at Royal Perth Hospital and Sir Charles Gairdner Hospital. As the minister is aware, we were involved in some media comment on that. The minister promised in a press release in November 1994 that $2.1 million would be provided to upgrade those

clinics and provide more facilities at Royal Perth Hospital and more staff at Sir Charles Gairdner Hospital. The criticism I have heard is not that the minister lacks a commitment to that program, because he does not. The $2.1 million that was promised was not specifically provided in the budget. It has not been specifically provided for those programs. It is expected to come out of the department's or hospitals' health budgets. Has the department specifically provided that $2.1 million anywhere in any budget, past or current, and will it now be provided to those two hospitals as a discrete, identified sum so that they can get on and do the things that the minister wants to see happen, as do I?

[8.10 pm]

Mr J.A. McGINTY: The Department of Health advised me in 2004 that those two things would be done. The breast cancer services would be expanded. In fact, at Royal Perth Hospital I was shown where they were going to knock out walls and expand the facilities. I thought that was tremendous. I was very disappointed to learn a couple of weeks ago that that has not happened. It seems that the people involved in providing the service at Royal Perth Hospital changed their minds about where they wanted to be located. Consequently, at their own leisurely pace, they went away and discussed and very slowly agreed to do something different from that which I was advised would happen. I was never advised of the change of plan, so I was upset when I found out that what I was told would happen and had announced would happen did not happen. I understand that, since the matter became public, appropriate works have been committed to within the next few months. The capital works will be undertaken to expand the floor area. The people who are currently occupying the space are leaving next month. When they go there will be some immediate modifications to the building. The capital works I indicated that will occur at Royal Perth Hospital to expand the services offered will be undertaken. It will not be before time. I was disappointed with what happened. The real issue that the member raises is the question of money for additional staff at Sir Charles Gairdner Hospital. I was informed that the money was available. I expect that it will now, as a matter of priority, be made available if it has not been already and that the staff will be recruited. I will ask either Linda Smith or John De Campo, whoever is responsible for that area, to provide the member with more up-to-date information on that.

Dr K.D. HAMES: I thought that the minister was going to provide the $2.1 million out of government coffers as additional money.

Mr J.A. McGINTY: No.

Dr K.D. HAMES: The reality is that it is coming from both those sources. That was supposed to integrate them rather than have them operate as two separate entities. Did that happen? Is it happening?

Mr J.A. McGINTY: I give the member the assurance that it will happen. It is not an additional provision of money on top of the budget. This year's budget is $3.9 billion. While every million dollars is a significant amount of money, if the health service said that it would do it, it will do it. In that context, I am not sure whether it is Ms Smith or Dr De Campo who would like to confirm that.

Dr J. De Campo: I can confirm that Linda Smith and I, on behalf of the two health services, are committed to an integrated service. In fact, the staff are working as an integrated service, which is fabulous. A lot of things are now integrated: vascular and neuroscience are two examples. On the operating side, we have arranged to recruit staff against an operating budget of about $1 million. That is to do with nurses and doctors for the integrated service. The service provision will be at both sites but, largely, recruitment will occur at Sir Charles Gairdner Hospital with the new money. The capital works money is largely at Royal Perth Hospital. As the minister said, there was a delay. It required a large number of the outpatients to move to the old dental hospital. That was opened just before Christmas, if I remember correctly. It has freed up space for the rather modest renovations; nevertheless, they are renovations in the main building.

Dr K.D. HAMES: A toilet where the patients are would be a great step forward!

Dr J. De Campo: The capital works are being completed at Royal Perth Hospital and the recruitment is occurring at Sir Charles Gairdner Hospital, which is in accord with the minister's direction.

Dr G.G. JACOBS: While we are discussing breast cancer services, I will mention the related issue of breast screening and mobile mammography, particularly in regional areas. For instance, in my area the mobile mammography clinic visits only every two years. Women who need to be screened on an annual basis have to make a trek somewhere else. I suggest to the minister that, to have an effective screening program for regional areas such as mine and that of the member for Wagin and lots of other places, it should be an annual service. I wonder whether the minister will take that on board. I have mentioned that previously in the house.

Mr J.A. McGINTY: I know that recently BreastScreen WA modified its eligibility rules for automatic recall and the definition of women at risk. I think that was the phrase; it referred to people with a significant family

history and the frequency with which they were to be recalled. I will take up the issue raised by the member because it is a very real point. I will discuss it with the people responsible to see what can be done. I will certainly take up the matter.

Dr G.G. JACOBS: Continuing with the theme of key efficiency indicators, can the minister provide some real indicators for the way the health system is performing in Western Australia? I refer to the issue of elective surgery wait lists. What is the current number of patients on wait lists for elective surgery for hip replacements, knee replacements, grommet insertions, cataract surgery and endoscopies? What is the current wait list for outpatient clinic appointments in those categories?

Mr J.A. McGINTY: The total number of people on the wait list at the end of March was 15 118. As the shadow minister is aware, we have been in the process of changing the reporting methods for elective surgery to more closely align with national requirements. That exercise is now complete. The next published figures will take into account a number of procedures, particularly those performed by non-specialists that are not included in the reported wait list figures. The new system will show two things. It will include more procedures, so the number of people on the list will grow. It will also show that there has been a higher throughput; in other words, more elective surgery has been undertaken than that which has traditionally been reported. We did the exercise for March this year. It showed that, under the old system of reporting, the total number of people on the list was 15 118 and under the new reporting rules the figure had risen to 16 832. I am happy to provide information about the procedures that are now included that were not previously included. We are starting from a different base, which is 11 per cent higher than that which we previously had. Some 11 per cent, or some 303 additional cases, are now caught by the procedure than was previously the case. Having said that, we are in the process of finalising new elective surgery procedures and rules that will go to the timeliness of those procedures. They will provide for everyone to get their elective surgery within the clinically desirable time, which has never been the case in Western Australia. We are hoping to achieve that in the medium term. We have a key performance indicator to that effect.

We are also looking at things such as cancellations. That arose from the case of Mr Ted Curtis - which was highlighted by the member for Dawesville - who, in my view, was treated abysmally, having had his procedure cancelled seven times. There are now new rules to prevent that from ever occurring again, provided the rules are followed. We are in the final stages of consultation on the new content of elective surgery rules. There will be an 11 per cent jump in the total number of people on the list, but it will be accompanied by higher throughput. Nonetheless, I expect to see that number continue to come down. This will make our reporting uniform with the way in which these matters are reported elsewhere.

We do not have information with us to answer the member's specific question about orthopaedics, but it is regularly published. It has not been so regularly published while we have been making the transition from the old reporting rules to the new reporting rules, but it certainly sets out the number of people waiting for orthopaedic surgery, and the different categories to which the member referred. The second question concerned the waiting time for outpatient appointments.

[8.20 pm]

Dr G.G. JACOBS: The waiting time to be assessed.

Mr J.A. McGINTY: Yes, that is right; the waiting time for an outpatient appointment to be assessed on the need for surgery. One of the things I am very pleased about is that we have seen, over the past nine months, a significant reduction in the number of people who are waiting. The member might remember that there was a total figure of -

Dr K.D. HAMES: Thirty-one thousand.

Mr J.A. McGINTY: Thirty-one thousand. There were 30 825 people, to be precise, but near enough to 31 000, waiting for an outpatient appointment to be assessed on their need for surgery. That number has declined to 24 000 over a period. A significant amount of that is operational efficiency within the Department of Health. The hospitals have been cleaning up their data on waitlists. For example, a number of people were put on waitlists at more than one hospital and names were not removed from waitlists once the patients had had their appointments - things of that nature. We are trying to make the whole system operate a lot more efficiently. It is very pleasing to see not so many people waiting. In addition to what we are doing with elective surgery - which I hope will see a very significant reduction in waiting times, and, for that matter, the number of people waiting for elective surgery - we must also tackle that wait for the wait issue. We are confident that a range of initiatives in outpatient reform will drive down the waiting time and the number of people waiting for outpatient appointments. When the consultation is finished, and I expect it to be within the next few weeks, I am happy to report to the house or directly to the members on those provisions, or to arrange a briefing for the members.

They are very significant reforms that will have an immediate impact on the health of public waiting lists for elective surgery which, in the popular mind, is probably one of the great indicators of the health of the public health system.

Dr G.G. JACOBS: One of the factors I was after is the waiting times for people to actually see someone in an outpatient clinic. I will share with the minister that I recently saw a surgeon about my knee, and he said I had torn the cartilage and that I need to have an operation. I could have the operation because I was privately insured, but he told me that the orthopaedics waiting list for an assessment for that to be done in the public system had blown out to four years.

Mr J.A. McGINTY: I am sure that is not right.

Dr G.G. JACOBS: That was not to get to surgery but to get an appointment to see the orthopaedic surgeon on a public outpatient list.

Mr J.A. McGINTY: Hopefully that was not someone thinking the member was not insured and trying to frighten him into taking a paid arrangement with him! No, that is just not true.

Dr G.G. JACOBS: Will the minister tell me the current waiting times for some of these procedures - for instance, a hip replacement?

Mr J.A. McGINTY: The outpatient departments at the major hospitals are able to give patients a rough indication of how long they will need to wait for an outpatient appointment. They are too long, but I have never heard of anything approaching four years, for any condition at any hospital.

Dr G.G. JACOBS: Even two years?

Mr J.A. McGINTY: Sure, it is too long. That is why I am saying that outpatient reform is designed to address that. That is what we are working on at the moment. I accept that that is far too long. It is unacceptable in a modern health system like the one we have. We are working on that. Outpatient reform will bring down that waiting time. We need to be able to drive that further and put extra resources into that. There is the question of the surgery itself. It depends, of course, on whether the patient is a category 1, 2 or 3 patient. However, most people have their surgery within the clinically desirable time. I assume the member's condition is non-urgent - category 3 - in which case it is clinically desirable to have it done within 12 months.

Dr K.D. HAMES: There are two parts to my question. Firstly, when will the minister again put those figures on the Internet? He has not published figures since June 2005 - nearly a year ago - and they were published in September for June. Secondly, would it not be possible to look at an alternative system in which a patient needing to go on a waiting list could see a specialist in the private sector first? Specialists will bulk-bill for most pensioners, and if they do not, they charge a fairly small amount. If the patient then has to see a specialist in a public hospital, it can be fed through them, making much better use of the private sector in determining surgery.

Mr J.A. McGINTY: That does happen, and there is provision in the new rules for it to continue.

Dr K.D. HAMES: They can do that, but they do not have to; they can get direct referrals from a general practitioner.

Mr J.A. McGINTY: They need to be assessed by the specialist, not by the GP, on the need for surgery. That is the procedure that is currently in place. There is nothing to stop somebody visiting a specialist. The patient may well need to meet the difference between the Medicare payment and the fee that is charged by the surgeon, or it might well be that some of these specialists bulk-bill pensioners and people with health care cards. They can go on the list from that.

Dr K.D. HAMES: I am talking about trying to reduce the number of patients that the surgeon making the determination on waitlist surgery has to see. Even those surgeons can see people privately in their own rooms. Mostly they say they will not. When I sent a patient to a surgeon I would say that the patient is thinking about having private surgery, and so the surgeon had better see the patient first to decide. That way the surgeons could not say no.

Mr J.A. McGINTY: I am hoping that the outpatient reform program that is under way at the moment will sufficiently tackle the existing problem to be able to effect an enormous improvement in the waiting times for people to see a specialist in an outpatient context, with a view to then getting their surgery. We are tackling both ends of the problem with elective surgery, by putting more resources into it and driving the efficiencies there and having the new targets I have just mentioned to the member -

Dr K.D. HAMES: What about coming back on the Internet?

Mr J.A. McGINTY: Sorry?

Dr K.D. HAMES: What about the figures coming back on the Internet?

Mr J.A. McGINTY: Oh, yes. Sorry, I should say that the reason for the delay in the past few months is that we have been adjusting from one system to another. That adjustment is now complete, and there is no reason that information cannot be back on the Internet within weeks, on the new reporting scale rather than the old one.

Dr K.D. HAMES: I - we, presumably - would like a briefing. Thank you.

The CHAIRMAN: The member for Kimberley is not present, so the next question defers to the member for Dawesville.

Mr D.F. BARRON-SULLIVAN: Madam Chairman, sorry to be a nuisance. I am on the list, am I not?

The CHAIRMAN: Yes. I am following the list as the previous Chair had it.

[8.30 pm]

Dr K.D. HAMES: Page 559 is the page that refers to the patient assisted travel scheme. The question is about what we can do to improve it. I know there is mention of reviews and things that are happening. My electorate has two key problems with the PATS scheme. One is that the 100-kilometre zone goes right through the middle of my electorate. People on one street qualify and people on the next street do not. Secondly, it is just the amount of money in PATS now. It was fine when petrol was 50c a litre; now it is $1.30 a litre and it is very difficult for people. The people who are suffering most are oncology patients, who can go only to Sir Charles Gairdner Hospital clinic for radiotherapy. They often have to come to Perth five days a week for five to six weeks in a row. Finding accommodation in Perth is exceptionally difficult for them. There is a bus service but the trip takes a full day. Elderly patients having chemotherapy and radiotherapy for cancer are often very sick and it is very difficult for them. I am asking the minister whether he will have another look at the scheme. We fiddled with it when we were in government, sometimes perhaps for the better and certainly sometimes for the worse. Will the minister have another look at the scheme to see what he can do to change the 100-kilometre zone? The Cancer Council of WA is very keen for something to be done to address the problem and to look at the amount of funding.

Mr P.B. WATSON: Did you say more than 100 kilometres or less than 100 kilometres?

Dr K.D. HAMES: If someone lives less than 100 kilometres from Perth, that person cannot apply, or the qualification for approval is different.

Mr P.B. WATSON: Yes, I know, but do you want it to be more than 100 kilometres?

Dr K.D. HAMES: The 100-kilometre zone needs to be looked at because it goes through the middle of Dawesville and there are patients with cancer there on one side of Dawesville who miss out. It is a very long way for them to come to Perth. I accept that it is a lot further from the member for Albany's electorate.

The CHAIRMAN: Members, shall we look for an answer?

Mr J.A. McGINTY: I think the member for Wagin - certainly a member of the National Party - said to me when petrol prices first soared, "What about the poor old PATS patients; why don't you give them a bit of relief and increase the number of cents per kilometre that is paid?" So I did that and then got hammered by the National Party for it not being enough. I walked straight into that one.

Mr T.K. WALDRON: We did say that we appreciated it, but we thought the minister could have gone a bit further.

Mr J.A. McGINTY: I am now very wary about propositions that come from members of the National Party, as they might end up belting me around the ears!

Mr A.P. O'GORMAN: When we get the airline, it will fix a lot of the problems.

Mr J.A. McGINTY: We did provide a modest increase for people who travel four or more times a year to access specialist treatment or treatment for which the PATS subsidy is available.

Mr T.K. WALDRON: Yes.

Mr J.A. McGINTY: The other issue with cancer care - which I will speak about, although it is not a response specifically about PATS - is that the two new linear accelerators at the cancer centre at Sir Charles Gairdner Hospital have now been completed and are in the commissioning stage. It looks like a magnificent facility and people can expect to be treated in state-of-the-art facilities. That is a big step forward. The centre will be officially opened in the next few weeks and I expect the time spent waiting for radiation therapy treatment will be significantly slashed as a result of that significant upgrade. I also refer members to the cancer services plan for the whole state, a plan that has significant ramifications for country cancer patients. That plan recommended

that there be two cancer centres in Western Australia: one at Sir Charles Gairdner Hospital and one at the proposed Fiona Stanley hospital. We have accepted that recommendation and that will be incorporated into the proposed Fiona Stanley hospital, which I think will be of some benefit to the member for Dawesville's constituents in terms of ease of access.

Dr K.D. HAMES: It will be about 10 to 15 minutes away.

Mr J.A. McGINTY: It will be accessible by public transport: it will be on the railway line and it will be on the bus line. It will be a lot more convenient for everyone living south of the river. Another issue is that the 100-kilometre limit in PATS is for routine cases. For chronic cases, and I will take advice from other people, I thought someone undergoing daily treatment, such as chemotherapy or something of that nature -

Dr K.D. HAMES: No, they have been knocked back.

Mr J.A. McGINTY: For the 70-kilometre limit?

Dr K.D. HAMES: Yes. The 100-kilometre zone goes through almost the heart of my electorate, as distinct from many others. Patients have come to me complaining that they had been refused PATS because they lived 50 metres inside the zone. It is hard to work out exactly.

Mr J.A. McGINTY: But for chronic conditions -

Dr K.D. HAMES: These are cancer patients going to Sir Charles Gairdner for radiotherapy.

Mr J.A. McGINTY: Seventy kilometres is the limit, not 100 kilometres.

Dr K.D. HAMES: Is it?

Mr J.A. McGINTY: That is within the existing guidelines.

Dr K.D. HAMES: Why would they have been knocked back?

Mr J.A. McGINTY: That specific issue has not been raised with me, but I would have thought that covered the member for Dawesville's constituents who require constant care and treatment.

Dr K.D. HAMES: I am glad to know that, because it has not covered them. They have definitely been knocked back, so that is good to know.

Mr J.A. McGINTY: Can I say that this is just my own opinion, subject to the advice that I will receive. They should be eligible if they are within the 70-kilometre limit when they are on a daily or an almost daily regime.

Dr K.D. HAMES: With all these advisers here, can no-one tell the minister?

Mr J.A. McGINTY: I am sure they can.

The CHAIRMAN: Does the member for Wagin have a further question?

Mr T.K. WALDRON: Just a quick question. PATS is a good scheme and we keep trying to tinker with it to try to improve it. I read recently that there was talk about a national scheme. I do not know what is proposed and how it would work.

Mr J.A. McGINTY: For PATS?

Mr T.K. WALDRON: Yes. I read only about four weeks ago that a national scheme was being floated. Has that gone any further?

Mr J.A. McGINTY: No. It is not something that has ever been raised with me.

Mr T.K. WALDRON: I read about it in the paper.

Mr J.A. McGINTY: Did the member for Wagin get it from any reliable source?

Mr T.K. WALDRON: It might have been a National Party source!

Mr D.F. BARRON-SULLIVAN: My long-awaited question relates to two or three references on page 542 on specialised mental health care services. The minister will see that over the last year about $5.7 million was underspent; in community mental health care, in the same column, about $4.2 million was underspent. Also page 546, which links in with that, indicates that only 60 per cent of discharged mental health inpatients are seen within seven days of discharge and 74 per cent within 14 days of discharge. As the minister knows, it is very important that a lot of mental health care patients who are discharged from hospital be seen by community health nurses and so on. As the minister is also undoubtedly aware, there are also difficulties, particularly in the metropolitan area - I single out the south metropolitan area, which covers areas such as Armadale and Kelmscott.

The staff in those areas are finding that there are impediments for community health workers to actually get out and see mental health care patients. That explains to quite a degree why many mental health care patients are not being seen within a fortnight of discharge from hospital. There are two key reasons. The first, which is something that is beyond the minister's immediate control, is the terrible mobile phone reception in an area such as Kelmscott. Secondly, within the South Metropolitan Area Health Service - and I am aware that this is also the case elsewhere - there are not enough government cars to go around, as a result of which many mental health care patients are not seen within seven or 14 days of discharge. I note in the budget that there was significant underspending in both those areas. Will the minister consider improving the means of communication for staff who visit discharged mental health care patients, particularly by providing satellite phones, as the reception is appalling and in some areas it is nonexistent? Also, will the minister consider increasing the number of vehicles in the South Metropolitan Area Health Service so that health care workers can get out and visit discharged mental health care patients? The Occupational Safety and Health Regulations state that in cases such as this an employer must ensure that a means of communication is available. The minister would understand that many people are either deterred from seeing patients or have to use their own vehicles to see them. Therefore, to get that figure hopefully to a higher rate than 74 per cent, will the minister consider providing satellite phones and improving the availability of vehicles?

Mr J.A. McGINTY: In 2004 the government announced a mental health strategy that had five components. In essence those five strategies were to add to the bulk of the effort that we were putting into mental health services. They involved more inpatient beds for the acutely mentally ill, more accommodation for the sub-acutely mentally ill, emergency department responses for people with mental health conditions and the employment of something like 430 additional professional mental health staff to implement those various strategies. They also involved a range of health and safety matters affecting mental health nurses, particularly after the bashing of Debbie Freeman, which highlighted a number of shortcomings, including the communications issue to which the member has referred. That was $173 million, a lot of which was tied up in capital for the construction of the new accommodation facilities for the mentally ill. The member is quite right to point to the underspending in this area during the financial year about to end. The total underspend amounts to some $14 million. We were simply unable, in the heated construction market, to get the facilities built, particularly for inpatient beds. Therefore, the staff were not needed and there was an underspend. The Treasurer has agreed to allow us to carry forward that $14 million into the coming financial year, when we expect the new inpatient beds and the new facilities to be available; therefore, that expenditure will be incurred, albeit a little later than was otherwise intended. The total underspend that will be carried forward is $14.56 million, all of which is part of the additional funding for the mental health strategy to which I have referred. The first of the five components of that strategy was to deal with emergency department mental health liaison nurses. I think that either 20 or 25 nurses were to be employed so that there was a mental health capacity in each of the key emergency departments to deal with mental health patients who present, because they can often be a tremendous drain on the resources of busy emergency departments. Extra beds and staff were provided to enable that to occur. The second initiative -

[8.40 pm]

Mr D.F. BARRON-SULLIVAN: We are really talking about mental health care patients who have been discharged from hospital, and we are trying to ensure that they are seen within seven to 14 days by community health workers.

Mr J.A. McGINTY: Sure, and I am coming to that point, because that is part of the mental health capacity building strategy. The second component of the strategy was to have an extra 107 secure and open mental health beds within the system; the third component was to enhance community mental health services; the fourth was community accommodation; and the fifth was the health and safety, qualifications, training etc of mental health staff. I will give one example of the enhancement of community mental health services. The psychiatric emergency team has been disbanded and replaced with two teams - one team for the north metropolitan region and one for the south metropolitan region - so that there is greater capacity to respond in the community. New services have been opened. Modern systemic therapy teams have now been employed, child and adolescent community services have been enhanced, and intensive community youth services have been developed. A big effort has been made to provide services in areas in which they had not been previously provided. Specifically, in relation to the south metropolitan area follow-up, I do not know whether Dr Peter Wynn Owen can comment on the two points raised by the member; that is, the communications issue and the timeliness of those follow-ups.

[Mrs J. Hughes took the chair.]

Mr D.F. BARRON-SULLIVAN: Basically, vehicles and satellite phones.

Dr P. Wynn Owen: The South Metropolitan Area Health Service has in fact received funding within the health strategy for key initiative 5 for satellite phones. It is going ahead with the plan to purchase and is deciding exactly where to place those phones. Recognising the issue that the member has raised, that should occur very shortly. One point about the data on patients receiving follow-up is that patients receiving non-face to face follow-up or non-community mental health clinic follow-up are not captured in the data. Thus, those people who are contacted by telephone in the period post-discharge and those people returning to other day treatment programs or rehabilitation services are often deemed not to require an outpatient appointment at a community mental health clinic. I agree that the figures are not ideal, but they are better than they were. I think that the figures are higher if this point is taken into account.

Mr D.F. BARRON-SULLIVAN: I have a further question.

Mr J.A. McGINTY: The member has already scored satellite phones! What more does he want?

Mr D.F. BARRON-SULLIVAN: I know; it is brilliant. The obvious question is: how many satellite phones? I understand that the service will be up to about 20 vehicles short if it is to provide vehicles to community health workers. How many satellite phones will there be, and is there any likelihood of an improvement in the availability of vehicles?

Dr P. Wynn Owen: I am not sure exactly how many phones there will be; there has been an allocation of dollars, rather than a number of telephones to the South Metropolitan Area Health Service. The issue of vehicles is with the South Metropolitan Area Health Service itself, although some of the mental health strategy funding, including for the development of two additional community mental health teams within the south metropolitan area, would have allowed some capacity to increase its vehicle fleet.

Mr T.K. WALDRON: I found it a bit hard to find a reference in the budget papers under which I could ask this question, but I finally found one. Reference is made to road safety initiatives at the bottom of page 541. Of course, if there is a road accident, quite often blood is needed. I have previously raised this issue with the minister. There has been a recent call for more blood. People in inland country WA cannot give blood. I know that the mobile service was discontinued. Has any thought been given to restarting the mobile blood collection service? Is any thought being given to having other collection centres, so that people in my region can donate blood and not feel frustrated when they hear desperate calls for blood and cannot give it? It is a genuine question.

Mr J.A. McGINTY: Sure, and I understand that. The Australian Red Cross is responsible for this service. The funding arrangements between the state and the commonwealth require agreement, so it is not something on which we can direct the Red Cross or which we should unilaterally provide funding for. The advice we have received from the Red Cross when the issue of mobile clinics has been raised is that they are simply not cost-effective in servicing moderate-sized country communities. That was the general nature of the information; it was not precisely in those terms. Therefore, the Red Cross withdrew the mobile clinic from - I forget exactly which community it was, but the member might know it -

Mr T.K. WALDRON: It withdrew the mobile blood collection unit. It used to travel to different areas. It used to go to schools and it created a culture of donating blood in kids over the age of 16. It seems a shame. The issue is constantly raised with me, because people cannot give blood. I know that the Red Cross has the final say, but I am sure that if the minister directed the Red Cross, something could be done in the future. It is inequitable that people in those areas cannot give blood when they want to do so. We can say that they can give blood when they are in Perth, which a lot of them do, but the reality is that it is very inconvenient and they do not do it because of time constraints.

Mr J.A. McGINTY: Sure. I drop in to Fremantle Hospital every quarter; it is just a walk away from home and my office and it is easy. That is something that -

Mr P.B. WATSON: That answers a lot of questions that people have been asking!

Mr J.A. McGINTY: The member will keep!

Mr T.K. WALDRON: I do not want the safety standards for collecting blood to be affected. I understand the need for those standards.

Mr J.A. McGINTY: It is not a safety issue.

Mr T.K. WALDRON: However, the safety issue is the reason that we do not have a blood collection unit in Narrogin.

Mr J.A. McGINTY: No; I think it is economic. It is the cost associated with it. I am not an economic rationalist. I think a community benefit can be gained from doing exactly what the member is advocating.

Mr T.K. WALDRON: During my grievance on the issue, I made some suggestions about how it could be done, including taking the van to major field days, the Royal Show and major events. That would become more cost-effective. I would like the minister to encourage the Red Cross to reconsider it.

Mr J.A. McGINTY: We did. We raised it with the Red Cross at the time and the answer that came back was no. It is the Red Cross's call. Given any opportunity, including tonight, I urge the Red Cross to reconsider that service, because there is a broader benefit that is not purely economically rational.

Mr T.K. WALDRON: I agree with the minister.

Mr P.B. WATSON: I refer to the major achievements for 2005-06 listed on page 559 and the patient assisted travel scheme. An evaluation of the introduction of call-centre technology was carried out in the south west. The technology is being used in the administration of PATS in the south west. A lot of concerns are raised with me about PATS and what people are entitled to. Are there any plans to have call centre technology in the great southern region?

[8.50 pm]

Mr J.A. McGINTY: This does not relate to the last interjection that the member made, but, unfortunately, the answer is no. We would obviously look at it if there were sufficient justification for it, but it is not currently under consideration.

Mr P.B. WATSON: Has it been successful in the south west; and, if so, in what way?

Mrs C. O'Farrell: It is relatively early days since we took over responsibility for the South West Area Health Service. That is one of the things that we will look at. I understand that the indications are that the system works quite well in that region. In terms of its applicability to other regions across the country, and there are six of them, I would need to be convinced that it is affordable and cost effective. If it is, then it is a system we would move to if it has clear benefits, but if it extrapolates to a very high cost with no benefits, then we will not be doing it.

Dr K.D. HAMES: I refer to page 560, just to let me talk about issues to do with Princess Margaret Hospital for Children. This issue relates to child abuse and the unfortunate case mentioned in the newspapers in the past couple of days of the child who died in PMH a year ago. I cast no aspersions on PMH, because its staff did exactly what they could. Going through the review that the department has released and looking at the child protection unit, it states under "Ability to meet demand", which refers to waiting times, that they are excessive and that there is increased risk of an adverse outcome. Under the second head of "Ability to meet standards", it states that it intermittently failed to fulfil clinical practice guidelines or standards of practice. This occurred a year ago. What has changed in the year? What improvements have been made to assist people working in that unit? They have asked for an extra FTE consultant and an extra FTE social worker and two interview rooms. We have been through the issue of the $15 million. As the minister knows, the $15 million is for capital works. There is only $2 million for next year. PMH doctors say that they want extra recurrent funds to address all these issues. As the minister knows, 55 per cent listed "3" somewhere in the report, indicating a major problem in their departments; that is, over half. What is the minister doing to address those concerns in the overall report, apart from capital funding dollars? I pose the key question: where is the minister getting that money? Is it coming out of additional recurrent expenditure or out of money in the budget now?

Mr J.A. McGINTY: A couple of observations most probably need to be made. First, $15 million has been set aside for some time for capital works at PMH to ensure that it is able to provide a good quality of care pending its move to the new site. As we discussed earlier, I would expect that within the next couple of months we will make a final decision on the site of the new children's hospital. From discussions I have had with doctors at PMH, they see decisions about where it will be and what it is co-located with as being the long-term objectives.

Dr K.D. HAMES: That is true; I agree.

Mr J.A. McGINTY: Obviously, in the meantime we must make sure that the services are up to standard and expanded where significant gaps are exposed. That is the beauty of the gaps in services report that was prepared by the clinicians at PMH. The $15 million, while it is spread over the next five to eight years -

Dr K.D. HAMES: It is $2 million next year.

Mr J.A. McGINTY: That is flexible. It is capable of being brought forward. The arrangement I have with the Treasurer is that, provided it fits within the capital works limits set for each year, there is the ability within the

portfolio to move those capital works moneys around. There would be the capacity, for instance, if another project were to be delayed, to bring forward some of the PMH money. Frankly, I think we will have to do that.

Dr K.D. HAMES: That is good, but those are recurrent funds.

Mr J.A. McGINTY: No, this is the capital side. For instance, we have committed to a new major procedure room and - this part will not be that expensive - to an office renovation for the doctors. Those are the sorts of things that we have already committed to up front. We will be getting in there and spending that capital money to get that work done. The first issue is the long-term location of the new children's hospital, the second is the capital works, and the third is recurrent expenditure. Normally people do not need to repeat things to me, but the doctors felt that they needed to repeat to me several times that they were in need of more recurrent funding for a range of matters. The Botox clinic for cerebral palsy children was apparently given funding only to start it up and for one year's operation. Obviously, we do not start up a service like that and then shut it down at the end of the financial year, so money needed to be found internally. We need to look at recurrent funding in the context of a $3.9 billion budget. This report has revealed particular pressures at PMH. The doctors simply said in respect of most of the issues that there was a gap in service and they would be happy if people went away to develop a proper business case so that the doctors would know what it would cost and could then set about implementing it. To say that they will do it properly rather than immediately demanding that tomorrow something should happen is a very sensible and rational view on their part.

Dr K.D. HAMES: They need fairly specific kinds of things: for example, they need 1.1 FTEs for cardiology liaison. They must have done a fair bit of work already to work out exactly what they need, and they have told the minister what they need.

Mr J.A. McGINTY: One of the things I will not do is simply throw money at a problem because it is a political issue. It will be done properly with business cases and issues being properly assessed. For too long health has not done that. Money has simply been thrown at a problem in the hope that it will go away. That is the past.

Dr K.D. HAMES: The minister does not have a business case for closing Royal Perth Hospital and redoing Sir Charles Gairdner Hospital, but that is a different matter.

Mr J.A. McGINTY: I am even hopeful that we will get the member's support for the closure of Royal Perth Hospital as part of the total plan to rebuild our hospitals.

Mr A.P. O'GORMAN: Page 566 refers to drug and alcohol services. The second dot point reads -

> In partnership with the non-government sector and with local community action, expanded alcohol abuse prevention programs and drug abuse prevention programs will be implemented through the Enough is Enough and the Drug Aware public health campaigns respectively.

I am keen to know what those campaigns involve and which non-government agencies are involved in partnership with the authority to deliver the service. How far does it extend; is it regional and metropolitan?

Mr T. Murphy: First, the Drug Aware campaign is a brand that has been in existence for some time. We have had continual public education efforts carefully targeted to where drug users are, such as night venues, some hotels and so on, for an extended period. In early June we will be launching a more substantial public health campaign targeting amphetamine use. That will include education through the media of youth press, radio and the Internet, as well as convenience advertising in nightclubs, hotels and the like. This program will be delivered substantially by the Western Australian network of alcohol and other drug agencies, which are the peak organisations for non-government services, in line with government policy that public health campaigns are delivered substantially by non-government agencies. This is an important partnership that brings in not only government services but also the network, which represents some 80 different agencies. Additionally, groups like local drug action groups, which are volunteer groups throughout the state, get involved in these campaigns. The same approach applies for alcohol campaigns. We have in planning, and have had some exposure of, the Enough is Enough campaign message. That largely targets a culture of drinking that results in drunkenness in the community, and aims to build up an intolerance of that mode of drinking. We will see a rolling campaign, particularly through regional areas, aiming to get agencies as well as community members, through a range of community organisations, active in their communities, advocating for sensible drinking practices and the appropriate service of alcohol through licensed premises.

[9.00 pm]

Mr A.P. O'GORMAN: While we are on that, the needle and syringe distribution program will be expanded into the south west. Can Mr Murphy tell us how extensive that needle and syringe distribution and, I assume, disposal campaign has been and how successful it has been?

Mr J.A. McGINTY: It is a very penetrating question!

Mr T. Murphy: In general terms, the needle and syringe exchange program has been very successful in limiting the spread of HIV AIDS. I think we all know that this state and this country have been relatively free of the spread of that disease through injecting drug users. We are pretty confident too that it has limited the spread of hepatitis C. The incidence of that disease continues to increase, but partially at least as a result of uncovering people who were infected as many as 20 years ago. Over the years, the number of needles and syringes distributed has grown steadily. It is some three and a half million a year now, approximately. That is partially a disturbing reflection of the increase in injecting drug use, but, on the other hand, it is a reflection of our penetration into that group of people who are sharing needles less. Our aim is to have comprehensive statewide coverage of the availability of needles and syringes. What we have been experiencing over the past few years is a shift in the distribution from chemists, and people purchasing that equipment through commercial chemists, to public facilities, which includes a range of exchange programs, including, in areas such as the south west, local hospitals.

Mr A.P. O'GORMAN: I believe the syringe exchange program was discontinued in Joondalup some years ago. Is it back in the Joondalup area now and is it operating successfully, do you know?

Mr T. Murphy: Needles and syringes are certainly available in Joondalup. I am not sure which particular service the member is referring to. It may be the mobile exchange.

Mr A.P. O'GORMAN: It is the mobile service.

Mr T. Murphy: The mobile exchange is run by the WA AIDS Council. It tends to target its delivery to where there are sufficient numbers to justify the service going there. Without checking with the WA AIDS Council, I would be confident that that is the basis on which it would make that decision.

Mrs C.A. MARTIN: I refer to the second dot point from the bottom on page 566.

The CHAIRMAN: Is this on the same subject?

Mrs C.A. MARTIN: It is about drug and alcohol services. The second dot point from the bottom relates to volatile substances and the training that is available for Aboriginal workers. Can I be given a bit more information about this? Is that about petrol sniffing?

Mr T. Murphy: Yes, petrol sniffing predominantly, but the occurrence of volatile substance abuse also covers glues and a range of household products. I must say that we are in a relatively fortunate position in Western Australia, where use is sporadic and not chronic in either Aboriginal communities or regional centres. However, when that use does arise or when services come up against that problem, the Drug and Alcohol Office will provide training and resources for those workers.

Mrs C.A. MARTIN: Does that mean that the Drug and Alcohol Office would work with the Kimberley Aboriginal Medical Services Council, the Broome Regional Aboriginal Medical Service and the other AMSs in my region?

Mr T. Murphy: It would more likely be the community drug service team in the Kimberley, which in turn would work with the Kimberley Aboriginal Medical Services Council and its member Aboriginal community-controlled health organisations. It also takes us to specific communities. For example, a good deal of work was done in Balgo in the past couple of years.

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

Dr K.D. HAMES: I will use page 544, which is an emergency department section, to talk about the winter bed strategy. We have not heard about one yet. There have been no announcements about winter bed strategies. Will the minister tell us when he will do that, what money he will allocate and where he will put those beds? I recall that last year the minister purchased some beds from places such as Mercy Hospital. In fact, I think the minister had trouble and was shopping around, trying to purchase sufficient beds to cover the winter bed strategy. When will the minister do it, how much will be allocated, and where will he get the beds? And, yes, I would like one of those Minties!

Mr D.F. BARRON-SULLIVAN: It is times like these you need a McGinty!

The CHAIRMAN: The Minties fairy has been in here while I have been out.

Dr N. Fong: We are preparing, and are well prepared, for winter 2006. As the member knows, the continuing demand on our emergency services and emergency departments across the whole metropolitan area is something that is shared with every state of the nation. I had a meeting with my fellow chief executive officers just two weeks ago, and the activity levels are about the same. Many of the reasons for that are well known, not the least

being in the member's own area of general practice, in past days. Access to general practitioners and consultations by members of the Western Australian community is well down on what it would be if we were able to access the number of GPs that this state should have. We have 10.3 consultations per person per year. The national average is 11. If we use that calculation, we are between one million and 1.4 million GP consultations down in this state. If we use another method, it has been flat lined at about eight million consultations per annum. With three per cent growth at that rate, we are about 500 000 down. Whichever way we model it, we have a lack of primary care, which we think is one of the reasons that more people are turning up at our emergency departments.

Notwithstanding that, we are putting strategies in place to deal with the upstream management of that demand before people hit the hospital. We have referred to a number of those strategies tonight. The three key things that we will be doing in upstream demand management for the winter this year will be really revving up and cranking up the Hospital in the Home and Rehabilitation in the Home programs. This time last year we were seeing 30 patients a day in the Hospital in the Home program. That is now a hundred. At the end of this winter, we expect that figure to have grown by at least another 50, and our target for the whole of this year is to increase that by 150, so that at the end of this financial year we will have 250 Hospital in the Home patients on any given day across the metropolitan area. It is not that difficult to do when one considers that on any given day we have 565 or so palliative care patients being cared for at home with community care, non-government sector organisations and primary care practitioners. We will also ensure that our upstream demand management initiatives for winter are assisted in the area of mental health. We have said before that mental health is one of the key blockers and causes of distress and high workloads in our EDs throughout the year, but particularly at this time of the year - winter - when we have the other coughs, colds and flus coming in. We expect to have, through better management, using community mental health teams and psychiatric emergency teams, which we talked about earlier, about another 15 beds that will be in a sense saved and not used through those upstream initiatives.

The second thing we will do is continue our strong focus on better management of patients in the hospitals through aggressive patient flow and length of stay strategies to reduce the length of stay across our metropolitan hospitals. In one of our area health services we have been successful in reducing the length of stay from 4.8 days to 4.0 days in the past 12 months. Obviously that creates more capacity if one does the number of admissions per year, and that frees up beds. We will do that progressively, not just because it provides more beds, but also because it will be better for patients if we can get them out of hospital. We expect - this is a fairly conservative estimate - that throughout this winter, with the aggressive patient flow program and length of stay management, we will have an additional 35 beds. We will be moving about 10 beds - five north and five south; they are small numbers - through reducing some of the elective surgery activity to make extra general medical beds available during this period. It is quite precise and quite detailed. The bed availability across the wards gets down to single digit numbers.

We will also be promoting further the moving out of patients who do not need to be in hospital. We have identified that at any time across the metropolitan area there are approximately 50 care-awaiting placement or sub acute-type patients who do not need to be there. We have probably identified now about half of the places that they could move to. We have contracted with some other organisations for transitional care. That will provide an extra 50 beds. As I said before, at the moment the mental health centralised bed management is a little ad hoc, although it is well managed despite that. The better management of mental health patients into intermediate care facilities, with the extra beds at Armadale and, hopefully, Bentley in a couple of months' time, will free up beds that are currently held by mental health patients who should not be in hospital. They are the first two things we will do - upstream management, and better management in hospitals.

The third thing would be to add some funded beds that are in the mix already, to get back to the member's first point. We will be adding 55 beds. Fifteen of those will be in the north and 40 in the south, with about 20 at Royal Perth and about 25 at Fremantle.

[9.10 pm]

Dr K.D. HAMES: How many at Sir Charles Gairdner?

Dr N. Fong: Fifteen. We are already recruiting for those. The north has already recruited, and the south is in the process of finalising that. I have spoken about the additional 17 mental health beds at Armadale and, hopefully, Bentley. We have five emergency beds in the emergency department at Fremantle, which will come online similar to the ones at Joondalup and Royal Perth. Overall, when we add that together, a lot of work will need to be done to make this work, but we believe we have the bed equivalents to manage demand in the system this year. We can add that to the aggressive campaigns that we will be doing in immunisation over the next couple of weeks, and all the other things, which I will not go into, that we are doing to enhance primary care. I

agree with the member that it will take some time for that to crank up. We are putting more resources into that at the beginning of this financial year, including the chronic disease management team and so on. We are hopeful. It will be tight, but we are confident that we know what the problem is and we have a plan to meet it.

Dr K.D. HAMES: Those plans sound very good, and I know the health department has been working on a lot of those for a long time. That is my point. It has been doing a lot of those things for quite some time. I refer to the hospital that has only 590 beds but really uses 630 beds. The department is presumably going to give it 15 beds on top of that. Sir Charles Gairdner Hospital has been doing this aggressive discharge campaign, and it has been very successful. Yet, on a Monday morning not one month ago, when it was not yet winter, 15 patients were in emergency waiting to be admitted. On that Monday morning, 100 patients in the three major hospitals were waiting for beds. That is 100 patients short. It was not winter, but a standard day. That increased demand is occurring Australia-wide. All those programs are being put in place, but winter is only one month away. These programs will not suddenly create a huge number of beds in one month. Are 15 additional beds enough to cover the situation in the short term? I accept that in the medium term or even this year it might be enough, but winter is only one month away.

Mr J.A. McGINTY: What Dr Fong has outlined would free up more than 230 hospital beds to be used during this coming winter. Dr Fong has referred to the reduction in the average length of stay at Sir Charles Gairdner Hospital from 4.8 days to 4.0 days. That is the equivalent of 90 000 bed days in a year.

Dr K.D. HAMES: But that has already happened.

Mr J.A. McGINTY: No, it is happening. That is the point.

Dr K.D. HAMES: Dr Fong has been doing that already.

Mr J.A. McGINTY: Sure. We have been driving it, but it has not yet been achieved at Fremantle or Royal Perth.

Dr K.D. HAMES: Those beds have already been freed at Sir Charles Gairdner. However, while that program is in place, there were still 50 people waiting in the emergency department.

Mr J.A. McGINTY: The Hospital in the Home program is now taking off. As has been indicated, this time last year there were 30 hospital beds in the home. There are 100 today, and there will be 250 during the next financial year.

Dr K.D. HAMES: And in one month's time?

Mr J.A. McGINTY: It will ramp up considerably. The use of the Hospital in the Home program will result in quite a significant increase in the number of beds available. This morning I opened the new Victoria Park depot for the St John Ambulance Association. I had a good discussion with the ambulance service about patient distribution. It would be wrong to look simply at Sir Charles Gairdner Hospital when patients are now distributed according to the hospital that can best meet their needs in terms of the demand that is already there, the one that is most appropriate for their condition, and where they can be seen the fastest.

Dr K.D. HAMES: The minister has heard the ambulance service's complaint that its ambulances are being used as beds. I have a graph showing the latest ramping rates. They are dreadful.

Mr J.A. McGINTY: All those patients are inside the emergency department. None of those patients is staying outside in the ambulance in those circumstances. We have looked at all those issues that Dr Fong has described so well. We are trying to change the hospital-centric view in Western Australia that if people are ill they need to go to hospital and make people less dependant upon hospitals, particularly those with chronic diseases and those who can be appropriately treated at home, in order to free up beds for those people who really need them. The AMA has said that we need 200 beds this winter. We are proposing 230 as a result of these initiatives, which include the opening of quite a large number of beds. We are also freeing up beds for other purposes.

In addition to what Dr Fong described, in this calendar year there will also be a very big increase in the number of mental health beds available with the 12 extra beds at Graylands Hospital and the 16 at Hawthorn Hospital as a step-down facility. That is an additional 28 beds that will be available as we tail out of winter, admittedly, but people know that respite is coming, particularly on the mental health front. That area has constantly been drawn to my attention by all the ED doctors whom I have spoken to about the great demands that are placed on their services.

Dr K.D. HAMES: It is good to see the minister's great faith. I have great faith in the emergency departments, but the media will still be happy this winter, because it will be reporting on the severe overcrowding in the emergency departments. Time will tell.

Mr J.A. McGINTY: The member seems to be a doomsayer.

Dr K.D. HAMES: No. I am a predictor.

Mr J.A. McGINTY: The member can hope.

Dr K.D. HAMES: I hope I am wrong.

Mr D.F. BARRON-SULLIVAN: I take the minister back to page 542 and the answer he gave me a while back about the $14 million in underspending on various mental health services. I will use service 2 to look at this in more detail. The intention was to increase funding in that area last year from $104.8 million to $120.7 million. What is the full-year cost of that service with the increase built in? It will make it easier to frame my question when I know that.

Dr N. Fong: Part of the difficulty in answering this question is that mental health is spread across three services that we have listed. The minister mentioned before about the underspend of $14 million this year. We do have that figure for the total amount for 2005-06 and 2006-07. The figure for this year, including the $14 million carryover, will be $47.269 million. That includes the $23 million that was allocated in year 3 of the mental health strategy in 2004-05 plus the carryover and an additional $8.7 million, which takes it to a total of $47.269 million.

[9.20 pm]

Mr D.F. BARRON-SULLIVAN: When you mention $47.269 million, what is that? I am looking at a figure here for this year of $125.899 million for service 2, which is specialised mental health services.

Dr N. Fong: That is the ongoing funding for mental health; this is the mental health strategy funding.

Mr D.F. BARRON-SULLIVAN: That is exactly what I am trying not to get drawn into. What is the full-year cost of service 2, including the services that were supposed to be included last year? Is $125.899 million now the full-year cost of the service, including the increase that was meant to be built in last year? I will make a very simple point in a moment but I need the answer to that.

Dr N. Fong: Of the $120.65 million that was budgeted for 2005-06, the estimated actual was $114.916 million, which is the underspend. As the minister said, that is the money that has not been spent on inpatient beds because they are not yet constructed. Therefore, they are not staffed or utilised. The member can see that the figure jumps up in 2006-07. It increases to $125.899 million from what was spent in 2005-06.

Mr D.F. BARRON-SULLIVAN: This is servicing those debts? It is employing people; it is the recurrent side of things?

Dr N. Fong: That is correct.

Mr D.F. BARRON-SULLIVAN: Dr Fong is really saying that the $125.899 million for this coming year is the full-year cost of providing that program. The point is that one of the things that people in the mental health care sector hate is to be used as a milch cow. That is what has happened here. They dipped out on funding last year. This year they are getting the full-year cost of operating the program but they are not getting the extra that they missed out on last year. The $14 million that was underspend last year just went back into the budget.

Mr J.A. McGINTY: I will explain it another way. In terms of mental health inpatient beds, the mental health strategy gave an allocation of money to employ nurses and doctors to service those beds when they were built. We expected that they would have been constructed and the staff would have been employed during the course of this year. They were not. That $14 million has been carried forward into next year, which is when we expect a number of those beds to be up and running.

Mr D.F. BARRON-SULLIVAN: At the expense of other services.

Mr J.A. McGINTY: No. Not at the expense of other services.

Mr D.F. BARRON-SULLIVAN: Look at service 2. I just want to isolate one area of the budget. Last year, $120.65 million should have been spent. This year, $125.899 million should be spent to provide the full degree of that program. Last year, there was a shortfall of about $6 million. This year, the $6 million is not being added to the $125.899 million. The department cannot have it both ways. Either the full-year cost of the program is $125.899 million and the mental health services miss out on the money they were supposed to get last year or, alternatively, the full-year cost of $125.899 million will be provided and the $6 million will be built in in some way or other for specialised mental health services. That is just one service area. Unfortunately, it has missed out. This is something that people in the mental health care sector loathe; they hate being taken for granted and being used as a milch cow to feed the rest of the health system.

Mr J.A. McGINTY: I will bring the discussion back to the inpatient beds issue. The expenditure was not made because the mental health services could not make that expenditure. They did not have the beds or the staff to service them.

Mr D.F. BARRON-SULLIVAN: Which service item is that in?

Mr J.A. McGINTY: Service 2. They simply did not have the beds to staff. As such, no expenditure was incurred. We then spoke to Treasury and it agreed for us to carry forward that amount of money that was not spent because the beds were not constructed at that time.

Mr D.F. BARRON-SULLIVAN: In the case of specialised mental health services it is $6 million that was not spent last year. The money is now being spent this year, if it can be - there is another big question there. The point is that the services missed out on that money last year. It is all very well to say that the money has been brought forward. They have missed out on the $6 million in the program.

Mr J.A. McGINTY: What would the member expect us to do if we did not have the beds and the staff were not employed? Should we give the services the money anyway because they have been good people?

Mr D.F. BARRON-SULLIVAN: It leads to my second question. With programs of this size, it is very hard to build them up to a full-year cost status in the actual financial year. Would the minister bet his left one -

Mr J.A. McGINTY: I beg your pardon!

Mr D.F. BARRON-SULLIVAN: - that they will spend $125.899 million on service 2 in 2006-07 or will we see another carryover into 2007-08?

Mr J.A. McGINTY: I would expect that the overwhelming bulk of the $125.899 million, if not all of it, will be spent doing the course of the coming year. The issue that arose during the course of 2005-06 was delayed construction time. Once that is met, there is no reason the full quantum should not be spent on the staff involved. It is simply a case that the expenditure was not incurred. It will be incurred next year when the beds are opened.

Mr D.F. BARRON-SULLIVAN: We will wait to see.

Dr G.G. JACOBS: The sixth dot point at page 550 refers to the Western Australian country service specialist services plan. The department uses the plan to create regional resource centres, of which there are six. They are commonly known as hubs, in the sense of being part of a hub-and-spoke model. There is a plan to upgrade Merredin and create a resource area within that region. Merredin does not have an adequate general practitioner population. At best, Merredin has a doctor population of 1.5 full-time equivalents. Is the minister aware that services have already been drawn from Kellerberrin? I am referring to the gastroenterology service. Merredin is far from being an expanded specialist service able to take up the service that Kellerberrin and its surrounding area have been deprived of. In practical terms, how will this be created and what will the department do to make Merredin happen in this medical model? Why are specialist services, such as gastroenterology, closed in Kellerberrin when the medical model in Merredin is not up and running? I am quite concerned about that from a regional perspective.

Mr J.A. McGINTY: The issue in Kellerberrin was one of equipment and safety. It was not a decision based on economy or a decision to centralise services or anything of that nature. It was something peculiar to Kellerberrin. It might well have happened in Kununoppin or Wagin or wherever. The director general recently spent some time in Merredin and can comment specifically on his knowledge of the situation there.

[9.30 pm]

Dr N. Fong: We are very aware of the difficulty in Merredin. We have 1.5 full-time equivalent general practitioners trying to cover that whole region, whereas Narrogin, with eight GPs and a surgeon and so on, has something similar to our model; so we are very aware that it is understaffed. Chris O'Farrell and the WA Country Health Service are working very hard with the joint working party of the Central Wheatbelt Division of General Practice, the Shire of Merredin and the Western Australian Centre for Remote and Rural Medicine to significantly deal with this issue. We are confident that we will be able to recruit people into the town. Merredin has only just lost two GPs - I think a husband and wife team - who moved elsewhere recently. We are very aware of it. There are ways in which we are providing cover for the town now on a 24-7 basis. Interestingly, we do not have just short-term fixes here. When I was in Merredin two weeks ago there were 30 students there from the University of Notre Dame Australia for a full week doing cultural awareness or whatever one wants to call it, country enrichment, or learning what it is like to be a doctor in the bush. These are wonderful longer term opportunities again to get people, kids in particular, to understand that the bush is a good place to practise. We have Spinifex, of course, which is the rural arm of medical students that tries to encourage those kids to go back to the bush. So they are not all short-term fixes. As members know, it is a big problem in

the bush and we are not going to promise that we will fix it overnight. However, it does not mean that we will resile from our model, which is the hub for Merredin stretching out to all those central wheatbelt towns. I am confident that our people know how to recruit these people and they will do so.

The CHAIRMAN: I am conscious of the time. We have half an hour left and I have five members' names left on this call sheet.

Mr T.K. WALDRON: I refer to "Major Initiatives For 2006-07" on page 558. The third dot point from the bottom states -

> The treatment and associated services for cancer patients living in country communities will be enhanced through the appointment of Rural Cancer Nurse Coordinators.

That is a good thing. Will the minister let me know when and approximately how many of those rural cancer nurse coordinators will be appointed? I do not want a long explanation, but can the minister explain their role and how they will work?

Mr J.A. McGINTY: Before Dr Towler answers that, I just express my disappointment that the member for Wagin did not ask me about the new hospital that we are building in the wheatbelt as a result of this budget.

Mr T.K. WALDRON: Which one is that, I am sorry?

Mr J.A. McGINTY: Morawa, for $9 million.

Mr T.K. WALDRON: I am sorry, I did not know that.

The CHAIRMAN: The member for Wagin missed it.

Mr T.K. WALDRON: Hang on! It is in three questions' time! We will probably run out of time. That is a good thing. I appreciate that. I welcome that.

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

Mr T.K. WALDRON: The minister knows that I am fair.

Dr S.C.B. Towler: I thank the minister for the opportunity to talk about the role of the rural cancer nurse coordinators. The cancer nurse coordinators are a key element of the new cancer initiative, which is funded by the government under the task force report. We have been working closely with the Country Health Service and the emerging cancer network to establish the model for rural cancer nurse coordination. There is a difference between the function in the rural sector and the model that we are using for metropolitan cancer nurse coordinators. In the rural sector the model is very much more of a direct case management model, with a proximity to individual patient service delivery in facilitating the journey of that patient in support of the patient's cancer diagnosis and getting treatment between the rural sector and the metropolitan area. This is a new initiative. It has been emphasised in the Australian better health initiative. It is also a model that we have managed through the success of a submission from the cancer network to the Australian government to receive some additional funding around developing teaching and training the emerging cancer nurse coordinators. In the first instance there will be 10 rural cancer nurse coordinators, who will be appointed by the Western Australian Country Health Service in collaboration with the emerging cancer network. This is a good story for Western Australia and we look forward to a great outcome.

Mr T.K. WALDRON: I agree with Dr Towler.

Dr K.D. HAMES: Am I able to refer to the budget fact sheet that was put out as part of all the budget papers?

Mr J.A. McGINTY: Only if it is accurate!

The CHAIRMAN: The member is meant to be referring to a budget paper, but if he can link his question somehow to these other documents that I have before me, I will allow it.

Dr K.D. HAMES: It was part of all the budget papers.

The CHAIRMAN: It might stretch it; have a go.

Dr K.D. HAMES: It is to do with the 51 new doctors and about 200 nurses that are coming on stream. I am concerned about whether that is enough. I have been told recently that there is no leave at the moment for doctors at Sir Charles Gairdner Hospital because there are insufficient doctors there. With the lack of doctors in Western Australia and the fact that we are second only behind the Northern Territory in having the lowest number of doctors per head of population, I am concerned that 51 new doctors is a very low number. I know that the minister does not have any control over the number of doctors coming through the training system, but obviously recruiting is a key component. I want the minister's opinion on what that number will do. Will it increase capacity or will it just cover what has been lost out of the system or what is not in the system at present?

The CHAIRMAN: I think there is a very loose link somewhere to FTEs or something, minister, if I am really generous.

Dr K.D. HAMES: It is my second-last question and we are nearly out of time.

Mrs C.A. MARTIN: The second last the way he is going; it is the last for all of us.

Dr N. Fong: We are always trying to increase our medical workforce. We have a very low rate of doctors per 100 000 population. It is the second lowest in the commonwealth. We are again doing immediate and long-term things. One longer term thing, which is only two years away in 2009, is the graduation of, not a further 140 interns, but 305 interns into the system, which will then continue to kick on over the following years. If we are able to attract more higher education contribution scheme places, which the Council of Australian Governments and the Prime Minister promised just recently, we may have between another 60 and 80 medical students starting in 2007, which will be again a good thing, but that is a long-term thing.

Dr K.D. HAMES: Is it true about Sir Charles Gairdner Hospital and the leave?

Dr N. Fong: I am not aware of that as being true. I do know, and it has been reported to me informally, that this time of the year is traditionally a time when overseas doctors who have come out here to work return to summer in their countries. So June and July are always tight in terms of resident medical officers. We have a lot of overseas-trained doctors in the system, as the member knows. There were 444 as at June last year and we rely greatly on those overseas-trained doctors. Part of the 51 referred to in the budget fact sheet probably relates to the fact that we are employing more salaried officers in some country places; for example, in Busselton and Geraldton, where we are increasing salaried officers, instead of visiting medical practitioners, in those hospitals. That is what the number would refer to.

Mr P.B. WATSON: How long do we have now?

The CHAIRMAN: Not very long now. I'm getting grumpy now. It is getting late.

Mr P.B. WATSON: Okay, I cannot ask about the emergency medical centres, as I cannot find a line for it, yet they have got $240 000.

Mrs C.A. MARTIN: Join the club!

The CHAIRMAN: Bad luck!

Mr P.B. WATSON: A line on page 582, halfway down, states -

> continue the ongoing $24.1 million program . . . for renewal of country housing to attract and retain country staff;

Will the minister tell me the areas to which the country housing relates, and is the housing Government Employees Housing Authority houses or houses directly for people who work for the Department of Health?

Mr J.A. McGINTY: The Department of Health is not part of GEHA, so the provision of housing is done directly by the Department of Health, not through the Government Employees Housing Authority. The major area of pressure was in the provision of housing in the country, in the Pilbara. We have felt that particularly acutely in Port Hedland in recent times. With the construction of the new $90 million hospital in Hedland, the need to attract medical staff has resulted in us making a major investment there in acquiring houses for long-term lease from BHP Billiton. The lease payment for each house in Hedland is $700 a week and we have leased 12 houses from BHP Billiton there. We also have money for the construction of additional houses because the housing stock in Hedland had been severely run down. The problem is not confined to Port Hedland, but it is primarily in the north west of the state. However, Mrs O'Farrell might be able to add to what I have said and comment on the situation in areas other than the Pilbara.

[9.40 pm]

Mrs C. O'Farrell: We have close to 500 accommodation units throughout country health services. Our exposure to staff housing is the greatest in the north west, including some of the very remote areas of both the Kimberley and the Pilbara. We are now faced with housing requirements in other regions as well, where we have not had so much demand in the past. We have a work force with higher demands. The goldfields is an area where we are providing more housing, as is the mid-west, the Murchison and the Gascoyne. Nurses no longer typically live in nurses' quarters type accommodation, so we are faced with providing, as much as we can, contemporary living units, ranging from one and two-bedroom townhouse complexes or strata configurations, stand-alone two, three and four-bedroom homes to executive-level homes for medical specialists and doctors and senior people who expect that. We have a fair infrastructure demand to accommodate our staff.

Mr P.B. WATSON: The minister is aware of the problems we have with getting specialists in regional areas like Albany, Geraldton and Kalgoorlie. Has the department looked at making it a part of the package to try to encourage specialists to go to regional areas?

Mr J.A. McGINTY: I thought the member said "asbestos".

The CHAIRMAN: So did I. It is "specialist"

Mrs C.A. MARTIN: He said "specialist"; I heard it.

Mr P.B. WATSON: There is a comment I could make across the chamber, but I will wait.

Mr J.A. McGINTY: Thank you.

Mr P.B. WATSON: I have my interpreter here.

Mr J.A. McGINTY: We will get a speech therapist for the member, I think; he can go on the waitlist for it!

This year we are spending $5.5 million on housing. Mrs O'Farrell may be able to add something to whether it was provided to attract specialists to country areas.

Mrs C. O'Farrell: Yes, we do. Part of the housing investment we are making is to create more executive-style housing to offer to people to encourage them to stay.

Dr K.D. HAMES: Why does the minister not go back to what was proposed but refused years ago, which was to get the Government Employees Housing Authority to manage housing? The quality of GEHA housing is now excellent. It is very well controlled and coordinated. The standards are very high. That was proposed during my time, but the Department of Health refused then. Surely it would be a much simpler way of doing it.

Mr J.A. McGINTY: I am supportive of that view, because the provision of housing is not the core business of the Department of Health. Another government agency provides housing for almost every other government department with staff in regional areas. I would be very supportive of the idea of GEHA taking responsibility for Department of Health housing, as it does for education, police and most others.

Dr K.D. HAMES: They would still want to.

Mr J.A. McGINTY: Yes. It is something that I am happy to have another look at, and if there is a proposition from GEHA, I would be, in principle, supporting it.

Mrs C.A. MARTIN: Would it be viable to pilot it in a certain area? I would suggest the Kimberley; we could upgrade or replace everything and get a proper asset manager in. If it was done in a closed area or region, it would probably work better.

Mr J.A. McGINTY: As a former housing minister, I have seen the operation of GEHA first-hand, and I think it does a very good job. It is also something that is its business, whereas the Department of Health might have pressures in other areas and so quite often housing can be a lower priority because it is not the core business that it undertakes. I intend to have a discussion with the new minister, Michelle Roberts. I had discussions with the previous minister, Fran Logan, to this effect, but the ministry then changed. I think it is worthwhile looking at, because there would then be one housing manager managing the raft of properties in the different areas. It is something which I am sympathetic to, but which has not been top of the priorities.

Mrs C.A. MARTIN: If the minister really does want a pilot area, he should think of the Kimberley.

The CHAIRMAN: Nice try, member for Kimberley. I have three left on the sheet. Let us see if we can get through them.

Mr A.P. O'GORMAN: I have just noticed that I am the only metropolitan member here, so I am going to ask the minister some metropolitan questions.

The CHAIRMAN: Very good idea.

Mr A.P. O'GORMAN: Yes. Too much goes to the regions, I think.

Mrs C.A. MARTIN: It is nice being a minority, is it not?

The CHAIRMAN: Behave, members. You absolutely have the Chair's attention now.

Mr A.P. O'GORMAN: I refer to page 584 and the health reform and broader health initiatives funding. The Joondalup Health Campus development stage 1 has been allocated $126 million.

Mrs C.A. MARTIN: What?

Mr A.P. O'GORMAN: We have not gone south of the river yet.

The CHAIRMAN: I have listened all day to what you country folks are getting. Just behave for a while.

Mr A.P. O'GORMAN: Can the minister tell us what stage that has reached? I expected to see bulldozers out there turning the grass. They have been promising to start that building since last March, and I do not think it is there yet. Can the minister tell us what stage it has reached? I have a further question about the southern tertiary hospital, which is the Fiona Stanley centre. At what stage is the planning for that? I would like to know about both of those to put a metropolitan perspective on things.

The CHAIRMAN: The member is sharing his largesse with those southern suburbs.

Mr J.A. McGINTY: As members are aware, Joondalup is designed, in the medium term, to become a tertiary hospital servicing the northern suburbs of Perth. In the short term, we have a north-south model with Charles Gairdner and Fiona Stanley hospitals being the central points for the tertiary hospitals servicing those areas. The clinical services framework shows Joondalup as having approximately 445 beds in 2011, increasing to 580 beds in 2016. That is constantly being reviewed and adjusted. Obviously, the private provider, Ramsay Health Care, is proposing significant investment in a stand-alone, colour-coded private hospital, which would free up the existing beds and facilities that are used for private patients as part of the public hospital, and which will progressively transfer back to the public system over the years ahead. Public works included in stage 1 are the expanded emergency department. A phenomenal number of people use the emergency department. I think -

Mr A.P. O'GORMAN: It is around 48 000.

Mr J.A. McGINTY: Yes, the last I heard it was heading towards 50 000, so 48 000 people is obviously a very large patronage of the emergency department. We also want to provide a significant number of additional beds in Joondalup. Other works include the support facilities, including operating theatres, and other clinical and non-clinical facilities at the hospital, as well as the mental health facility. Construction will start in December 2006, and is currently scheduled to finish in September 2009. That is going to be constantly reviewed. The total cost is $126.3 million.

We expect to complete the business case for the Fiona Stanley hospital, the southern tertiary hospital, in July this year for presentation to the expenditure review committee. We go to tender in December 2007, with construction starting in February 2008 and concluding in 2011. That is on target, and will be well under way by 2008 and certainly by 2009.

Mr A.P. O'GORMAN: I also ask about the redevelopment of the Swan District Hospital.

Mr J.A. McGINTY: The new hospital in Swan districts, opposite the railway station - again, close to public transport - will be a completely new hospital. The details of that have been provided, but it is intended that construction of that would finish in the same year as the Fiona Stanley hospital; that is, 2011. We intend completing the business case by December this year and going out to tender in May 2008, with construction starting in July 2008 and finishing in March 2011.

[9.50 pm]

Mr A.P. O'GORMAN: It would have been nice to deliver it before the election!

Dr K.D. HAMES: As a supplementary question, that funding works out to be about $500 000 a bed. Is that the accepted standard for a secondary hospital? Is that a standard figure for construction? We were talking about $1 million a bed for the Fiona Stanley hospital, which will be built on a greenfield site. This is also a greenfield site. Will that be enough?

Mr J.A. McGINTY: Mr Ross Keesing will comment on that issue.

Mr R. Keesing: We are talking about the difference between a tertiary hospital and a secondary hospital. The Midland hospital will be of a different nature. We are providing -

Dr K.D. HAMES: Will $500 000 be enough?

Mr J.A. McGINTY: In fact, it works out at $671 000 a bed.

Dr K.D. HAMES: I do not think so. I will get my calculator out again and check.

Mr J.A. McGINTY: I am not bad at numbers.

Dr K.D. HAMES: I refer to page 541. I have a simple question about the continence management program. One of my constituents is very pleased about that program. There are no details about how that funding will be spent; there is just an allocation of $1.7 million in the coming financial year. How will it work?

Mr J.A. McGINTY: There is a bit of an issue between the Disability Services Commission and the Department of Health about which agency should administer the scheme. Currently, it rests with the health department. There are two components to it. The first is an advisory service for people with incontinence on how to manage incontinence, and the second is a subsidy for incontinence aids.

Dr K.D. HAMES: My constituent is more interested in the subsidy. How much would that be? Does the minister have any idea?

Dr G.G. JACOBS: We are not talking about the commonwealth scheme.

Mr J.A. McGINTY: There is an existing scheme, and we are replicating that. In terms of the amount of subsidy per person -

Dr K.D. HAMES: I am not asking the minister to provide that by way of supplementary information, but just to let us know -

Mr J.A. McGINTY: We have that information; I just do not seem to have it with me at the moment. In response to the question posed by the member for Dawesville, I undertake to provide by way of supplementary information details about the continence management and subsidy scheme.

[*Supplementary Information No A55.*]

The CHAIRMAN: As a member of the committee, the member for Roe will receive that information as well.

Dr G.G. JACOBS: I refer to page 548 and medical staffing at Kalgoorlie Regional Hospital. My question relates to the same issue I raised earlier; that is, the establishment of regional resource centres, and how Kalgoorlie will work as a hub. We can build bricks and mortar, but staffing is critical. I draw the minister's attention to the emergency medicine physicians, because without those people the resource and referral centre will not work for places such as Esperance. Without those staff, patients from Esperance and surrounding areas will not be able to be referred to Kalgoorlie. How will the problems in Merredin and Kalgoorlie be addressed if there is not an adequate number of specialist medical staff for these centres to operate as regional resource centres? I believe that will be a major concern in this state. What major investments can we make, and what major incentives can we provide? If there is a problem about where specialists live, perhaps the model should be turned around and Esperance should be made the hub and Kalgoorlie the spoke; I do not know. We must attend to some of those concerns so that this medical model will work.

Mr J.A. McGINTY: I agree; Kalgoorlie is a very attractive place. I was born there!

Dr G.G. JACOBS: I see that the minister is having trouble attracting emergency medicine physicians, however.

Mr J.A. McGINTY: I do not think so. As an example, in recent times we have recruited a very highly skilled German-trained general and trauma surgeon, Dr Ludwig Plaumann. He has been appointed as a salaried general surgeon at Kalgoorlie Regional Hospital. He started in January this year and is already making a very big impact on surgery in particular at Kalgoorlie hospital. We have also recently recruited two salaried medical specialists. One specialist will commence employment in August and the other will commence in September.

Dr G.G. JACOBS: What are they in?

Mr J.A. McGINTY: I do not know their specialties. However, that illustrates that, as hard as the recruitment issue is, if we are dogged and pursue people, all sorts of things are achievable.

Dr G.G. JACOBS: Unless a high-dependency unit can be established for critical care, it will not make Kalgoorlie functional as a referral centre for places such as my town.

Mr J.A. McGINTY: I agree.

Dr K.D. HAMES: My question relates to budget growths and deficits. It is a fairly light-hearted question, because the minister continues to boast about being a non-deficit minister, yet page 530 shows a deficit, albeit a minor one. The budgeted figure in 2005-06 was $3.101 billion, but the estimated actual was $3.133 billion. An overrun of more than $30 million has been estimated. In the context of past overruns, that is pretty good; nevertheless, will that not prevent the minister from saying that he does not run a deficit?

Mr J.A. McGINTY: It needs to be qualified in this way: when we interpret financial results for an agency such as the health department, a balanced budget results when the agency delivers its services within its approved expenditure limit. We have done that; we were working to the approved expenditure limit. A balanced operating result occurs when expenditure in any given financial year equals or is matched by revenues from government - that is, appropriations - and agency-generated or own-sourced revenues. It is quite possible, and this will happen come 30 June this year, for an agency to deliver a balanced budget - that is, to deliver a financial result within the approved expenditure limit - while also reporting an operating deficit in the same year. That will occur when the timing issues associated with the recognition of expenses and revenues in a financial year may result in expenditure and revenue not being matched in the year in question. This is just accrual accounting.

Dr K.D. HAMES: Can I clarify that the minister is saying that he has a budget figure, and if he goes over that budget figure but Treasury approves additional expenditure to cover whatever that cost overrun is, he will be within budget? Is that what the minister is saying?

Mr J.A. McGINTY: No, I am not saying that. If there is an approved expenditure limit -

Dr K.D. HAMES: Relate it to the figures in the budget papers. The approved budget was for $3.101 billion.

Mr J.A. McGINTY: I think it was more than that. Which page is the member referring to?

Dr K.D. HAMES: I am referring to page 530. The 2005-06 budget was $3.101 billion and the 2005-06 estimated actual was $3.133 billion. That is $32 million over budget.

Mr J.A. McGINTY: The approved expenditure limit for the current year was $3.648 billion, which is fully funded.

Dr K.D. HAMES: Where is that figure?

Mr J.A. McGINTY: It is in the income statement on page 586. The important point is that what has been reported in the *Budget Statements* does not indicate a projected cost overrun for the health department during this year. We were working to an approved expenditure limit of $3.648 billion and we have delivered that.

Dr K.D. HAMES: On page 586 the budget for the total cost of services is $3.5 billion.

The CHAIRMAN: The member will have to follow up that information in another way.

The appropriation was recommended.

*Committee adjourned at 10.00 pm*_____