Division 71: Health, $2 316 348 000 -

Ms Guise, Chairman.

Mr Kucera, Minister for Health.

Professor B. Stokes, Commissioner of Health.

Mr J.D. Kirwan, Executive General Manager, Public Health Purchasing.

Mr A. Kirkwood, Acting General Manager, Finance and Resource.

Mr M. Jackson, Director of Environmental Health.

Mrs C. O'Farrell, Executive General Manager, Health System Performance.

Mr D.N. Inglis, Principal Policy Adviser.

Professor G. Lipton, General Manager, Mental Health Division.

Dr D.A. Jones, Acting Chief Medical Officer.

Mrs F. Robb, Media Secretary, Minister of Health.

Mr A.R. Buckley, Director of Asset Management.

Mrs R.S. Webber, Service Policy Adviser.

Ms S. McKechnie, General Manager, General Health Purchasing.

Mr P.A. Stephenson, General Manager Public Health.

Mr M.H. Moodie, Executive General Manager, Finance and Infrastructure.

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

Mr B. Campbell-Fraser, Chief of Staff, Minister for Health.

Mr KUCERA: I would like to acknowledge the presence of Professor George Lipton who this week announced his retirement as Western Australia's Chief Psychiatrist. He will be a sad loss to both me and the Department of Health. He has chosen to go and work on his boat, which is something that I would like to do! I acknowledge the excellent work that he has done and the milestones that he has reached in psychiatry and mental health in this State.

Mr BOARD: We are dealing with page 1237 of the *Budget Statements* and the overall grand total for appropriations for Division 71. In a number of statements made both publicly and in the document *2001-02 Economic and Fiscal Outlook*, we have been told that an additional $385 million has been provided to the health budget over four years to improve service delivery. Will the minister identify exactly where that appears in the *Budget Statements*, given that it does not appear in the forward estimates for the next four years?

Mr KUCERA: First, I will mention the overall construct of this year's health budget. This year the Government has provided health with an additional four per cent, or $80 million, in recurrent funding over the final recurrent out turn of last year. I emphasise that it is on the recurrent out turn of last year. The previous Government continued to top-up the health system throughout the year, regardless of service issues. The cost increases in the teaching hospitals were a major problem. As stated by the Treasurer, Hon Eric Ripper, in his budget delivery speech -

> Over the next four years an extra $385 million will be provided to improve health services . . .
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> But it is only too clear that no amount of extra money would be enough for a health system confronting high community expectations, increasing costs, powerful vested interests, structural inefficiencies and ineffective financial management.
>
> Everyone in this place recognises that health finances are growing at an unsustainable rates and that major reforms are vital to ensure that taxpayers' dollars are used in the most effective way possible to achieve the standard of service the community expects.

The budget announced by the Government on 13 September has essentially been framed on an accrual appropriation basis. It is important that I stress that. At the same time, initiatives funded for the first time include superannuation and a capital user charge. We will point those out as we go through the *Budget Statements*. It is important to note that this budget is output based. I stress that. All our budgets are framed on the premise; that is, they focus on a level of service delivery for an allocation. They do not deal with allocating wages or other costs which are called input costs to hospitals. Funding that is provided to hospitals is made up

of a package of funding that includes state government funding, as per the budget, commonwealth specific purpose payments and other sundry funding. Therefore, three items need to be referred to.

[9.10 am]

This year, for the first time, the Department of Health has worked through a bilateral process with all hospital's health services to carefully explain the indicative funding allocation and the expectations with regard to activity requirements. I stress that again because that is what frames an output budget. While the department allocates an output basis, each hospital creates a detailed input budget in order to plan for the level of activity required. One health service may comprise many hospitals and its local board distributes local budgets. As part of this process, each chief executive general manager was asked to complete a standard template for strategies required to achieve budgets, which was also a requirement for a broad budget construct to be completed. I realise that this is not very brief but it is important that I set the framework for this question.

The CHAIRMAN: Minister, I have not allowed for lengthy statements to date and I am in no mood to change. However, I realise that in some way, ground work is being set for the answer to the member's question.

Mr KUCERA: All the hospitals and health services have now submitted their strategies and budget data, which is in the process of analysis by the department. I must say that this has not been an easy task this year. Further discussions will take place with hospitals and health services to discuss the proposals and as minister, I will review them.

For comparative purposes, the following allocation changes have taken place this year; plus three per cent for metropolitan health services; plus eight per cent for rural health services, because we realise the specific needs in rural areas; and we are expecting corporate services to reduce their allocation by 20 per cent. Once final numbers have been determined, they will be made available to Parliament.

In conclusion, I stress that I have asked for budget to be achieved without any reduction in services. Reform to the health system is vital with a need for both structural and system reforms, but this will take time. Therefore, hospital health services must commence to reduce costs and increase effectiveness so a managed budget is achieved. The Government is concerned about rural issues but hospital boards, managers, the community and the department need to work together to achieve a more effective way to meet health needs.

I am sorry that that was such a long way of explaining the structure, but it is necessary. I will now defer to the Acting Commissioner of Health and his officers to outline the specific line items and the issues that the member for Murdoch has raised.

Mr KIRKWOOD: One of the important things to state about the budget this year is that it is a full accrual appropriation budget. In addition, a couple of other components have been added in - a capital user charge and superannuation. It is difficult to look at those numbers and compare them with what the member is saying. Those figures are comparable to previous forward estimates. To look at the current budget for a comparison, one needs to go back, construct and bring the whole amount up the line. Broadly speaking, the biggest part of that figure relates to election commitments, which is $246 million for recurrent spread over four years. The other items are other moneys that have been plugged in for operating costs over that four-year period. Therefore, the predominant part is election commitments followed by further funding for further operating costs. This all output based and as input costs, those figures do not show and are built into the broad construct of the budget.

Mr BOARD: I do not accept that and find that to be an unsatisfactory answer. Public statements have been made that an additional $385 million over four years has been put into the health budget. Under any examination, that cannot be found within this budget. Although the figures indicate that the move to full accrual accounting could be in excess of 13 per cent of the total budget, in real terms, there is a significant decrease in this budget to meet services. If there has been an additional allocation of $385 million, it should show in the budget somewhere. What is the real cost of moving to full accrual accounting and what is the actual increased amount for services?

Mr KUCERA: I will defer to Professor Stokes for that information. However, it is clear from the differences in the current budget overall that there is a $68 million increase. In addition to that, one only has to go back to last year's allocation to see there has been an increase of about $140 million.

Mr BOARD: That was money the minister put in.

Mr KUCERA: Precisely, but it was part of the basis of building up to that - allocations, then the out term, and now this year, accrual.

Mr KIRKWOOD: As the minister said, there is a $68 million increase bottom line. There is an $80 million increase in recurrent moneys, but the budget has been adjusted so that it is totally comparable. Last year's

figures have been adjusted for add ins such as superannuation and the capital unit charge. We then get a comparison for the sake of this budget paper, which is how it has been constructed. It is not a case of "It was that last year, and now it is this." The whole budget has been realigned so that there are comparable figures.

Mr BOARD: I understand that the adviser is in a difficult position, and in no way do I criticise him at all. I have the utmost respect for his position -

Mr KUCERA: Is this to be answered through me, as minister?

The CHAIRMAN: Yes, it is.

Mr BOARD: If public statements are to be made that the budget has increased by $385 million over four years, it should show in the budget. We should not be talking about a real increase of only $80 million which is somehow, in some hokey-pokey way, hidden in the figures. It should be clear for people to see where those increases are because they are not reflected in the grand total of appropriations over the forward estimates.

Mr KUCERA: Before I defer to my advisers, the increase of $68 million is recurrent. As I said in my original statement, the budget is made up of a number of issues, not simply the income that comes from the State. A raft of other issues included in the $385 million are shown clearly throughout the budget papers.

Mr BOARD: With respect, minister, they are not reflected in the total allocations. They should be there because that is in fact what the total allocation is.

The CHAIRMAN: Member, can the minister be allowed to respond?

Professor STOKES: Mr Kirkwood will explain the operating expenditure on page 125 of the *Economic and Fiscal Outlook*.

Mr KIRKWOOD: This clearly outlines that the election commitments for this year's operating expenditure were approximately $46 million. Those figures are included in the total budget process. If we want to get deeper into that issue and continue to analyse it, right now is probably not the time to do that and perhaps we could prepare a statement.

Mr BOARD: This is the only time we have unfortunately.

Mr KIRKWOOD: The budget is totally different this year. With all of those other components added in, one cannot just look at it and say that those figures were constructed from last year's estimates and brought forward, which cannot exactly be seen here. However, page 125 of budget paper No 3 clearly shows the $246 million that has been included, which is a major component of what the member is talking about, and it is spelt out in the budget paper and included in the broader context of the construct.

Mr BOARD: In view of that comment, it means that the figures that we have are not credible. What Mr Kirkwood is saying is that the minister can make public statements about the increases in health that are not reflected in the budget. Therefore, what is the relevance of the budget to public statements?

Mr KUCERA: I will not respond as it was a comment rather than a question.

Mr BRADSHAW: I refer to page 1237 under purchase of outputs, item 112. Has the minister's office or the Department of Health prepared questions for the government members of this estimates committee?

[9.20 am]

Mr KUCERA: I understand that we have advised the people who represent the Government.

Mr BRADSHAW: Have those people been advised about prepared questions to the minister's office or the department?

Mr KUCERA: I am not aware of them, but I know that they have been advised and I suspect that some questions would have been prepared by my staff members.

Mr AINSWORTH: I refer to Purchase of Outputs on page 1237 of the *Budget Statements*, item number 113. My question relates to the contribution to hospital fund for 2000-01. The minister may prefer to provide the answer to this question by way of supplementary information. How much did each hospital overspend last year? What was the increase in consolidated funding required to meet that expenditure? What is Treasury's consolidated fund allocation for this year? If there was overspending last year, and the previous Government was unable to prevent the health budget from increasing, what measures has this Government put in place to prevent further overspending in the budget?

Mr KUCERA: I will deal first with the last issue that the member raised. I will refer the specific issues dealing with the line items to the Acting Commissioner for Health and I will talk generally about the way the Government has approached the budget this year. I refer the member to page 1238 of the *Budget Statements*.

This year, a report was commissioned by the Health Administrative Review Committee, which recommended that major reform take place in the health budget in order to implement strategies. There is no doubt that the health budget is under major pressure; the same pressures were faced the former Government and indeed by previous Governments for many years.

Specific problems, including the shortage of nurses and clinicians in this State, are exacerbated by international problems. The higher prices for consumables are also having an impact on the health budget. The report of the Health Administrative Review Committee provides the Government with a good framework with which to match those broad-based review strategies and reform strategies that must be put in place. Firstly, I refer to that review's recommendation that there be a single unified health system to work with a common vision and direction. We have already started that kind of reform. However, that is a long-term reform process that will occur over the first term and maybe even the second term of this Government or whichever Government happens to be in place in years to come.

All of those reform processes have been linked to short-term strategies that we have asked the general hospitals to put in place. That is part of moving towards output-based management; that is, the Government requires a certain level of service that it has costed, and we expect that level of service to be provided. There is no reason that that cannot occur with the strategies that the Government has put in place. That is a broad-brush view of the reform process. A raft of recommendations by the Health Administrative Review Committee is listed in the budget papers, and there is no point in my discussing them individually because of the need for brevity.

The health managers and hospitals decide how they will proceed with individual strategies. The Government has told them that the bottom line is their budget. The bottom line is that their policies must work within their budgets without any reduction in services. That has raised a number of issues with each health service, but we expect them to be able to manage that. Last weekend I spent time in the great southern and the mid-southern regions, and the week before I spent time in Geraldton. Most of the health managers have realised that that is the clear direction from the Government and those strategies will be put in place. The Acting Commissioner of Health can elaborate on the individual strategies that those health managers will employ. The major pressures on the health budget will not be placed on the rural sector, which has received most publicity, because most of the managers of the rural health sectors feel that they have been dealt with reasonably well. The real pressures will come to bear in the city and in the major teaching hospitals. Nobody says that we have fixed health.

Mr BRADSHAW: You said that you would fix it.

Mr KUCERA: Nobody has suggested that that is the case. A long-term reform process has been implemented - although I know that may not be so much of an issue in the member for Roe's rural areas. I will ask the Acting Commissioner for Health to speak about the short-term strategies.

Professor STOKES: The short-term strategies have been considered and are being actively pursued within tertiary hospitals. First, we are considering activities that will increase the cooperation between hospitals from the clinical perspective. Secondly, we are considering areas of corporate reform that can be shared, including salary and wages, industrial relations and human resources. We would like to bring about changes in the clinical way in which things are done. For that reason, we are grateful for the cooperation of our doctors. Members of this committee should be aware that throughout this country, adverse events in clinical medicines cost about $6 billion, the Western Australian share of which would be about $600 million. It is important to consider areas in which the safety and quality of health care can be improved. Every extra day that a person stays in hospital adds to the costs.

Another issue that has been raised is the sharing of technology and having the appropriate technology for this State. Technology is an extremely expensive exercise; for example, heart mates, which are useful to maintain people who suffer from cardiac failure before a heart transplant, vary in cost between $30 000 and $150 000 each. Most of the heart mates cannot be used again, which adds to the disposable expenditure. We are actively considering those areas with our colleagues. I can provide a supplementary list of that information if that is required.

Mr AINSWORTH: The initial part of my question was not about what I have just heard. I specifically asked how much each hospital overspent last year. What was the increase in consolidated funding required to meet that expenditure? What is Treasury's consolidated fund allocation for this year? It might be better if that information were provided by way of supplementary information. I have written my questions, and if the minister could provide that supplementary information, I would appreciate it.

Mr KUCERA: I can. I will ask the acting commissioner whether we are in a position to supply some of that information today. However, if the member would prefer the questions to be answered in full, I will provide that supplementary information.

The CHAIRMAN: What information will the minister provide?

Mr KUCERA: The questions relate to the contribution to the hospital fund for 2000-01 on page 1237 of the *Budget Statements*. The member asked how much each hospital overspent last year. Is the member referring to every hospital in the State?

Mr AINSWORTH: Yes.

Mr KUCERA: He also asked about the increase in consolidated funding required to meet that expenditure. I presume the member refers to the consolidated funding top-ups that were made by the previous Government.

Mr AINSWORTH: That is right.

Mr KUCERA: The member also asked about Treasury's consolidated fund allocation this year. Does the member want the figures for each hospital? There is a difficulty with that. We may be able to break it down only to the allocation of funding to area health authorities or health services, because they make a conscious decision themselves about the break-up -

Mr AINSWORTH: The health services would be sufficient.

Mr KUCERA: Are we talking about area health service allocations?

Mr AINSWORTH: Yes. The last item has been dealt with.

Mr KUCERA: The last item about what measures have been put in place to prevent an overspend has been dealt with. I note that the member gave notice of a supplementary question. However, before the member asks that question, the acting commissioner wants one of his staff members to make a comment.

Mr KIRKWOOD: I will clarify the final point. I understand that the member wanted to know how much of the contribution to the hospital fund is allocated to hospitals. They are not the only funds allocated to hospitals. Hospitals receive commonwealth funds for special purpose programs, and other funds that are outside of this process are collected into one package, which is then distributed to the hospitals. I want the member to understand that I cannot provide him with the answer to his question because other funds are included that make a bigger pool of funds which are distributed. However, we can provide the member with the amount that is provided to the contribution to the hospital fund, plus the other funds that are added.

[9.30 am]

Mr BRADSHAW: Is overspending by the hospitals deducted from their budget allocation for this financial year, or is it written off?

Professor STOKES: I did not hear the question.

Mr KUCERA: Is overspending in the hospitals penalised in the subsequent budget? Is it taken off or added on?

Professor STOKES: It is squared up at the end of the year, and they start again.

Mr KUCERA: I understand a number of small hospitals had one-off payments last year for specific items. They are not included, as I understand, in this year's budget allocation, because they were one-off payments and will not be needed this year.

Mr BOARD: I refer to the minister's answer and to the fact that the budget has come down three months into the new financial year. The minister has already indicated this morning that full accrual accounting has been adopted, and many additional costs have been loaded into these figures. The increase in the budget over last year's budget estimate is three per cent. In real terms that is 0.86 per cent. A whole heap of additional costs are now expected to be met by the hospitals. Knowing that the major tertiary hospitals, at least, have already overspent their budgets three months into the new financial year, on a monthly basis, how will the minister meet the demand increase, running at nine per cent, with a budget that has had such a small increase in real terms, and with hospitals already overspent to the tune of $120 million?

Mr KUCERA: That was a difficulty the previous Government had, which I find when I look at the budget allocations and funding top-ups that the previous Government gave to various cost centres during the period of eight budgets. The reality is that, without those major reform processes beginning to kick in, budgets will always be at risk. If Governments continue to do things exactly the same way, that issue will arise. It is about working to budget. This is the first time, as I recall and as I am advised, that hospitals and major cost centres throughout the health industry have been told that this is an output and activity-based budget. The money has been provided for the level of service they are to apply, and they must work to that. This budget is about the big picture. When the Government says that hospitals have overrun budgets, it is a projection the hospitals might

wish to make, but they have been instructed very clearly to work to budget. I will defer to the Acting Commissioner of Health, if he wishes to make further comment.

Professor STOKES: The whole of the health budgets in this country are not necessarily appropriate to meet demand, and things have to be done differently. It is essential for hospital managers and clinicians to do this, and we wish to support them in that. This is the first time that the wheel of the *Titanic* has been spun, to shift the bow off the iceberg. A very genuine attempt is being made to do this, but it will take time.

Mr BOARD: I appreciate that, and I will not hold up the committee, because I know the government members want to ask questions. One would have expected that some of those major changes would be in place prior to putting the restraints on the budget. The growth in demand is not being changed, while the funding is being restricted as a result of the Government making changes. However, those changes are not in place. The reality is that those changes will not stop the demand or the pressures on the tertiary hospitals. The Metropolitan Health Service Board, which no longer exists, was put in place to make those major changes. No major changes have been made, and I feel the Government will be under enormous pressure in the new year, because there is no change in either demand or the way services are being delivered.

The CHAIRMAN: That was not actually a supplementary question. I did not hear a question asked, so it is the minister's call whether he responds.

Mr KUCERA: I will make a brief comment in response. The longest journey always starts with the first step, and when a process is to be changed, the first step must be taken. The Government has taken the first step in a major reform process. In fact, in many ways, the Government is following some of the steps taken by the previous Government, and is carrying on many of the reform processes begun by the previous Minister for Health. I have had discussions with him about the pressures on him, and on the previous Government. The present Government has said it will put in place, firstly, a regime of accountability and, secondly, an openness that has been missing in the past. An opportunity will be offered for the public, for the very first time, to lift some of the veils and see what is behind them, and how the health services in this State are constructed. It will be a long and hard battle, but the first step has been taken.

The CHAIRMAN: I am more than happy to allow members to develop themes. Everyone knows that this portfolio is extremely important, but I would ask that, when asking supplementary questions, members actually get to the question. I will allow a fair amount of latitude, but, in fairness to everybody present who wishes to participate and ask questions, I ask that supplementaries be succinct. Statements are inappropriate.

Mr QUIGLEY: I draw the attention of the minister to his statement that this is an output-based budget, and refer to page 1266 of the *Budget Statements*, where it is stated that the total cost of health services during the budget period will be $2.55 billion. By my rule-of-thumb reckoning, this constitutes about 25 per cent of the entire state budget. The minister has also talked about transparency within the agency. Is any strong audit process in place to ensure that irregular, improper or corrupt practices do not occur in such a large agency involving the expenditure of so much public money?

Mr KUCERA: That is a scary question in some ways. Audit processes are in place. In fact, a major audit has recently taken place of one of the major hospitals, and audits have been done of trust accounts. The reports of those audits are not fully in the public arena as yet. I have some concerns, and the Acting Commissioner of Health has expressed some concerns to me about practices that have gone on. Inquiries are taking place, such as the Douglas inquiry, which is running at present, though I do not wish to pre-empt anything that may come out of that. Wearing my previous hat, from my previous life, I have already seen practices that disturb me and need to be put into the public arena later on. Transparency is necessary, though this is probably not the forum to canvass issues like that. Under the Health Administrative Review Committee process, members will see - it was at my insistence when I spoke to the committee - that a full audit process has been put in place, under the directorship of the proposed director general of health. That process will have the capacity to audit each individual cost centre and consider each concern that arises. The Acting Commissioner of Health has been scrupulous in bringing those kinds of issues to my attention. The Government has confirmed that any kind of corrupt practice in government will be rooted out. I defer to the Acting Commissioner of Health for further comment, if he wishes. Very firm machinery will be put in place to ensure that the concerns raised by the member for Innaloo are dealt with, but I do not have any specific issues to raise in that regard.

[9.40 am]

Professor STOKES: As the minister said, the issue is extremely important, but one other component needs careful auditing - that is "auditing" with a small "a" - which, of course, is the clinical outcomes from the moneys that are spent in health and what they are doing to improve the health of the Western Australian community. We

will put a lot of effort into that area through the quality programs that are being developed. The Health Administrative Review Committee report recommends that a health watch committee be set up. One of its main tasks will be to look at the results of the number of cardiac interventions etc and other issues. There is no doubt that Governments of whatever persuasion must make some decisions with the community about what we should fund in health and what we should not fund.

Mr AINSWORTH: In the event of a health budget shortfall, would the minister contemplate using funds from individual trust funds of major hospitals to help fund the shortfall?

Mr KUCERA: The simple answer is that I do not know at this stage. One of the things the audit of the trust fund will do is examine the nature of the trust funds and what they are there for. It may well be that we do not have the capacity to do what the member is asking. The question is pertinent because of the very considerable amount of money that sits in hospital trust accounts. At this stage we are not aware of the capacity to use it.

Professor STOKES: A few days ago I received a report from Ernst and Young, which has audited the trust accounts of the hospitals. I am having a meeting with people from Ernst and Young and the Under Treasurer in order to go through the results of the audit and discuss what action might need to be taken concerning those trust accounts and, in particular, their setting up. I understand from the Under Treasurer that there is a very large number of trust accounts. It may be an appropriate time to examine those in a general, generic way.

Mr KUCERA: The Public Accounts Committee recently raised the issue. As the acting commissioner has said, there was mention of these issues. That is why we have moved down this path. I do not want to alarm people. There is a need to look at the issue; it is as simple as that.

Mr QUIGLEY: On page 1267 under the current assets heading, reference is made to restricted cash assets and to a figure of $24 million for the 2000-01 budget. Is this line item the entirety of the trust funds, and does it include the moneys held in trust for public hospitals?

Mr KIRKWOOD: The 2000-01 budget estimate of $38 million in the line above $12 million is restricted cash, which means that it is restricted for a specific purpose. The two figures amounting to $50 million are more in line with the total.

Mr WATSON: Page 1239 indicates an increase in funding for the patient assisted travel scheme of $1 million per annum. How will it be used?

Mr KUCERA: Essentially it is for getting specialist services to people in rural and remote areas, particularly where at present we cannot get specialist services. It is a two-way street. People in rural areas have a great deal of discomfort with the PAT scheme. Many people think that it could be better operated. That is why we set up the internal review of the PAT scheme. That review has virtually concluded and has brought clear indications to us that we need to make major changes to the program. We will be sending a formal review process into the rural communities. We have already announced that. We have set up a series of formal meetings with the Department of Health. As I said recently to the member for Roe, we will be pleased to help rural members by supplying packages of questions and so on in order that they may conduct programs in their electorates. We want to make sure that everybody gets a clear view of what people want from the PAT scheme. The $4 million is being put into the process to increase the level of service and the capacity of people to access the scheme.

Mrs O'FARRELL: There is not very much more to add to that. The additional money for the PAT scheme is welcome because the costs of running the scheme are going up every year. The review is very welcome because it is proposing a number of potential ways forward. It will look particularly at trying to target the available funding to people most in need. It will consult with the community about some of the more innovative options for the future. The program of consultation is about to commence. We anticipate that we might come up with a slightly re-engineered scheme for the future.

Mr BRADSHAW: If another specialist is located closer to a patient, no PAT scheme money is available to patients wishing to continue going to a specialist in a place like Perth. People have a rapport with their doctors and their specialists. For a patient living in Harvey, if a specialist service is available in Bunbury as opposed to Perth, the PAT scheme would not be available for that patient. Will that policy continue or will the minister consider allowing people to stay with their specialist rather than being hived off to another?

Mr KUCERA: It is a very good question. The member is right; people do have a very personal relationship with their doctors and specialists. The PAT scheme was set up to allow people to access services. When I was in the south last week, issues were raised with me about the misuse of the scheme. Some people in the community use it as a way of supplementing their incomes or coming to Perth for other reasons. We should not be running schemes for people who wish to abuse them. We should run the PAT scheme to allow people in rural areas who need access to those services to be able to get the very best services. When we talked about the direction of the

Government in the matter of health, Dr Geoff Gallop was insistent that rural services should be well catered for. An enormous amount of money has been poured into city facilities over the past few years. I am not sure that has been the case with rural areas. Some good work has been done in rural areas, but a clear commitment needs to be made to make sure services are available to people in rural areas.

[9.50 am]

Mr MARLBOROUGH: The first dot point on page 1238 indicates that one of the significant issues and trends is providing world standard health care to the Western Australian population. That is of particular concern to me at the moment because of the dearth of doctors in general practice in the Rockingham-Kwinana area. I know from our previous discussions that the minister has first-hand knowledge of this issue, but things are not getting better. I shall quickly refer to what is happening in the Kwinana-Rockingham area, which is part of the metropolitan region. Since January last year Kwinana alone lost 14 medical practitioners through either retirement or semi-retirement. I have been party to assisting doctors and the local government authority in making written submissions to replace the provider numbers of those doctors. I am concerned that the provider number system that we must enter into when doctors leave the area and take their provider numbers with them is inappropriate to assist us to fill those needs. My electoral office is now used weekly as a key go-between for existing surgeries and the Department of Immigration and Multicultural Affairs in trying to get doctors from South Africa, Canada and Britain to fill these vacancies. The position is complicated when doctors retire or move out of the system, because they take their provider numbers with them. The community then has to submit an argument to have those provider numbers returned to it. In the past 12 months we have been allocated four to replace 14. An application has now come before the Rockingham region reflecting the same picture. Where does the Commonwealth's responsibility begin and end and where does the State's responsibility begin and end with these provider numbers? As the minister knows, doctors cannot operate in general practice and claim the associated benefits without them. Is there a short-term plan to overcome what I believe is a critical situation in community health in regional centres in the metropolitan area?

The metro area has on average 850 patients per doctor. In Rockingham and Kwinana there are between 3 000 and 3 500 patients per doctor. People who are ill can no longer consult their medical practitioners in those towns without waiting nine days. They are told by their local doctor to consult a doctor of their choice in Fremantle because doctors there will be able to see them. That is a dramatic situation with which we have been living since January 2000. I cannot see a short-term method of fixing it. I am concerned that health standards are being jeopardised by the lack of general practitioners in the area. The provider number system is a headache to us all. There must be a plan in place and a method of overcoming it urgently.

Mr KUCERA: I will refer the member's specific concerns to the Acting Commissioner of Health. I have met with the colleges of general practitioners in that area and also general practitioners of WA on a number of occasions. The second and unintended problem of the shortage of doctors is the pressure it places on the public hospital system in Rockingham-Kwinana, and in Peel and other peripheral hospitals, when a GP is not available. I am advised by the general managers of those hospitals that up to 70 per cent of the people accessing services through the front door of the emergency branches in those hospitals are essentially GP patients. I agree with the member for Peel that it is a difficulty. I have had individual discussions with Hon Dr Michael Wooldridge, the federal Minister for Health and Aged Care. A group in the Australian Ministerial Council of Health Ministers is looking at this problem as part of overall work force planning. In fact, three weeks ago I wrote to a doctor in South Africa who had taken the trouble to e-mail me when he saw the newspaper reports on the Internet about Swan District Hospital. The member is correct that it is an Australia-wide problem. I will defer to the Acting Commissioner of Health to deal with the specific relationship between the State and the Commonwealth.

Professor STOKES: The member for Peel is correct: Kwinana has an absolute major need for primary medical services. I also draw the attention of the committee to a similar problem in the north of the city at Merriwa, which is equally under-serviced. We have had a major struggle with the Commonwealth to get four temporary positions in that area. In Kwinana the problem is three-fold. The first problem is that doctors do not want to live there - I say that unashamedly. Secondly, there are high Aboriginality and aged care situations in Kwinana that do not attract many doctors to work there. Thirdly, the Commonwealth Government does not understand our needs in that area. Although other doctors are attracted there, unless they are given a provider number, patients are hampered in their attempts to receive full benefit rebates. I hope that the commonwealth committee to which the minister referred will help us in that regard. We are doing as much as we can, but we cannot force doctors to go there. We are considering an increase to the staff at the Rockingham-Kwinana District Hospital, particularly in the emergency department, to assist that situation.

Mr KUCERA: The nature of the discussions we had with the general divisions of practice were about the establishment of GP clinics in and around the peripheral hospitals, such as Rockingham, which would allow us 24-hour access to those kinds of services, but there are some problems with that.

Finally, on the problem of the provider numbers, a recent report supplied to the health ministers' conference recommended major changes to the registration process for doctors, with different gradation of registrations. That would mean that as doctors move out of the industry and perhaps work in a different area, they would be able to continue their GP registration, but not necessarily in the same way in which our desperate needs preclude us from getting back those provider numbers. There is a real consciousness of the problem in the community. The bottom line is that the federal Government must do something about it. It needs to get off its butt and realise, as the acting commissioner said, that we have needs not only in Rockingham-Kwinana but also right around the State. The main need will come to bear on us with aged care. There is currently a real crisis in aged care that the federal Government will not recognise.

Mr MARLBOROUGH: I ask a supplementary question. I am pleased to hear that an inquiry is in place, although it may just prolong the agony. Has either the Commonwealth or the State seen fit to put a time limit on the inquiry? Is the inquiry specifically directed at the issue I raised about the shortage of doctors in Rockingham-Kwinana or is it broader than that? If the recent history we have lived with in that area reflects what is occurring in the northern suburbs and in other outer metropolitan areas elsewhere in Australia, the evidence is already there for people to act on. We cannot wait much longer. We cannot have 3 500 people who are ill waiting up to two weeks to see a general practitioner. That is the present situation in the metro area. As the minister said, it is putting massive pressure on the local hospital system. Is there a time limit on that committee's inquiry? Has it been set up specifically to deal with the issue or to deal with broader issues? If it has been set up to deal with broader issues, can this issue be fast-tracked.

Professor STOKES: The committee has already reported. I have not seen the report, as it was completed only recently. The inquiry looked at broad areas. I will obtain a copy of the report for the member.

The CHAIRMAN: Supplementary information will be supplied to the member for Peel.

Mrs EDWARDES: To the committee actually.

The CHAIRMAN: What is the name of the report?

Mr KUCERA: I understand it is a report of Professor Bruce Barraclough on adverse outcomes in Australia. It was recently reported in the Press. I believe the report has a proviso that refers to the registration of doctors. Two reports were produced to the council on the same day on a similar issue; therefore, there may be an overlap in the reports. Rather than specifically quote that report, I will get back to the committee with it.

[10.00 am]

The CHAIRMAN: We have the report on the adverse outcomes.

Professor STOKES: I will obtain details on that.

Dr WOOLLARD: My question relates to the public health sector, but before I move on to that question, I will refer to the minister's comments about the problems in aged care. Parity in wages has been discussed in all sessions this week. This Government is talking about aged care, but I do not believe that it has moved towards ensuring that there is parity in salaries for nurses who work in aged care.

I refer the minister to page 1238 of the *Budget Statements* and the reference to persistent challenges to the health system, both new and old. I also refer to the tenth dot point on page 1256 of the *Budget Statements*, which states -

> In consultation with metropolitan hospitals, strategies are being developed and implemented to increase the efficiency and effectiveness of bed management . . .

The patient turnover in hospitals has experienced a tenfold increase over the past 10 years. Patients with medical and surgical conditions are being discharged after only a few days, rather than two or three weeks. What is the Government doing to help patients who are discharged early? I have not found any allocation of funds for a domiciliary nursing service, which is badly needed if patients are sent home early. We do not want those patients to be forced to return to hospital time and again as repeat admissions because there is a lack of care facilities at home. My first point is: what is happening with domiciliary nursing, and specifically with the use of registered nurses in domiciliary nursing? There is a great concern in the community that the Government hopes to increase the number of carers within the community. Although carers play a vital role in health care, registered nurses are needed for patients sent home, often in fairly acute conditions.

My next point relates to discussions between the Department of Health and the Commonwealth on nursing education programs. The Minister for Education informed me of those discussions yesterday and I asked him whether he was involved in those discussions. Is the aim of the discussions to increase the clinical component of the program for registered nurses? If not, what is the subject of the discussions?

The CHAIRMAN: The minister has basically been given two questions in one.

Mr KUCERA: Yes, I am aware of that. I have made a note of the questions and they relate to home nursing and nurses' training. Does that summarise the questions?

Dr WOOLLARD: Yes.

Mr KUCERA: I will begin with the first question, which asked what the Government is doing to help patients who are sent home from hospital, particularly in terms of aged care. I was surprised that I did not see the member for Alfred Cove at the opening of the Moss Street Day Therapy Unit in East Fremantle two or three weeks ago. I understand that the centre, which is in the annex of the old Fremantle hospital, is in the member's electorate. It is a magnificent centre; it will supply a raft of physiotherapy and allied health services for people who have been discharged from hospital. Those people are treated in a wonderful heritage setting, which is akin to their homes. I urge the member to visit that facility. That is the first issue. In terms of home care generally, the Government wants to move forward on that issue through the use of commonwealth funding available through the home and community care program and funding for specific services. In a moment I will defer to the Acting Commissioner of Health, who can tell the member about specific strategies.

The second part of the question concerned nursing training. That is one of the key issues I have come up against since becoming Minister for Health. I do not accept the member's contention about carers. The scope of nursing ranges from the most highly paid and trained technicians - our wonderful registered nurses - through to those people who carry out simple care duties in the wards and in people's homes. The scope of nursing must include all levels; there should never be an either/or situation when care is provided in the community. It should never be split on those levels.

In terms of nursing generally, I am waiting for Judge Kennedy to report on new visions and directions. I understand that her report will be completed soon. I understand that she and the people who have been involved in that process have examined the scope of nursing and have recognised, as indeed have nurses on the ground, that the scope of nursing has changed since the days and vision of Florence Nightingale. The vision of nursing and the use of nurses have moved from that point. That is important. One of the recent bright points in nursing training is an innovative program set up by a health manager in Geraldton. The current inflexibility in university training in this State precludes the ability to provide bridging courses between enrolled and registered nursing to people in country areas. The health manager took it on his own back to register a program with the Northern Territory University, which allows enrolled nurses to undertake training by correspondence. It has allowed that health manager to establish a training facility. An excellent nurse trainer has taken up residence in the town. I understand that some 120 nurses are registered for that program across the State - a couple of people are undertaking that course in the member for Albany's electorate. Those managers are working desperately to make sure that the gaps in training are bridged. There is no lack of will across the health industry in this State to get nurses into the program. There is no lack of will across the world to get nurses into the system. This issue is not just about registered nurses; it is about the whole continuum of care. Registered nurses have recognised that and are becoming frustrated with the level of technology with which they must deal. They are not able to provide the hands-on care that they would like.

The member has struck the key issue within health at the moment; that is, the supply of well-trained and well-equipped nurses. That covers the whole scope of care. This is not just about registered nurses, because many thousands of people in the health care industry are not registered nurses. We must never lose sight of that. They are as important as every other part of the equation. I am sorry, but I am a bit passionate about this issue because it will be a key to the future health of the health system. I will defer to the Acting Commissioner of Health to provide details about specific programs.

Professor STOKES: A significant amount has been put aside to develop more home care activities. One of those initiatives is to work with the metropolitan hospitals to consider better discharge policy planning and nursing within the home. About $6 million has been allocated to metropolitan health authorities to develop better management strategies to cope with an increasing emergency demand. I will ask Mr Kirwan to comment more specifically on those points.

Mr KIRWAN: I reassure the member for Alfred Cove that nursing or other staff in aged care areas in the state government system, such as those in the small number of state government nursing homes, permanent care units

and care awaiting placement facilities like the one in Mt Hawthorn, are paid the same as other hospital staff. There is no pay differential.

Dr WOOLLARD: As public hospital sector nurses?

The CHAIRMAN: The question must go through the minister.

[10.10 am]

Mr KIRWAN: Anyone employed by a hospital board or facility that deals predominantly with care-related and nursing home-type patients are paid the same as if they were employed by Royal Perth Hospital. There is no pay differential in the system. The issue of the pay differential is between private profit and not-for-profit organisations, which receive commonwealth funding. This Government, and the previous Government, raised that with the federal Government on several occasions, because the question of pay differential is a concern. Obviously, if the aged care area cannot be staffed, the residents will come back into our system. That is inappropriate and affects the bed management issue. Although staffing rates and pay and conditions in the private for-profit and not-for-profit sectors are not a state responsibility, the State has on several occasions raised its concerns with the federal government ministers. I reassure the member that all staff in our system are paid the same. There is no pay differential between state hospitals and the state government nursing homes and care and assessment facilities like those in Mt Hawthorn. We have developed a range of initiatives for post-acute, out-of-institution care, if I can describe it that way, which is different from care in the community as it focuses on more than the public or private health accommodation issue. We have reviewed a number of those programs. HomeWard 2000 is a significant hospital-in-home program providing nursing care that involves the General Practice Divisions of Western Australia and the Silver Chain Nursing Association. There are a number of successful hospital-in-home programs in this and other States. Although the models are slightly different, hospital-in-home care is essentially about providing predominantly nursing care in a post-acute setting. Those areas are under review, because we believe there are ways in which a systems approach could drive some reforms and efficiencies. I agree with the member that the model is predominantly a lower end-based model. We contract Silver Chain to provide some of those services. There is an overlap between some of the home and community care programs and our programs because these people are frail and aged and therefore come into contact with both the health service and HACC. Much is happening in this area. I repeat that nurses working in the services we provide are paid the same as those working in an in-patient setting. There is no differential in pay or conditions. The model is one of post-acute care. Interestingly, the private sector is now asking us about our early discharge programs, as particularly the large private hospitals are full, which is a relatively new occurrence.

Mr KUCERA: I have two major concerns about the wage difference between private sector and state employment. Two classic examples of those problems have arisen in the past six months. The first is Forrest Gardens at Bunbury. For whatever reason, the transmission of business clause was taken out of the agreement that would have moved staff from the state facility to a private facility. This effectively allowed the people taking over Forrest Gardens, the private operators, to offer very low wages to employees who are probably already the lowest paid people within the health care system. That was reprehensible. It is a transmission of business that should not have been allowed. As a State, we have had to step into that argument and second the state employees to back up their wages in a proper process. That is not the way it should be done. Whoever made that arrangement needs a good kick in the backside.

The second example is the emerging practice among some private health care and aged care industry areas whereby nurses and carers are offered roles as contracted people, as subcontractors. This precludes them from all the benefits of a normal award system and denies them the safety nets they would have as workers. They are two practices about which I cannot do very much because they relate to the federal system; however, the federal Government must look closely at those kinds of practices. These people are some of the lowest paid people in the health industry; yet, they provide the greatest level of care. I am fairly passionate about this area.

Dr WOOLLARD: I share the minister's passion for health, and for nurses in aged care. Last week he mentioned the opening of the Moss Street Day Therapy Unit. I was very disappointed not to have been invited. It was a practice of the previous Government, as a matter of courtesy, to inform local members of openings in their electorates. This has happened to me now in both education and health. I hope the Government redresses this so that members are notified in future.

Mr KUCERA: I am glad the member has pointed that out. I will take it up with the Department of Health. I am sure it has been noted. I was surprised the member was not there. It is an excellent facility and caters exactly for the people about whom the member is talking.

Dr WOOLLARD: I would have liked that courtesy. My question relates to deskilling. The minister has spoken about a new role for nursing and creating different levels of nurses. Who is he talking to about this? Task-oriented nursing was the practice 30 years ago. We have moved on to total patient care nursing whereby a nurse looks after all the needs of a patient. My concern is that the minister's comments today and previous comments in the House indicate that he wants to deskill registered nurses. Patients should be given top-level care, and not second-rate care.

Mr KUCERA: Nothing could be further from the truth. We are keen to raise the status of nursing in this State. We have reinstated the Health Administration Review Committee report and will be appointing a head of nursing for this State, who will have status equal to the Chief Medical Officer. The member should make no bones about it; this is a key issue for health. We are keen to progress the model of nursing and nurse practitioners that operates in New South Wales so that we can lift the status of registered nurses to a level that reflects their training and the technology with which they must now work. That is my personal ministerial view. I defer to Christine O'Farrell.

Mrs O'FARRELL: The focus of the recommendations of the Western Australian study on nursing and midwifery will be the continued upskilling of registered nurses and the push to legislatively support an expansion of nursing practices so that nurses have greater roles and, in some cases, independent practices. Part of the study also relates to the scope of nursing practice. We hope to provide an enabling arrangement whereby nurses are better legislatively supported to work with a range of carers. We must have a well-equipped work force with a good and proper skill mix to face the future challenges and demands of patient care. We will require registered nurses who are skilled, qualified, experienced and legislatively supported to conduct a higher scope of practice.

Dr WOOLLARD: The minister did not answer my question about his discussions with the Commonwealth.

Mr KUCERA: The Australian Health Ministers Council is setting up a working group for a national planning program for the nursing and allied health work force. I will refer to the report that comes from that. The council has a meeting today, at which I will insist that we have membership of that working group. Mrs O'Farrell will explain the composition of the New Vision, New Direction study group, which is headed by Justice Kennedy. My understanding is that the top level of the nursing fraternity is involved in that group, with which I have met. It also involves some of the people who are working on the shop floor, or, to use a hackneyed term, at the coal face.

Mrs O'FARRELL: We have noticed the tension between the education sector and the health delivery sector. Those two sectors must work collaboratively to ensure that nurses training in universities have much greater scope for hands-on practice and begin their careers more industry ready. We have identified a number of practical things that we can do. We will also look to the higher education reviews to address those issues.

[10.20 am]

Mr BOARD: I have a supplementary question. I want to look at the allocation of budget items. A $240 million package was announced for nurses over four years. Where is that item in the budget?

Mrs O'FARRELL: The allocation of money to help services is through financing care outputs, as referred to previously. There is no line item in the health budget for nurses. The funding for the cost of the variation in the nurses' award is incorporated in the total allocation that goes to each health service for a specified range, type and volume of costed outputs.

Mr KUCERA: The pay agreement that deals with wages is embedded in the budget at page 1239. The item is $104.289 million. The figure is output-based. The rest of it is embedded throughout the budget in items such as training. There are some items connected with nurses' professional development packages. They are spread over the next four years and amount to about $12 million. An amount of $500 000 a year is allocated as a line item on page 1239 in relation to building the capacity of nurses. A raft of issues and items are scattered throughout the budget. The actual cost of the nurses' pay claim is factored into the overall health budget. It is the member's prerogative if he wants to go through individual line items.

Mr BOARD: The minister made a strong statement that his commitment to nurses was far superior to that of previous Governments.

Mr KUCERA: I did not say that.

Mr BOARD: Yes, you did. It does not appear in the budget. It appears that the delivery of health services in general terms is costed into the $240 million. It is a pea-and-thimble trick. It is not in the budget. I want a costing on where the $240 million is, how it is being delivered to nurses and how it fits into the four-year estimates of this budget. I will accept the information by way of supplementary information.

Mr KIRKWOOD: The only comment I can make is that this is an output-based budget and the member is talking about input costs. Input costs do not appear in the *Budget Statements*. The budget is prepared on the amount of activity and the agreed rate for activity, and that is how it is framed. We do not give each health service so much for wages and so much for goods and services. A certain amount of money is allocated for a certain amount of activity. Each group has to prepare an output-based budget.

Mrs O'FARRELL: I might be able to add to that. All nurses working in the system have received the pay rises and will continue to receive the pay rises. The cost of the pay rises is embedded in the total allocation to the health service. The fact that nurses are accumulating the pay rises is one tangible issue. Following this round of discussions for the enterprise bargaining agreement, we have learned that there is variability in the way individual health services interpret the intent of the terms and conditions built into the enterprise bargaining agreement. We are investing a lot of effort into supporting the implementation of the enterprise bargaining agreement to ensure that every initiative is picked up properly and fully implemented and monitored.

Mr BOARD: I appreciate that, but the point I tried to make is that a $380 million increase over four years was announced in the state budget, but it does not show up in the budget. The Government then said there was to be a $240 million increase for nurses alone. That was announced by the minister as an additional package for nurses. That would take up the majority of the increase. Clinicians and the Hospital Salaried Officers Association are also making claims. There is an additional 12 per cent impost on superannuation and capital. Can we obtain a real picture of where the budget is and what services will be delivered, or will we continue to talk about hidden outputs that cannot be explained? I need to know whether money for services has increased and whether some of the minister's press statements have any reality to them.

Mr KUCERA: The reality is that there is an increase in the amount in the budget. It is an output-based budget; it is not an input-based budget. The member is trying to turn it into that. The point the member made about superannuation needs clarification.

Mr KIRKWOOD: Superannuation is affected by an extra $91 million. Health services have been given an indicative figure with which to work. On top of that, we will pay them the actual cost of the superannuation. The superannuation will be funded. We can only pay what it costs.

Mr BOARD: What additional costs are put into the system to meet the full accrual accounting requirements this year? How does it equate to actual services compared with last year's services? Could I have that breakdown?

Mr KUCERA: That can be provided by way of supplementary information.

The CHAIRMAN: I am contemplating a short break in proceedings. The member for Kingsley has indicated that she would like to ask a question. I will shortly hand over to the next chairman a list of members who wish to ask questions. The following members wish to ask questions: the members for Kingsley, Albany, Murdoch, Innaloo, Alfred Cove, Roe and Murray-Wellington.

Mr BRADSHAW: I was under the impression that I had the call some time ago. I should be promoted in the list.

The CHAIRMAN: The member may be accommodated.

Mr BOARD: There is the difference between the member's turn and a supplementary question.

Will the minister show what provisions have been made for increases in salaries for salaried officers and doctors?

Mr KIRKWOOD: This question has been asked before. It will have the same answer. It is an output-based budget and the provisions are not shown specifically.

Mr BOARD: That does not help me. Either there is no provision or, if there are existing provisions, whatever additional payments are made to doctors and salaried officers have to come out of the provisions made for other purposes.

[10.30 am]

Mr KUCERA: The amount of money that is given to the services is based on the expected cost of the out-turn of services. This is an output-based budget; it is based on the amount of activity that was in there. There is also a provision for reform in the budget, and much of that will be involved in the reform process.

Mr BOARD: There is no reform at this stage, and the Government is in the midst of two difficult and important salary negotiations. Has the minister made a provision for that salary increase in his determination of what will be given to hospitals and other health services?

Mr KUCERA: We have provided for the calculated cost of the outputs of the health services, and that is indicated in what is now an accrual budget process.

Mr BOARD: It is just smoke and mirrors. We have no idea whether a wage increase has been built in. That is what the minister is saying, but I believe that the minister will not admit that the money does not exist, and that if there is an increase, it will have to be met within the existing budgets of the hospitals. That will be even more critical to the delivery of services.

Mrs EDWARDES: I refer the minister to page 1242 of the *Budget Statements* and the paragraph headed "Community health services". I refer to the area of child development and occupational therapy. Last year, the Liberal Government provided extra money to the North Metropolitan Health Service for six occupational therapists. That money has now run out. Currently, there are only two OTs in that area. Consequently, no school-aged child will be seen by an occupational therapist, and some children aged four and over will never be seen by an OT. I understand that a letter drafted to the parents of the children in that age bracket who are on the waiting list has not been sent on the basis that it might not look too good. Therefore, the parents of some of those children on the waiting list do not know that their child will never be seen by an OT. Will the minister explain what funding has been allocated in this budget for the provision of extra occupational therapists in the northern suburbs?

Mr KUCERA: For many of the allied health services, it is not just an issue of funding. There is a shortage of speech therapists and occupational therapists; there is a shortage in many of the paediatric services generally, not just in this State but across Australia. We are experiencing shortages similar to those we faced with clinicians and nurses. We need to be mindful that with these kinds of issues, the problem is not necessarily funding.

Mr KIRWAN: There are two issues here. The first deals with the waiting list bureau funding. We allocated about $800 000 of activity for long-wait allied health activity in the metropolitan area. That was not recurrent funding, and it was made clear to the metropolitan health services that it was an initiative to address the problem of 18-month waiting lists for areas such as speech pathology and audiology. That initiative was quite successful, and in some areas the waiting lists fell from 18 months to just a few weeks. We used the opportunity to clear up a significant backlog. The compounding factor in this area is the shortage of allied health staff in some of those areas; if we cannot employ the staff, it is problematic. The initiative to reduce the long-wait activity was successful in the northern suburbs, and there are other examples in the southern suburbs as well, where there was a shortage or unmet need in allied health community-based local services. However, in the budget allocations, most of the health services have specifically targeted funding to be spent. The North Metropolitan Health Service will get enough funding to open a community health centre in Clarkson which will address the problem. As part of the waiting list strategy, extra funding will be provided to those areas that are both long-wait surgical and long-wait allied health. However, the program was successful in reducing the waiting lists, and we will be doing whatever is possible with the area health services to ensure that those waiting lists are reduced. However, it was important that they had funding. The funding for those positions was sufficient until October or November, but they were not intended to be recurrent full-time positions. They were specifically funded to put in place a reduction of the waiting list time, as we do in other areas; that is, we bring the waiting lists down to an acceptable level, and within existing resources. In this instance, we have been putting more resources into particularly community allied health.

Mrs EDWARDES: My question was not about a shortage of occupational therapists; it was about a shortage of funding and OTs in the northern area. Some of the OTs who were employed - and would have liked to continue their employment within the health sector - have now gone over to other disability services. They are happy in that area, but would have preferred to stay where they were. This issue is not about waiting lists. We now have a group of children who will not be seen by occupational therapists; only those below school age will be seen. Some four-year-olds might be seen by an OT, but the majority of children in that age bracket and over will not. The Government can keep them on the waiting list for another 18 months or two to three years until it decides to provide extra funding, but that will not help those children in their early development years, particularly when they start school and really need that assistance. As I pointed out to the Minister for Education, the money he is allocating to schools to provide services for children with special needs will not go very far. The Department of Health should be providing these services in the northern suburbs.

Sitting suspended from 10.36 to 10.50 am

Mr BOARD: I will now move on from some of the larger questions. There is so much to explore in the various segments of service delivery. In view of the fact that the Community Drug Summit was held recently, I have a specific question about outputs for the Western Australian drug strategy. I draw the minister's attention to page 1241 of the *Budget Statements*. I find it curious that, in the table on that page, against the item "Changes in prevalence of drug use over time based on two major prevalence surveys" the target for 2001-02 is shown as

zero per cent. My first question is, why is that figure set at zero, rather than setting a target for improving the situation? Secondly, is it true that there has been no increase in funding to meet the requirements of the Drug Summit, above what was allocated by the previous Government in previous budgets?

Mr KUCERA: I will answer the second question first, if I may. The Government is awaiting the outcome of the summit, as the member is aware, so it has simply maintained the same budget levels as last year. In the case of the Western Australian Drug Abuse Strategy Office, the budget level has been maintained at what it was when the office was moved across to the Department of Health. No specific changes have been made in the funding programs at this stage, as I understand, but a considerable amount of money has been embedded in the mental health and drug areas to be used for drug treatment. One of the key outcomes of the summit was the clear recognition of the level of duplication across treatment areas, and the capacity to use funds more sensibly as a result of rationalising and bringing together those programs. I will need to see the outcomes of the deliberations of the summit, and the recommendations for restructuring, before the Government can move forward. The levels of funding have simply been maintained at this stage. Mr Terry Murphy, from WADASO, will answer the first part of the member's question.

Mr MURPHY: I will take the first item raised by the member, the effectiveness indicator of changes in prevalence of drug abuse. The plus two per cent shown in the table on page 1241 is a calculation on the two most recent national surveys which included Western Australia, and is a composite measurement of the nine major drug types - alcohol, tobacco, and seven illicit drug types. The two surveys were the national household survey in 1998, and the Australian school student survey in 1999. They were the most recent surveys available at that time, and that composite measurement came out at two per cent greater than the previous survey. In the light of an increase of two per cent, much of which is represented by alcohol, a target was set for this year of capping any increase, so that it can be realistically turned around in future years.

Mr BOARD: Is the witness explaining that, by the best estimates of his agency, the best that can be achieved is zero growth, rather than a reduction?

Mr MURPHY: Following an increase of two per cent in the previous year, that would be a positive achievement.

Mr WATSON: This matter may have been covered. On page 1266 of the *Budget Statements*, there is a separate line for superannuation. Some concerns have been raised in regional hospitals that the superannuation has been phased in to actual budgets. Is that correct?

Mr KUCERA: Yes it is, but it needs to be explained. A great deal of misinformation was put out in the country Press, particularly by one member of the House, in relation to this matter. There is clearly some confusion and misunderstanding on his part, though he is not here today. I will refer that question to Alex Kirkwood, from our finance area, so that the Government can clearly enunciate what superannuation is about in this year's budget.

Mr KIRKWOOD: For the first time this year, we have allocated funding to pay for both Gold State and West State schemes. Previously, this liability was assumed by the Treasurer. The figure shown in the *Budget Statements* is $91 million. On top of that there is the old pension scheme, which was being paid anyway. The $91 million is the extra amount. In terms of rural budgets, the bottom line shows that, right across the rural sector, there is an eight per cent growth. On top of that, a further $91 million will cover the cost of superannuation. This has been done because a very specific amount has been allocated. The money paid out by every health service will be reimbursed. No-one will be out of pocket, but if it is done as part of an overall budgetary process, one organisation might end up with $5 million when it has only cost $4.8 million. Because this item is specifically for a dedicated purpose, it has been kept slightly outside the broad budget process, but everyone has been told indicatively how much superannuation will cost. That will be funded separately, but no-one will be out of pocket. What each organisation pays out will be repaid, and it will be managed through a cash flow process.

Mr WATSON: How long will it take to receive that money? It could take six to 12 months.

Mr KIRKWOOD: Health services reach a position at which a level of funding is agreed, and they then do a schedule of payments, which comes to us, and we then pay those amounts of money. Part of that schedule of payments, or request for funds, will be a superannuation component, and we will make sure that is paid to compensate for what has already been paid out. The West State scheme is a percentage of wages, and the system has been set to capture that. Gold State is the five per cent part, and the whole thing is mechanised, so that invoices will be issued by GESB, and they will be paid and reimbursed.

Mr BRADSHAW: I refer to page 1237, item 112, "net amount appropriated to purchase outputs". The Health Administrative Review Committee recommended the establishment of a state clinical centre. Does this mean re-establishing what has just be disbanded; that is, the Metropolitan Health Service Board?

Mr KUCERA: The idea of a clinical centre is a group of doctors' doctors. Yesterday evening I met with a group of clinicians who wish to bring together two services that are applied in three different hospitals under three different sets of administration. If I were to do that as minister, there would be a great deal of resistance, so what is proposed is to bring together a group of doctors who would help to put the reform process through, but could also act as an advisory council to both the director general and the chief medical officer. I would expect the chief medical officer to be part of that group. It is a way of advising on reform processes. It is a system that has worked very well in New South Wales under its current Government. It has allowed the New South Wales Government to demystify some of the decisions that must be made for clinical reform. That is my understanding, but I will defer to the Acting Commissioner of Health to see if he supports that view.

[11.00 am]

Professor STOKES: The clinical senate will go a long way to giving support in the health system. It is not an administrative but an advisory group that will work through problems and issues and give an unbiased view on how changes should be made to health service delivery. An emergency department is a good example, as are cardiothoracic units. There will be discussions on whether new technology should be introduced. That is the principle behind the senate.

Mr BRADSHAW: By disbanding the Metropolitan Health Service Board, how does the minister propose to streamline services provided by tertiary hospitals without duplicating services? For example, different hospitals treat cardiac patients, so obviously duplication occurs. The Government needs to establish centres of excellence rather than duplicating or triplicating services in metropolitan tertiary institutions. How will the minister achieve that without the Metropolitan Health Service Board?

Mr KUCERA: I am not sure the member is asking about a specific line item but it is a very good question which goes to the very nub of the reform process. Much of the subject was discussed before the 20-20 report, which was put together by the previous Minister for Health, Hon John Day. It goes to the whole nub of the structure. The Health Administration Review Committee is reviewing elevating the role of the director general and bringing a clear direction back to that role by establishing his or her power, as it were, in the structure. This State has had five disparate systems over the past few years. In discussions with the previous Health Minister, it emerged that the same difficulties of bringing those systems together were experienced by the Metropolitan Health Service Board. Some of the work the board did is included in the report. The aim of the HARC review is to elevate executive levels to a proper platform. It will allow us to get rid of some of the duplication. As I have said on a number of occasions, it will also bring into the structure two clear lines of accountability: first, clinical accountability, in which the senate can assist; and second, fiscal accountability, which goes very much to the heart of the accrual accounting that has been developed over the past few years. I have said on a number of occasions that we need to draw a line in the sand and say where we need to go with clinical issues and with fiscal accountability in health. That is a very broad picture. The issue is about getting the structure right. Much of that will depend on the appointment of a director general of health who will then set up the structure and bring back into the process the good people who work for the Department of Health. It is not proper to have one group running hospitals in one area and one group running the health system in another. There must be a clear, unified, single direction for health in this State.

Mr BOARD: The minister has stated on a number occasions during and since the election campaign that the Metropolitan Health Service Board was an unnecessary layer of bureaucracy and a waste of funds. What are the costs of the quite significant number of new advisory councils and reforms to the management of the health system compared with the savings that the minister has made from disbanding the Metropolitan Health Service Board?

Mr KUCERA: I will not know until the structure is in place. It is far too premature to say. Some considerable savings have been made in administration since disbanding the board.

I take the opportunity to say that disbanding the board reflects in no way on it members. They were struggling with a structure that was not working in our view. The board members were certainly not the problem The problem was the way in which health was structured. Insanity is doing things in the same way and expecting change. We must move on. I expect to achieve some considerable savings out of the restructure. Across the health system, major teaching hospitals, for example, run similar-sized financial groups to that of the Department of Health. I suspect that in many of the bigger centres human resource offices would be as large as those in the Department of Health. Some considerable savings can be made by the centralisation of the processes of the

Metropolitan Health Service Board. I would expect down the track to be able to advise Parliament on the kinds of savings made from those changes.

The CHAIRMAN (Mr Andrews): I am conscious of allowing questions within the scope of the budget. We need to focus on the budget. The answers are becoming too long, so insufficient questions are being asked. I think I have the support of the committee in making that point.

Mr QUIGLEY: On page 1266 one of the large costs of services is $65.53 million for visiting medical practitioners. How do arrangements operate at Osborne Park Hospital, given that the Government will spend that amount on visiting medical practitioners?

Professor STOKES: Visiting medical practitioners involve all practitioners who are, as it were, private contractors to our system throughout the whole State. The figure is the estimated cost of those practitioners in the metropolitan area and the rest of the State who carry out fee-for-service services. The figure does not include the salaries of sessional doctors. It is a normal budgetary requirement. There is a slight increase in the budget from last year.

Mr QUIGLEY: The outputs obtained contain no performance indicator for that item. Are the other States as reliant on visiting medical practitioners?

Professor STOKES: We are more reliant than other States. We are examining the area. We are introducing clinical governance under which there will be a requirement for performance measurement of people providing that service. Unfortunately, all our rural and remote hospitals require general practitioners as visiting medical practitioners.

Mr QUIGLEY: It is said that Osborne Park Hospital has the capacity to handle elective surgery patients, although it has no emergency department, but that there is a problem with using sessional doctors and visiting medical practitioners. There seems to be some conflict between the sessional doctors and visiting medical practitioners - I do not know what it is or its basis - which seems to be affecting the ability to run Osborne Park Hospital theatres to their maximum capacity.

[11.10 am]

Mr KUCERA: I will ask Professor Stokes to explain the difference between salaried doctors, sessional doctors and doctors who visit hospitals.

Professor STOKES: Visiting medical practitioners to hospitals are like private contractors who are paid fees for the activities they perform. These activities are either visiting patients in hospital as physicians or performing surgical procedures without support from residents or registrars. The term “full-time doctors” is self-explanatory. Full-time doctors are salaried and work mainly in tertiary hospitals with support from residents and registrars. Sessional doctors are those who work for usually between 0.5 and 0.8 full-time equivalent, again usually in tertiary hospitals. Secondary hospitals in the metropolitan area traditionally have been serviced by visiting medical practitioners. We are gradually introducing more sessional activity and more full-time practitioners. For example, there is now a medical ward at Swan District Hospital serviced by residents, a registrar and three sessional visiting physicians. Osborne Park Hospital in the past introduced sessional obstetricians, and anaesthetists, but the majority of the surgical activity there is carried out by visiting medical practitioners. The North Metropolitan Health Authority, through the Sir Charles Gairdner Hospital, is considering establishing a surgical unit in the spare capacity of Osborne Park Hospital which would be staffed by sessional practitioners with residents and registrars. Discussions are taking place currently on that matter.

Mr QUIGLEY: I ask a supplementary question. Is the presence of VMPs causing a problem in staffing theatres with sessional doctors?

Professor STOKES: There is agreement with the Australian Medical Association - I say agreement with a small “a” because it is an understanding - that VMPs perform activities in our secondary hospitals; however, that must change. There was no significant conflict, for example, when a medical ward was introduced at Swan District Hospital.

Mr QUIGLEY: There are therefore some savings.

Professor STOKES: Sometimes there are savings. There would be no savings in having salaried staff in rural hospitals because there would not be sufficient activity to warrant them. However, savings could be made in the performance of surgery in public hospitals.

Mr QUIGLEY: In secondary public hospitals?

Professor STOKES: Yes. Salaried and sessional practitioners require the support of residents and registrars whereas VMPs do all of that work on their own.

Mr WATSON: The Acting Commissioner said that it would not save money in rural hospitals. Would it not save money if they had salaried doctors? I know that we are currently paying more than $2.4 million a year for visiting medical practitioners. Would it not be more viable to employ doctors at the hospitals?

Professor STOKES: If I said "would not be viable" I should have said "may not be viable". It depends on the workload and the number of cases. Full-time surgeons, for example, would need to have sufficient activity to occupy them for a year to warrant it. There may be savings in some of the larger hospitals by having full-time practitioners and Albany may be one example.

Dr WOOLLARD: My question relates to public health. The Minister for Planning and Infrastructure on Tuesday this week stated that the site of the former Heathcote hospital is owned by the Department of Health. The second dot point on page 1246 under public health states that the third metropolitan public health unit is being established in the southern corridor, and on page 1249, the second dot point under mental health states that the positive parenting program will become available throughout Western Australia. Has the minister considered using Duncraig House as a venue for the third metropolitan public health unit or the positive parenting program? What are the minister's plans for Duncraig House?

My second question on public health relates to the drinking water supplies referred to in the second dot point on page 1247. In the past decade Perth's water supply has had two standard levels for water quality: the National Health and Medical Research Council guidelines and above those the World Health Organisation guidelines. I believe that Perth's water quality previously met the WHO guidelines and that the standard has fallen to the NHMRC guidelines. Does the minister plan to implement measures to ensure that the standard of water quality increases to the WHO guidelines?

Mr JACKSON: As stated by the member, there are two standards. The current standards in place for drinking water are the 1987 NHMRC guidelines. Those guidelines have now been superseded by the far more comprehensive 1996 NHMRC guidelines. In Western Australia we have been working with the 1987 guidelines and are moving to the 1996 guidelines, which provide a far more comprehensive assessment of both the health and desirable criteria for drinking water. These are the national standards based on the WHO standards. Drinking water varies considerably throughout the State. However, in some regional centres there is non-compliance with both existing and other standards, which is being addressed by the Department of Health and the Water Corporation. There are some clear resource implications for compliance with the possible standard of drinking water in all regional centres, particularly with the desirable criteria such as total dissolved solids and salinity. Some areas do not meet the desirable criteria and some areas in the State, particularly the goldfields, have levels of nitrate which pose a risk to infants and which are higher than the health standards. In those circumstances we have recommended that bottled water be given to infants.

Dr WOOLLARD: The other part of my question related to Duncraig House.

Mr KUCERA: I will move onto that question, but I understand there is a supplementary question.

The CHAIRMAN: The member for Murray-Wellington has a supplementary question.

[11.20 am]

Mr BRADSHAW: Three towns in my electorate are well and truly above the 1996 recommended levels of solids and other matters in the water supply, and are probably at the top end of the previous recommended levels, if not slightly higher. What pressure can the minister bring to bear on the Water Corporation to instigate changes to bring it in line with the more acceptable 1996 levels?

Mr KUCERA: Does that question relate to a line item?

Mr BRADSHAW: It is a supplementary question to the one previously asked on water quality. It refers to the line item on page 1247 of the *Budget Statements*.

Mr KUCERA: Mr Michael Jackson will comment on that issue.

Mr JACKSON: I am aware of the cases that Mr Bradshaw has raised. They relate to Myalup and Binningup.

Mr BRADSHAW: And Preston Beach.

Mr JACKSON: Yes. The desirable criteria for levels of total dissolved solids were exceeded. A more recent analysis was undertaken which showed that the barium levels at Myalup and Binningup exceeded National Health and Medical Research Council levels. That advice has been provided to the Water Corporation. The department has a memorandum of understanding with the Water Corporation. As has been mentioned, some

resource implications are involved in the treatment of the water in those areas or in the provision of other sources of water. We advised the member, through the minister, of the most recent studies. We are working with the Water Corporation on that.

The CHAIRMAN: I refer the minister to the second question asked by the member for Alfred Cove.

Mr KUCERA: The first part of the question was whether I had considered Duncraig House in the light of public health issues. I have not. I am not aware whether it has been considered. I am not even sure whether the metropolitan public health unit is suitable for that type of thing. I will defer that matter to John Kirwan.

Mr KIRWAN: An allocation has been made for the creation of the south metropolitan public health unit this financial year. The intention was to create it last year, but we were unsuccessful. That will add to the services already provided by the north metropolitan public health unit, which was created a couple of years ago, and the east metropolitan public health unit, which has been in place for some time. That will provide coverage across the State. We would prefer not to consider the site to which the member referred for a number of reasons. As we have already heard from the member for Peel, there are a range of public and community health issues in the south west metropolitan area, particularly around Rockingham and Kwinana. From a public health perspective, those areas have the greatest need. This is a service-based model rather than an institutional model. Negotiations will be held with the south metropolitan health services in Rockingham, Armadale and Fremantle about the best location for that unit. The unit might be based out of existing service facilities, but will focus on providing services in the areas of public, population and community health as close as possible to the areas of need. The demographics of the south metropolitan area suggest that the areas of need are further south than Applecross and Ardross.

Dr WOOLLARD: My other question referred to the ownership of the Heathcote Hospital site by the Department of Health.

Mr KUCERA: My apologies, member for Alfred Cove. The department owns that site, but responsibility for its disposal falls to the Minister for Planning and Infrastructure. If the department does not require an asset, there is a process for its disposal. I understand that essentially to be the process. Alan Buckley, from the property services area of the Department of Health, is present. Mr Buckley, is there any need to elaborate on that point?

Mr BUCKLEY: Duncraig House is the former nurses quarters at Heathcote Hospital. It was converted to offices under an old structure and has been vacant since 1995. The Government Projects Office, which is part of the Department of Housing and Works, is managing that issue on behalf of the Department of Health.

Dr WOOLLARD: The Minister for Planning and Infrastructure said during the estimates committee hearing on Tuesday, 25 September that the Heathcote Hospital site was owned by the Department of Health. It seems that a bit of buck-passing is going on.

Mr KUCERA: The Parliamentary Secretary to the Minister for Health carried out a review of vacant sites. A number of proposals and options have been put forward for the use or disposal of those sites. If the Department of Health does not have a use for an asset, there are certain options for its disposal. The process of disposal or of examining those options is in the hands of the Minister for Planning and Infrastructure. We are yet to advise her of our final decision on that issue. We are not considering a use for that site at this stage, although that is under constant consideration. One option raised in the House by the Minister for Planning and Infrastructure the other day was that the site could be used as a naltrexone or drug clinic along the lines of the clinics run by Dr George O'Neil. That is a possibility for the future if it is required. It has not been seriously considered at this stage. The department has undertaken a review of the possibilities for disposal of the site and what will be best for the community and for health services. The department has a number of sites that have been left vacant for a long time, including the Heathcote and Sunset Hospitals. The previous Government did not make any decisions on them. We intend to make some decisions as soon as we have a clear view of what is required.

The CHAIRMAN: Members, I will give the first call to the member for Roe and then to the member for Murray-Wellington, before returning to the member for Roe. I am conscious of keeping a balance between the members who ask questions.

Mr D'ORAZIO: Will I get to ask a question?

The CHAIRMAN: Yes. The member for Ballajura is down at the bottom of the list with everyone else. This is the first question the member for Roe has asked in a while.

Mr AINSWORTH: I refer the minister to the major policy decisions on page 1239 of the *Budget Statements*. At the bottom of the list, under "Decisions taken since State Election", the abolition of the Metropolitan Health Service Board is listed. It was reported in *The West Australian* on 20 January 2001 that a pre-election promise of the Labor Party was to allocate some of the money from the abolition of the Metropolitan Health Service Board

to rural health services. Has the Government kept that promise? If so, how much has been allocated and to where? Can the minister guarantee that no changes will be made to the function of rural health service boards? Are they likely to continue and for how long?

[11.30 am]

Mr KUCERA: In relation to the first part of the member's question, $4 million has been allocated over four years to the patient assisted travel scheme. From memory, that can be picked up in a line item in the *Budget Statements* concerning election commitments. I cannot answer the member's question about where the remainder of the money has gone, unless I go into detail. I suspect the funding has been made as a general allocation. No specific allocations have been made other than to PATS.

The Health Administrative Review Committee anticipated that a further review of the role of rural health service boards and the establishment of health services would be carried out. As I recently indicated in the Press and to the House, this Government intends to establish and formalise area health authorities. If that review provides any indication of a need for change, we will consult with the boards. One of the things about the boards that concerns me - I raised this with the member for Albany when I went to his electorate recently to meet with the board heads - is the fiscal issues associated with the management of hospitals and the fact that many of those boards report directly to me as minister and therefore have direct financial responsibilities. I want to ensure that the individuals on those boards are not exposed in any way. I asked them earlier this year to make sure they are aware of their responsibilities as board members. Through this review, I want to ensure that their role in the financial management of the boards does not expose them in any way. I am not quite sure of the legal position, but, as minister, I would not allow that to occur.

The management of health generally is moving forward. Some of the major hospitals and health centres in the rural areas are now big businesses. Many millions of dollars are administered by people who are not always able to make decisions based on expertise or experience. I expect the review will take into account the formation of boards, the capacity for them to carry out without exposure the roles that the new world of health is putting forward, and the needs associated with the establishment of area health authorities. I have made a conscious effort to visit as many area health authorities as I can, and most come close to the model we envisage. There may need to be consultative changes with some authorities.

It is a long-winded way of answering the question, but yes, in time changes will take place. I have extended the life of the boards until December next year. We have 12 months to work through that process. I do not anticipate any immediate change.

Mr BRADSHAW: Page 1259 refers to the funding for home and community care. Is the minister aware that residents of homes for the frail aged are denied HACC services? The Hocart Lodge Aged Centre in Harvey recently requested a HACC service to transport a resident to a specialist service. The home was led to believe that, under the rules and regulations, HACC is not able to service those people. I think that is wrong. That facility is the home of the residents. Why should they be discriminated against? Is the minister aware of those rules and if so, can he change them?

Item (g) on page 1260 refers to the state government nursing home program. What is the state government nursing home program and how does it fit into the system?

Mr KIRWAN: The state government nursing home program is moving towards the end of its life span, starting with the closure of the two out-of-date and inappropriate care models of Sunset and Mt Henry Hospitals, which were originally the old men's and old women's homes. Frail aged residential care has become an increasing priority throughout Australia. People are now providing frail aged care in various settings - what we colloquially know as nursing homes, hostels and various stay-at-home support packages. The program will close because, with the Commonwealth's agreement, we have transferred the responsibility for the provision of frail aged care from the State Government to the Commonwealth. We have moved a number of beds from the Mt Henry and Sunset sites - particularly the Mt Henry site - to rural areas under the multipurpose service and other models. We are pursuing work in the Kimberley. That program will run for another one or two years before it is complete. We are maintaining some services through Brightwater Care Group and others. Some parts of that program also relate to people - particularly young adolescents and predominantly males - with brain injuries. Professor Stokes is probably best placed to comment on that.

The member referred to home and community care. Unfortunately, the situation he described is not uncommon. The HACC program does not generally operate in nursing homes, as we call them, and hostels. The funding for nursing homes and hostels - which is the responsibility of the Commonwealth and not the State - is intended to provide a range of services. I appreciate that it is problematic in smaller country areas where nursing home/hostel complexes may not be as large as those in the metropolitan area, which have their own buses and

those sorts of services. It is an issue that falls between the gap. The home and community care program is designed to provide services for people living in residential homes rather than institutions such as hostels and nursing homes. In some instances - and this has happened in Bunbury and other places - HACC will provide the service on a fee basis if the program is not at capacity and it does not disadvantage eligible clients. The home must pay for the service because it is hard to explain the expense if the user is not HACC-eligible. It does seem a little bureaucratic. Hostels and nursing homes are a commonwealth responsibility. HACC is a shared responsibility, with the Commonwealth contributing 60 per cent and the State 40 per cent of the funding. However, HACC is designed for people who are in the community rather than in either of those institutions.

Mr KUCERA: One of our election policies was the establishment of a working party for aged care. I have in the last week interviewed prospective chairs for that working party. The key pressure point in this State is - I thank the member for raising it - that gap in the system through which people are falling. There should not be a gap; we should be able to put down a footprint in an area, and deal with aged care jointly. The reality is that relations between the States and the Commonwealth have become almost adversarial, particularly the dealings I have had the displeasure to have with the current federal Minister for Aged Care. There must be a realisation that unless we move forward in aged care and get a true partnership on the ground, particularly in rural areas, the pressure on the public hospital system will be ever increasing. We are trying do that. I intend this year to put in place a working party that will bring together all the key people. It was an election promise, and it will be honoured this year. I would respect any views of particularly the rural members as to the membership of that working party and the kinds of people we need in it. It does not need to be lengthy issue; it is a matter of pulling people together. We recently conducted an exercise at Collie to see if we could get the key stakeholders in aged care to work together. It is an issue. Unfortunately, there was a lack of realisation about the impact on the States of the transfer of aged care responsibility to the Commonwealth. It should be a concern to all of us that these things cannot be done in partnership.

Mr AINSWORTH: Page 1272 shows a $470 000 reduction in spending on rural health support education and training. What will that mean for the level of services provided and which programs and areas will be affected?

[11.40 am]

Mr KUCERA: My understanding is that it is a commonwealth-funded project. It is fixed income that the State receives from the Commonwealth.

Professor STOKES: The figure represents what is predicted from commonwealth funding. I will look into that and provide some supplementary information.

Mr KUCERA: We are talking about the item listed as rural health support education and training for which the budget estimate for 2001-02 is $146 000.

Mr BOARD: I refer to output measures at page 1252. Under the section on timeliness, there appears to be an increase in the waiting time for elective surgery in category 1 compared to last year. The waiting time for category 3 has doubled since 2000-01. The average cost per weighted separation at public hospitals is the highest in the country, other than the Northern Territory. The national average is about $2 600. A further increase in the average cost per weighted separation in Western Australia is predicted, whereas the trend is in the other direction for other States. Given all the promises about health, why are those two areas predicted to blow out? I believe that a number of non-medical factors are built into the costs. The minister decided to abandon contracting in a number of public hospitals for services such as laundry and catering. If some of those services are brought in-house, costs may blow out further. Where are the efficiencies that the minister has talked about? Why is a further blow-out indicated in the targets?

Mr KUCERA: I will talk about contracting first. There has never been a blanket decision that all contracting would cease in hospitals. Sense and practicality have to be applied. Contracts that result in some of the lowest paid workers in the health system being paid less are cause for concern, especially regarding the level of care that must be given to the workforce and patients. Where possible, it will be brought back in-house. I visit hospitals that feed their patients in-house and those that use catering contractors. There is much difference in the level of service. Most of the complaints I receive about hospitals are about the food, not the medical services. The Government has made a conscious and sensible decision. I agree that it must be made on a cost basis. The previous Government got rid of all the laundry facilities in hospitals and gave them to private contractors. It would be a major initial cost impost if the Government had to rebuild the laundry services in hospitals. One of the problems with that is that it denies laundry services to hospitals in times of need if there is an industrial dispute.

There are two parts to the member's question about costings. The first part relates to timeliness for elective surgery. I ask the general manager of general health purchasing to answer that.

Ms McKECHNIE: The targets set for the 2000-01 budget are the targets set for the 2001-02 budget. We exceeded our expectations in the previous financial year. We intend to allocate $25 million to the long-wait elective surgery strategy this financial year. We are specifically targeting category 1 patients - those who are most urgent. The budget papers show a conservative figure. We will also target some long-wait, non-urgent patients who may have been waiting two or more years for surgery. The number of people on the waiting list at the moment is at the lowest level since 1993. We expect to continue our good results.

Mr BOARD: The Wait List Bureau has been very successful and it is a great initiative of the previous Government. Having achieved what the department has under category 3, I cannot understand why the minister would target a doubling of the waiting list in that area, other than to come back at some other time and say that it has been decreased. It is a strange way of doing it. The reality is that the waiting list has been halved through the efforts of the bureau and the funding. I cannot understand why anybody would indicate that it will blow out 100 per cent over the next 12 months.

Mr KUCERA: The member used the word "reality". This is what this is - it is a reality check. I am pleased with the way the waiting list operates. It is a shame there are not staff here today that I could compliment. It is a good initiative put in place by the previous Government. I am happy to applaud any good initiative, regardless of its political colour, if it helps to obtain better services in health. I am surprised by the figures given by Ms McKechnie about the current wait list levels. In the first three months of this year, the word "crisis" was never out of newspaper articles on health services in this State. I am told that, despite all the barriers and the industrial action of the first six months of this year, we are still able to reduce waiting lists. This is a reality check; we have set the same levels as set by the previous Government because this Government believes in being realistic about issues.

About 300 people who are in the State's acute hospitals today should be in nursing homes. Recent publicity was given to Kim Beazley's daughter. On the day of that incident, 41 patients who should have been more appropriately located in aged-care beds, were in the emergency ward of Sir Charles Gairdner Hospital. I appreciate the member's views. The term "blow-out" is a bit emotive. We are facing a reality check. It is very sensible for the Department of Health to put realism back into the figures instead of making predictions that, because of the issues in health, cannot be met. Realistic targets have been set. No blow-out is predicted. The figures simply show the targets set by the previous Government. Thanks to the excellent work of Michelle Wilkie and staff at the Wait List Bureau and some of the reform processes, targets have been exceeded. Quite frankly, that is a realistic way of doing things and I applaud them for that. I do not see it as a criticism; I see it as a reality check.

Was there a second part to the member's question?

[11.50 am]

Mr BOARD: The minister has not really answered why we are targeting an increase in average costs for weighted separations in public hospitals. As the minister knows, we are way above the national average. That is an area in which we desperately need to achieve efficiency. The minister has spoken about efficiencies, yet there is nothing in the targets that would indicate that that is the way we are headed.

Mr KUCERA: I will comment on a couple of issues before I hand over to Mr John Kirwan. I have inherited much of this process, and I do not resile from that. The difficulty is that the costs are up, and in many areas, services are down. A lot is made about demands, but the whole basis of output-based budgets is to make sure that we start to rein in the issue of rising costs and levels of services that are dropping. It is a very complex issue.

Mr KIRWAN: As a preface to the member's question, two issues are involved. One is that there are valid reasons for these areas to increase. They are weighted separation and areas of complexity, particularly with an ageing population in which we see a natural growth in some of the procedures being carried out. It is unfortunate that the figure is presented as a target, because it gives a misleading impression that we are seeking to increase our cost of production, which is the opposite of the department's intention. However, it does reflect the cost drivers within the system. The minister is absolutely correct. This is one of the areas that we have targeted and if we are successful with the reforms that have been put together, the cost per weighted separation and the other costs will reduce as the system's reforms and efficiencies are put in place. At this stage, as the minister has already pointed out, once some of those are in place, we will see that area turn around. Therefore, this is a budgeted projection of what it will look like.

The second thing - something that we are not necessarily comfortable with - is that the Australian Institute of Health and Welfare figures were quite disturbing. They showed that Western Australia was significantly more expensive than some of the other States. Those figures do not correspond with our own figures and other data

collections. We have looked at them and found two reasons for that. One reason is that data that was supplied by us, and additional data, was put into their model, and it produced a biased result. We are negotiating with the institute to correct that because it is important, particularly for the Productivity Commission and the Grants Commission figures. The institute has accepted that some variance is required. Also, there are very strange movements in some of the States in which they have had significant reductions that make us look more inefficient. One could ask questions about what has happened with some of those State's figures, particularly because of the large percentage changes. Therefore, there is an issue with data integrity and what is counted and not counted. Generally, our data is very good and I am prepared to say that some of the other States are not as good. However, the impression that we are more expensive in some of the areas is wrong, and, if the minister agrees, we will able to table the outcome, although it probably will not be ready for a few weeks. We are now having discussions with the AIHW about what those figures should look like.

Mr BOARD: From an examination of the figures, it appears that the disproportionate loading of the costs in Western Australia was not on the clinical side, but on the administrative side and on other support mechanisms such as laundry, catering and so forth, some of which we are now deciding to load further into the system. My concern is that by some policy decisions that the minister will make, he will inflate that figure even further contrary to what is happening in other States. Why is the minister going down that track?

Mr KUCERA: That is a very good question. As I have said on a number of occasions, we are going down that track because it is insane to do things the same way and expect things to change. The reform process must kick in. The issues the member raises about policy with regard to costs are very real. However, a general example in big teaching hospitals is the lack of preparation of a business case when new services or equipment is installed. For instance, in areas such as radiography, there has been a lack of thorough planning about the life cycle of machinery or the life cycle cost of a service provision. When one is looking at the containment of costs, they are fundamental business principles. If a service that is contracted out and is expected to make a profit can be provided in-house at the same cost or less, in which case savings are made and an improved level of service provided, that is an extra criterion that one must consider. In the health industry, one cannot simply talk about dollars. I have mentioned a couple of times in the House that a few years ago, a fairly notorious health minister in the United Kingdom said, "The chilling discovery you reach as Minister for Health is that all you are ever destined to talk about in the health industry is money." I must say that that is the case. We must get back to the point where we are discussing people's care. If a service is to be contracted back in-house - for example, the supply of food - two criteria must be applied. The first is cost; I totally agree with the member on that. In fact, that kind of accountability is desperately needed in health. However, secondly, and more importantly, is the criterion of care, and we must never resile from that. If it costs a bit extra to make sure that I do not have six or seven people in the department running around and writing-off complaints about food in hospitals, the hidden saving is probably far greater than the up front saving that the member is talking about.

Mr BOARD: If that were the case.

Mr KUCERA: Certainly, if that were the case.

The CHAIRMAN: I refer to the comparison with hospitals in the eastern States, particular with non-medical costs. Do we have a break down of the information from the eastern States hospitals as to which of those hospitals had private contracting for orderly services or laundry? In other words, what is the variation between the eastern States hospitals and Western Australian hospitals in their systems of non-medical provision?

Mr KIRWAN: We do not have the information at the level that the Chairman is asking for. Individual hospitals have several, what they call, "round-tables" for benchmarking programs. Therefore, our larger individual teaching hospitals - not non-teaching hospitals - would have access to information for comparisons within their group. As an industry, that information would not be collected in each of the States; the significant variance within the States would manage that. I would caution the member because the main drivers of the health system are clinical activity; not catering, cleaning or laundry services. These figures show that the main driver of costs is what is spent on clinical activities, directly and indirectly, not on hotel and other services. Therefore, one needs to apply the 80 to 20 rule. There can be variances but one goes down the path in which small variances are given relative to where most of the activity is happening, which is clinical activity by clinical staff.

The CHAIRMAN: The member for Murdoch might correct me, but my understanding is that the greatest variation is the non-medical cost between the States.

Mr BOARD: The efficiencies that came out in that report were doubled. We were running at double the cost in those areas - 100 per cent in some cases - above other States. The clinical areas were only marginally different.

[12.00 noon]

Mr KIRWAN: One of the problems with reporting at a national level is getting national consistency. When we looked at the report practice, we found that some areas in Western Australia were more expensive - for example, the remote and rural services. Effectively, Victoria has no remote or rural health services. The definitions are applied under the various definitions of what is remote or rural. Although the Northern Territory has the largest percentage of remote or rural people, Western Australia has the largest population in remote and rural areas. People in the country would appreciate that most of the health services that service rural populations are not large relative to those in other States, including New South Wales or Queensland, which have significantly larger populations in the remote regions. Our health model is more expensive because of the size of the State and its remote areas. The health system is more expensive because there are effectively no general practitioners in the north west; therefore, salaried medical services are provided by the department and the Aboriginal medical services.

When we unbundled the figures, we found that the different States were at different stages of accrual accounting. As Alex Kirkwood described earlier, ours is a full accrual accounting system, which inflates the figures. One must be careful when making comparisons with other States. The figures from the Australian Institute of Health and Welfare do not adjust for those States that report on an accrual basis where they report the figures. In some States, for example in Victoria, significant variations simply could not have happened in one year. There is a change in the accounting reporting. Currently, we are unbundling those figures so that we get a true record to make a true comparison.

Mr KUCERA: I will make two quick comments on that issue. First, it is obvious that the previous Government attempted to make savings by contracting out services. As John Kirwan said, the result of that has been a ratio of savings in that area of 80 to 20. The real reforms must be made on the clinical side of health if we are to bring these issues into line. Secondly, the member for Murdoch highlighted the issue of administration. Today, I have already spoken about the reform processes within this framework that was set up by the committee of eminent Western Australians that the Government put together. They clearly state that there is room for administrative savings about which the member referred. However, as John Kirwan said, within the budget allocations of the Department of Health, there is an expectation that the department will operate its administration costs with 20 per cent less funding this year; that is shown in the budget papers.

Savings have been made in administration. However, I come back to the fact that the real massive savings in health - the Assistant Commissioner of Health can relate some of those issues to members that have been referred to the Department of Health by the Australian Medical Association. The AMA said that sufficient money can be saved by making changes in clinical practices to pay for any of the claims it has made, even its ambit claims. The cost of administration is good point to raise; however, this State has tried to make savings in that area. The previous Government cut costs in the hospitals' food and cleaning services. It tried to make the food, cleaning and laundry services profit based. It is obvious that those areas have been crunched and cannot be crunched any further; nor can the workers in those areas be crunched any further. It is important to consider major clinical reform that can be introduced. John Kirwan states that that is the way forward.

Mr BOARD: I hope that the minister does not make policy decisions that add costs to those areas. The minister may be able to provide examples in which people have complained about this or that, but the provision of those contracted-out services is first-class. It would be a retrograde step to provide some of those services in-house. That would add additional costs to our tertiary hospitals and would cause them to struggle to be efficient.

Mr KUCERA: That is a comment, not a question. However, I will reply to it. I will provide an anecdote because the member is talking about specific examples. Recently, at the Broome District Hospital I met a wonderful woman named Aggie. For 31 years as a member of its staff she has fed patients at that hospital. Recently, I gave certificates of accreditation to a wonderful bunch of people in the catering section of the Fremantle Hospital. The administration of Fremantle Hospital resisted fiercely the contracting out of its catering staff; the member for Murdoch knows that. I congratulate whoever made the decision to keep that staff in place. Recently, the catering staff reached accreditation level, which is a credit to them. More importantly, that group of people remains a part of the fabric and the community of the hospital. They do not only feed their patients, they fix the bloody transistor radio - sorry - when it is broken. They go to the shops and buy a new lipstick for the old biddy whose grand-daughter is visiting that day. As part of the community of the hospital, they do the kinds of things that contracted services do not supply. I am sorry, it may be a philosophical political difference between the Labor Party and the Liberal Party, but, at the end of the day, hospitals are about people and the provision of care; they are not only about dollars.

The CHAIRMAN (Mr McRae): Before the member continues, I need to clarify what supplementary information the minister has agreed to provide.

Mr BOARD: Whatever I can get.

Mr KUCERA: I can get the member for Murdoch a meal at Fremantle Hospital! It is good tucker.

The CHAIRMAN: The first thing to be provided to the member for Murdoch is a meal at the Fremantle Hospital!

Mr BOARD: I will take up that offer.

The CHAIRMAN: Will the member be specific about the information that he requires of the minister?

Mr BOARD: I want any information I can get about the weighted separation at public hospitals. Mr Kirwan indicated that the figures in Western Australia were not interpreted correctly on a national basis, or that they were skewed. What are the costs and the breakdowns between the clinical and non-clinical areas? It is anticipated that there will be an increase in those costs. As far as I am concerned, other States have been able to achieve better results than ours. I know there are geographical reasons for that, and I do not take away from that; however, I thought that we would target efficiencies in that critical area. I want any information I can get about the breakdown in those weighted separations.

The CHAIRMAN: We are not talking about policy matters but about appropriation.

Mr BOARD: I refer to page 1253 of the *Budget Statements*.

Mr KUCERA: I can refer that matter to John Kirwan. There is a difficulty with the timeframe for when the supplementary information must be supplied.

Mr BOARD: If it takes longer, I am prepared to wait; however, I would like to see that information.

Professor STOKES: I will add that it is important that we provide information after our discussions with the Australian Institute of Health and Welfare.

Mr KUCERA: I should have made that comment. Currently, discussions are being held with the group that put together the benchmark figures for Australia. That issue was raised by my adviser David Inglis at the previous Australian health ministers' conference. It has been agreed that we will continue discussions to try to rationalise the differences and find out exactly what they are. I am prepared to provide that information as long as the member is prepared to accept that it will be provided outside the supplementary period.

Mr BOARD: I am happy for that to happen.

The CHAIRMAN: There is a problem with that because 12 October is the deadline. It might be better if the member puts that question on notice. That would allow the information to be provided.

Mr BOARD: That is good advice.

Mr KUCERA: I am happy to accept that.

The CHAIRMAN: I caution the member that once it is put on notice, the staff will not follow up that information as it is not supplementary information for the estimates committee process. The onus will be on the member.

[12.10 pm]

Mr D'ORAZIO: Visiting medical practitioners is my favourite subject. My question is longwinded and is in several parts.

Firstly, who actually controls the appointment of visiting medical practitioners? Particularly in country hospitals, who makes the decision to use medical practitioners? I refer to page 1266, the line item for visiting medical practitioners and the amount of $65 million in the current budget. At Albany Regional Hospital in 2000-01, $3.293 million was paid to visiting medical practitioners, and there were no salaried doctors. At Bunbury Regional Hospital $4.96 million has been paid to visiting medical officers, while salaried doctors were paid $1.873 million. At Geraldton, $3 million was paid to visiting medical officers, while $150 000 was paid to salaried doctors. These are the Department of Health's figures that have been given to me in a different form, and I am using them as examples. It is the principle I am seeking, rather than the actual numbers. In the light of the publicly acknowledged problem at the Bunbury Hospital, whereby one individual visiting medical practitioner received $500 000 in payment for his services to the hospital, who makes the decision to use visiting medical practitioners at country hospitals? Is there an overarching body that controls that within the Department of Health, or are the various hospitals allowed to make the decision themselves?

Metropolitan hospitals seem to operate in an entirely different way with visiting doctors. At Osborne Park Hospital, about $3.5 million was paid last year to visiting medical practitioners, and it increased this year. At Armadale-Kelmscott, $5 million was paid to visiting practitioners, and at Swan District, in my electorate,

$4.78 million was paid, from a total of $8 million. These hospitals all have about the same budgets. There seems to be no coordination. In February no doctor could be found to staff the emergency department of the Swan District Hospital, and the whole region was left without a medical service. I do not want that to happen again. Royal Perth Hospital and all the other teaching hospitals, do not have visiting medical practitioners. There are sufficient doctors in the system to supply these services at metropolitan hospitals. In the light of this comment, why does the system not have the flexibility for the Minister for Health and the commissioner to direct doctors to provide in those hospitals the services needed by the community at that second level? The situation in which the minister and the commissioner are unable to tell a doctor to cover the emergency service at Swan District, is totally unacceptable. In the metropolitan area, who controls the use of visiting medical practitioners and the areas in which they will operate, and what proportion of their budgets will be spent at those individual hospitals? In this system, there appears to be no control and no overarching decision making about who controls those budgets.

Mr KUCERA: The member, it appears, has raised five issues. The first matter is who controls visiting medical officers. Secondly -and I think this one is very important - who controls their role and how they operate within a hospital? The third issue is whether there is an overarching body that dictates how VMOs are used. The fourth one was the issue of flexibility, and my position as minister, and that of the Commissioner of Health, to be able to instruct people to go to particular hospitals. The fifth issue, similar to the first three, was who controls the access of VMOs, their budgets and how they operate. A further issue, raised in my visit to Albany last weekend, and of concern to the smaller hospitals, was who actually decides what VMOs do within the hospital. In one smaller hospital, which I will not name because the issue has now been sorted out, the doctor is the admitting person to the hospital and also dictates what procedures are carried out. Since a general manager is now at that hospital, and he has a very different view on admission practices, the hospital has been able to cut its costs from about $130 000 a year to $70 000. I will refer the questions to the acting Commissioner of Health.

Professor STOKES: I will deal first with the way in which visiting medical practitioners are appointed. In the smaller rural areas, that is done by the board and the general manager of the health service. It would usually be the appointment of the local general practitioner in the country town. They would be appointed to the hospital to carry out the admission and care of patients, but they would also be credentialled to do certain things within the hospital. There has not been a strong credentialling program in this country and in this State until relatively recently. That credentialling process allows doctors to do certain things because of their training; for instance, to remove an appendix. Some doctors these days are not trained to do that. There is an accreditation process at the hospital by the hospital board, and then there is the credentialling process that defines what certain doctors can do at the hospital. The common way in which accreditation to a hospital is carried out in rural areas, is that all general practitioners in that area are accredited at the hospital, because they all have patients from within that area. The policy of admission to the hospital is usually directed by a medical advisory committee, with the general manager, or a regional advisory committee. Visiting specialists of various types may also come to the hospital. They have to be accredited and credentialled to the hospital. A lot of their activity may be visiting outpatient work. The funding allocation in the hospital would be for both visiting medical practitioners and specialist attendances. The break-up is probably not clear in the line item. The next issue is whether there is overall control of VMOs in the rural areas, and the answer is no. Each health service decides who will provide the service.

Mr D'ORAZIO: That is why I asked the question, because I knew you would give me that answer. In the light of that comment, I ask the minister, is it not the view of the Department of Health that it should use the ability to cross-use various doctors in those regional hospitals, or hire them full time in the health system? Obviously, if a visiting medical practitioner is being paid on a fee-for-service basis - for which a premium is paid - far better service delivery could be obtained by having salaried doctors at those regional hospitals, especially the bigger ones, like Bunbury and Albany.

[12.20 pm]

Mr KUCERA: I will make a comment on that matter. A recent controversy in a country town was raised in the House. I will not name the doctor - it would not be fair, because he is a damned good doctor. As a visiting medical officer, this doctor earned $286 213 from a particular country hospital. In addition to that, he has a private practice, and I have no idea how much he earned in that, but I suspect it was a similar amount. It would cost the Government about $500 000 to pay that doctor a salary equivalent to the money he currently earns. It is difficult, in some situations, to put such a person on salary, because the amount he would earn on salary is nowhere near what he would earn in supplying that service to that town. The difficulty is that the town desperately needs a service. We had to come to an agreement that we would share the services of doctors between private practice and public hospitals. Some doctors' hospitals fees are lower than their private practice fees.

The acting commissioner will correct me if I am wrong, but that is my layman's view of what is happening. It is not simply a question of putting doctors on a salary. We would love to do that because the same doctor's salary would be somewhat lower. We can get doctors for less than $500 000 a year. For an answer to the technicalities of the member's question, I will defer to Professor Stokes.

Professor STOKES: The member asked about the sharing of services. Bunbury and Busselton emergency departments have an arrangement, which has not yet been completed, to share salaried or part-time doctors.

Visiting medical practitioners perform all duties in a hospital. If salaried and sessional doctors were to be used in areas where there was insufficient activity, we would be paying more for those than for the visiting doctor. Let us not forget that those doctors must return in the middle of the night to put drips in and all that sort of thing without the support of resident and registrar staff.

The member asked how VMPs are appointed in the metropolitan area. They are appointed in a similar way to those for rural hospitals. They are appointed by the hospitals and are accredited and have credentials. The hospitals have applied their budgets to the activity that is undertaken by the VMPs. I agree that in the metropolitan area we need to move over time to having salaried and sessional services. I think that everyone would agree with that. Certainly all of my colleagues agree that in the long term it is essential.

The member asked about the direction of doctors. Neither the minister nor the Commissioner for Health has the power under the current legislation to direct doctors out of one service and into another. We have had Crown Law opinion on that which has been given to the minister. It must also be remembered that emergency department doctors are specialist-type doctors. It is not really possible to send a physician to do emergency department work at Swan District Hospital where they must deal with a paediatric case, surgical case or whatever. A large number of general people are able to undertake emergency activities in the system. One might question the large numbers employed in the emergency department of Royal Perth Hospital, but they are working very hard. However, if we are able to do what we are intending to do - that is, to develop emergency department services in our secondary hospitals - that will certainly take the load off central hospitals and create the opportunity for staff to move out to other hospitals.

Mr KUCERA: This was one of the problems I grappled with in the Swan Health Service. My view as a layperson was that a doctor is a doctor is a doctor and that a doctor in an emergency department is the same as any general practitioner. In most country towns that is the case. A GP in a country town does everything from delivering babies to dragging people out of cars and treating them on the side of the road.

The reality in the big trauma hospitals is that a specialist group of emergency doctors has developed into the doctor's own college. It sets the benchmarks for the levels of emergency services that must be applied in emergency departments. This concern has been expressed by not only me but also people in other health services across Australia: considering what level of service should be applied is a little like Caesar judging Caesar. That is a national issue that the colleges of surgery and orthopaedics, emergency departments and many specialty colleges need to address. Neither this Government nor any other Government in this country sets the benchmarks for specialist services. The colleges do that. We are therefore captured a little by that fact when attempting to move doctors. The ability must be developed in the reform process in two ways. We need to look at the purpose of legislation. We also need to look at working, through cooperation with doctors, to ensure that the health system is properly serviced. Who am I to say what level of service emergency doctors should set? I am the person as minister who must pay for it, so it is a concern.

Professor STOKES: In order to decide whether the VMPs should be phased out and replaced by salaried or sessional doctors, an accurate business case needs to be made out for each service, region and hospital. Sometimes it is not cheaper to have full-time staff and sometimes it is.

Mr D'ORAZIO: No-one has a problem with benchmarking. I have a problem with the invincibility of doctors and the fact that no-one can challenge them, but that is another issue. The health system should be able to move doctors from Royal Perth Hospital to Armadale-Kelmscott Memorial Hospital or Osborne Park Hospital. Those hospitals are providing a metropolitan health service and need to be serviced. It is ridiculous that the minister and the commissioner are not able to direct suitably qualified doctors at Royal Perth Hospital to provide the same service at Swan District Hospital. Why is the minister not doing something about it?

Mr KUCERA: It would be a condition to be laid down in a contract. Individual doctors are contracted to individual hospitals. Doctors are not contracted to the developing area health authorities. Under the previous Government, a move was made towards establishing area health services. The simple answer to the question is to make it a condition of contracts, so that a doctor being contracted to the North Metropolitan Health Service could be moved into any hospital in that health service as the need arises. It was probably a dreadful analogy to use because of what has happened in the past couple of weeks, but some time ago I asked doctors what would

happen if a 747 came down at Guildford or the Swan District. I asked if we would say that there would be no doctors there to attend to people. The simple answer was, of course, no and that they would deal with it. The vast majority of doctors realise their role in society and will get on and do it. The simple answer to the problem is to put a condition into contractual arrangements.

Dr WOOLLARD: The last dot point on page 1238 states that drug abuse continues to be a significant problem in Western Australia and is a complex issue requiring multifaceted strategies. Page 1239 indicates that the Government will allocate $1 million each year for a naltrexone clinic. This relates to what we were discussing this morning. The Minister for Planning and Infrastructure on 19 September asked me whether I would support Duncraig House becoming a naltrexone clinic. I am not sure whether the Minister for Health and the Minister for Planning and Infrastructure are telling me to back off or Duncraig House will become a naltrexone clinic or if the Minister for Health is thinking of placing a naltrexone clinic next to a children's playground. The playground at Heathcote is visited by hundreds of children at weekends and during school holidays. Will there be a naltrexone clinic at Kings Park, next to Challenge Stadium, at Beatty Park or at Perry Lakes? I want to know where the minister is planning to put a naltrexone clinic. Will it be in the vicinity of a place where children are visiting and playing daily? As I have said before, I would like Duncraig House to be used as a library, healing centre or headquarters for the Heathcote Foundation.

[12.30 pm]

The CHAIRMAN: We are not discussing Duncraig House. Your question has been asked.

Dr WOOLLARD: But the minister this morning suggested that Duncraig House be used for a naltrexone clinic.

Mr KUCERA: I said that the issue was raised in the House as to whether it would be suitable for that kind of clinic. However, rather than debate the issue of what Duncraig House should be used for, I refer to the specific line item and ask Terry Murphy to explain the current situation with naltrexone treatments generally in this State. That may indicate where we are at with that matter and what the line item on naltrexone in the budget papers means.

Mr MURPHY: The line item in the budget papers refers to the Government's election commitment to provide $1 million to Dr George O'Neil's Australian Medical Procedures Research Foundation's naltrexone clinic, which is located and well established in Subiaco. There were a number of conditions on that funding: provided it was an election commitment, half of the funding was dependent on Dr O'Neil raising like funds, and providing financial and clinical accountability. As the state budget has just been handed down, those issues are currently being worked through to contract those services with the Australian Medical Procedures Research Foundation. The minister referred to naltrexone treatment generally. Naltrexone treatment can be provided by any general practitioner and no special registration and training are required. A number of general practitioners provide that service. The reality is that the general practitioners who choose to do so are those engaged in the network of general practitioners who are trained and supported by the clinical advisory services of the Government's Next Step Specialist Drug and Alcohol Services. Additionally, Next Step Specialist Drug and Alcohol Services also provides naltrexone treatment. It has a clinic, which forms a substantial proportion of its activity. It treated some 1 000 clients there last year and provides the drug free of charge.

Dr WOOLLARD: I ask a supplementary question. I asked the minister whether he believed naltrexone clinics should be located next to children's playgrounds.

Mr KUCERA: I do not see how that question relates to budget items. However, we were talking this morning about the use of a facility that is owned by the Department of Health. As I said, a matter was raised in the House recently by the Minister for Planning and Infrastructure about whether the member for that area would be averse to its being used as a naltrexone clinic. Obviously, if the premises remain with the Department of Health we will have to consider its usage. At this stage we have asked the Minister for Planning and Infrastructure to come up with a disposal strategy for the premises. They are not premises, as Alan Buckley said, that the health service would use in their current state. The decision on the method of disposal rests with the Minister for Planning and Infrastructure. When that process has been worked through, we will decide what to do with Duncraig House. It is as simple as that.

Mr BRADSHAW: I shall give a little background to my question. When I went to Harvey back in 1969 the local hospital had one hospital secretary - probably referred to now as a hospital administrator - and one office staff member. That was a 30-bed hospital in those days. It is now a 20-bed hospital or possibly 18. There is a part-time administrator, four office staff, a director of nursing who does mainly administration work and one nurse allocated to overseeing hospital standards. The Harvey health service has to contribute financially to an external human resources person, a financial administrator, an IT person and a fourth person whose function I cannot recall. Does the minister believe that if that bureaucratic burden were removed, more funds could be put

into providing actual health services? The hospital has a constant shortage of physiotherapists, speech therapists and those types of people. Is the minister also aware that the Harvey St John Ambulance officers have been told on occasions to bypass the Harvey Hospital because there are no beds available due to a lack of staff? Is the minister also aware that the Yarloop District Hospital emergency services close at eight o'clock each night because of a lack of nurses; and if so, will the minister do something about it?

Mr KUCERA: I am not sure to what line items that refers.

Mr BRADSHAW: It refers to purchase outputs.

Mr KUCERA: The member has highlighted an absolute need for reform in the health service, if what he said is correct. The member for Murdoch referred earlier to the issues of administration. One of the issues we must address is administration, but it also highlights to me the need for individual health services to work within their budgets and find the savings that are necessary in those budgets for the services they need and to come in on budget. It is as simple as that. This is all about service to the public. It is all about saying to health managers that they should manage the money we have given them in an output-based way to supply a level of service. They must decide whether to reduce their costs or reduce their services. The case the member has given me is a very good reason to look at a reduction in costs and I would expect the health manager in that area to look clearly at a reduction in costs, not a reduction in services.

Mr BRADSHAW: I come back to the matter of the ambulance bypass of the Harvey Hospital and the emergency department in the Yarloop District Hospital. Can the minister look at fixing up those two services so that they are not bypassed?

Mr KUCERA: I will refer that matter to John Kirwan.

Mr KIRWAN: The Yarloop situation is substantially due to the fact that the hospital cannot recruit nurses. Should they be able to recruit nurses, that issue would be addressed. However, I caution saying that both Yarloop and Harvey have emergency departments in the full sense of the word as they are referred to in metropolitan hospitals and larger regional hospitals. Diversion of ambulances will occur for a range of reasons, particularly because the area is served by full-time emergency departments in Bunbury and Peel. It is not unusual for ambulance crews to be directed - others might call it diverted - to those places, to teaching hospitals or to Armadale-Kelmscott Memorial Hospital because of the acuity of a patient's condition.

Mr BRADSHAW: No, it is to do with the lack of beds.

Mr KIRWAN: Those hospitals do not have emergency departments. They are effectively primary nursing posts. If it is about nursing beds -

Mr BRADSHAW: It is about beds, because I inquired.

Mr KIRWAN: The Harvey activity with respect to bed issues would relate to problems with beds for aged care in that area. As the member would be aware from previous estimates committee hearings, several attempts have been made to attract more nursing home beds to that area so that nursing home patients who are currently residing in our hospitals could be better placed in services outside the system. A range of issues must be dealt with there. However, the area is well serviced with the Bunbury and Peel emergency departments. The situation outlined by the member is not dissimilar to the closure of the emergency department in the Pinjarra hospital, which was not necessarily because of a shortage of nurses.

Mr KUCERA: I understand from having had so much contact recently with emergency department debates that the standard time for people to get to a major trauma centre is 30 minutes. I am not sure how far the Harvey and Yarloop areas are from Bunbury or Peel.

Mr BRADSHAW: About half an hour.

[12.40 pm]

Mr KUCERA: That is well within the range of the acceptable time to get people to a major trauma centre stipulated by the Australasian College for Emergency Medicine. However, the member raised an issue concerning nursing to which I had earlier alluded. We are intending to push forward with the idea of creating nurse practitioners, who will be ideally situated to provide triage and on-the-spot emergency assistance to help with the stabilisation of patients. I hope to follow a similar model to the one in New South Wales. A future answer to the type of difficulties currently being experienced is to establish these highly trained people within hospitals and to offer them proper remuneration for their qualifications.

Mr WATSON: I will seek advice from the Chairman. I provided the wrong figure when I referred to medical practitioners visiting Albany. The figure should have been $3.29 million, but I said it was $2.3 million.

Mr BOARD: You will have to miss your question now.

Mr WATSON: No, I am just being honest.

Mr AINSWORTH: It is a rare thing.

Mr WATSON: Thank you.

Mr KUCERA: The member for Roe should not believe everything he reads in the newspaper.

Mr WATSON: I refer the minister to dot point nine on page 1256 of the *Budget Statements,* which says that -

> The Oral Health Centre of Western Australia will be established in collaboration with the University of Western Australia. The availability of Government subsidised orthodontic services in rural regions will be further improved with additional investment in this area.

What will that investment be and how will it affect rural regions?

Mr KUCERA: The creation of the Oral Health Centre of Western Australia was an initiative of the previous Government. I applaud it as one of that Government's good initiatives. This Government is committed to completing that process. This specialist dental service and training centre will eventually replace the old, run-down Perth Dental Clinic. It is desperately needed. I visited the Perth Dental Clinic yesterday; it is time to move on from it. The new centre will provide specialist services to deal with metropolitan treatment issues and for the training of general dental technicians, clinicians and staff. In addition, it will provide specialist services for country people. Access to surgery will be provided at Princess Margaret Hospital for Children and Sir Charles Gairdner Hospital. That will provide support to rural people who must come to the city to access those services.

Mr WATSON: I will ask a supplementary question: will some of the dentists from the Perth Dental Clinic move to country areas?

Mr KUCERA: I discussed this issue with the staff at the Perth Dental Clinic yesterday. This is a long-winded way to answer the member's question, but I need to provide some background to my answer. Both the acting commissioner and I have held robust discussions with key stakeholders from the university, the current management of the dental services and staff. All the technicians except the 0.5 peridontists will be accommodated in the new centre. However, the Perth Dental Clinic also supplies a range of general dental services, similar to those provided by the person one visits on the corner to get a filling fixed. It is not intended that general dental services will be provided at the new centre. There will be a surplus of people who will want to transfer from the old service to the new, and they have been given four options. We will try to accommodate those people who wish to go to the new dental service. We are increasing the capacity of country and city dental surgeries to take on people who cannot be accommodated at the new centre. People will be given assistance to move to country or city positions if jobs are available. We will also provide packages to those people who do not want to remain in the system. I have offered an opportunity for people to take up country postings. We will assist them in doing that.

Mr WATSON: Can I put in an offer for them to go to Albany?

Mr KUCERA: Certainly; as long as we can find dentists who wish to go there.

Mr BOARD: I have a supplementary question on that issue. Great concern has been expressed about this change. The previous Government was committed to it, but three additional clinics were to run in conjunction with the new training facility at Sir Charles Gairdner Hospital. Those clinics are not yet ready. I understand that the Armadale clinic is close to completion, but I am not sure about the progress of the north metropolitan clinic. It appears that it will not be able to take up the additional dental services that are currently being provided. The concern is that the capital works program has not kept pace with some of the decisions made by the department and the University of Western Australia. I know that the training at the centre will be first-class, but can the minister guarantee that there will be no decrease in general services?

Mr KUCERA: Nothing in this world is certain. The Acting Commissioner of Health and I were disappointed when we learnt about the level of planning that had been put in place for the transition to these services. There is a culture in health that disturbs me; the view is that we can simply keep the old premises open. That is unacceptable. I know the previous Government intended to close the old premises. The new clinic in Armadale will come on stream at about the same time as the hospital, which is due to open in November this year. That will be opened before the old clinic is closed. We expect people from within the Perth Dental Clinic to start taking up positions in the new service and we will reduce the level of general surgery in the Perth Dental Clinic to accommodate that change. The Morley clinic is due to open in July. Alan Buckley has confirmed that. I

understand that the third clinic, to be located in Coolbellup, will not be available for some time. We intend that to be part of this process.

In the interim, I have held discussions with staff at the clinic. They require certainty. The member is right; there has been a great deal of uncertainty about this issue, which disappoints me. There are 15 chairs at the Como clinic and only one is being used for general surgery at the moment. The other 14 are used for training. There is no reason they cannot be brought on stream. I have asked the Acting Commissioner of Health to carry out an urgent review. A group from existing surgeries has been put together. They are public facilities, but there is no reason, in this day and age, for them to be open only between 9.00 am and 3.30 pm or 4.00 pm on weekdays. There is no reason that those facilities cannot open at the same time as private facilities, such as between 8.00 am and 8.00 pm on weekdays, and on Saturday mornings. They could then provide a proper service to the community. I am told that a greater service will be provided if that equation is used. It must be brought into play. We are now faced with a situation in which there are only three months for that to occur. Some fairly robust discussions were held yesterday. As minister, I cannot direct that those things occur, but I can certainly make a strong suggestion, which has been picked up by the Acting Commissioner of Health. A team of people will be in place by the middle of next week to ensure that those matters proceed. To ensure that Parliament is given an overview of that process, I have instructed that group to report directly to the Acting Commissioner of Health every two works until the process is in place. He will then report to me.

In that way, I will have a clear indication of our direction. The short answer is that I cannot at this stage guarantee that confusion will not result from this major change process. The Government has every intention of making sure that it not only retains but also improves the level of service so that it is more amenable to the people who require it.

[12.50 pm]

Mr BOARD: Is the third heading in the capital works budget - the community health facilities expansion - related to the Coolbellup service?

Mr KUCERA: I understand that it is not; nor has it been mentioned in any of the forward estimates. That is disappointing. This budget was framed before the issue arose.

Mr BUCKLEY: The forward estimates have capacity to cater for the clinic at Coolbellup. Also, $4 million of the new works program has been allocated for planning. There will not be a delay in the delivery of the project. We have a $4 million allocation to do whatever planning we need to get this on stream.

The CHAIRMAN: Was that project in the forward estimates for 2001-02?

Mr BUCKLEY: It was not specifically listed as a project in the forward estimates, but the 2001-02 new works program contains an allocation for planning.

Mr KUCERA: This is disappointing, as every indication from the previous Government was that the Perth Dental Hospital would close as soon as the new services opened. We had anticipated using the existing site, for either disposal - as was talked about for Duncraig House - or use by Royal Perth Hospital. A decision has not been made, but the process must be put in place. It is disappointing because it represents a double cost to the dental service that is not estimated within the system. This is part of the culture of health that the team with which we are working is attempting to change.

Mr D'ORAZIO: Has work started on the Morley clinic?

Mr KUCERA: The contract has been let. It is expected to be on stream in July next year.

Mr D'ORAZIO: What is the location?

Mr BUCKLEY: The high school site near Westfield Galleria.

Mr D'ORAZIO: That is Embleton.

Mr KUCERA: Yes.

Mr D'ORAZIO: It is next to the council buildings.

Mr KUCERA: I assure the member he will get a new facility.

Mr D'ORAZIO: Embleton is in the seat of Maylands, not Ballajura!

Mr KUCERA: No doubt the member for Maylands will be very pleased.

Mr BOARD: The issue of the third clinic has been raised with us and the minister many times. Is the allocation of $4 million for only its planning or will it also provide a new or reconstructed building and the delivery of services? How does that money equate to the cost of the delivery of that service?

Mr BUCKLEY: The $4 million is a general allocation for statewide planning for new works projects.

Mr BOARD: Is the money not specifically for this project, but for all planning?

Mr KUCERA: There should have been provision for this clinic in the forward estimates. The previous Government knew the major dental hospital was to close and that there would be a shortfall in services. This has concerned me ever since it was brought to my attention. I have capacity to vary the capital works program for health during the term of this Government. I assure the member that we are looking at it. It came to light yesterday, and we have also had discussions about this clinic over the past three or four weeks. The member is right: it is an issue that needs to be revisited. There will be a need for services in that area.

Mr BRADSHAW: The minister indicated that some dental staff would be surplus to requirements. If the department moved staff out, it would mean fewer people servicing the community and therefore a reduction in services. There is a huge waiting list for dental services. How will the department be able provide the same level of service?

Mr KIRWAN: There will not be a reduction in services. The reason for the difference in staff requirements is that we are bringing together the University of Western Australia dental school, a teaching provider, and the Perth Dental Hospital, a service provider, in one institution that will provide training for dental nurses, dental hygienists, dental technicians and assistants. They will all be brought together under one model, which has a significant amount of synergy. Under this model, dental surgery, particularly advanced surgery, will be done by masters and other postgraduate students. They are qualified dentists who are doing specialist training under the supervision of the university staff. It is a unique model. Fewer Department of Health staff will be required on site because of the different organisation of the surgery areas.

Mr KUCERA: This is a vexing question for some of the specialists within the service. This was raised with me yesterday by a periodontist who currently works for the department full time. Under the new model, her services will be required on only a part-time basis. She is understandably upset about that. As I said to the group yesterday, this should have been catered for. We cannot ensure that she is accommodated in the new system because we think it is a good model, but we will work towards making sure that she has the capacity to make some career choices. She has been in the department for many years, and I want to make sure she is valued before any major changes are made. We will make every effort to accommodate those people.

Mr BOARD: I move on to mental health. Over recent years we have all become aware of the increasing demand and need for a greater public mental health service. This budget refers to a number of aspects of mental health, including prevention and diagnostic treatment. I refer specifically to page 1255, but I could easily have referred to a number of other pages. I ask the minister to outline the plan for the greater delivery of mental health services in Western Australia. I am particularly interested in dot point six, which states that a contract has been entered with Mercy Hospital to provide in-patient services for older adults in the lower north metropolitan area. A new unit is to be constructed at that hospital. Is that a temporary measure or is the department considering purchasing more services from the private sector as a means of addressing some of the difficulties faced by the public sector? Could the minister answer that after he has outlined the general mental health program for the State?

Mr KUCERA: My understanding is that it has been completed.

Professor LIPTON: Focusing on that issue, I could take up the entire lunch break. The Mercy Hospital project is the outcome of our entire policy on psychiatric and mental health services for the aged. We have moved a long way from having long-term patients in psychiatric geriatric hospitals. They are now acute hospitals. Patients are diagnosed and receive initial treatment. Those who are long-term patients and need nursing home or community care have moved, or are moving, into such facilities. Each of the regions has an acute psychiatric unit but there was not one for the inner-city. Such patients were being admitted to the geriatric unit at Royal Perth Hospital, which was not entirely satisfactory. The Mercy Hospital has a very attractive geriatric unit, if anyone has seen it -

Mr KUCERA: Not yet!

Mr BOARD: I am aware of the first-class facilities.

Professor LIPTON: I have booked a room as well!

The CHAIRMAN: How much longer will you need to finish your answer?

Professor LIPTON: About one minute. In addition to its geriatric unit, the hospital will have a psychiatric unit. It is for short-term stays. There is a 10-year contract and the building cost is about $3.6 million. The contract is currently out for tender. We hope to be finished in about one year. It will be a real contribution to the inner-city area.

Mr BOARD: I am very interested to know what is the wider program.

Sitting suspended from 1.00 to 2.00 pm

Mr BOARD: Professor Lipton was answering an earlier question in connection with mental health issues as listed at page 1255. We were looking at why there has been some contracting to the private sector for in-patient services. Professor Lipton was going to indicate some of the new developments for the expansion of mental health in Western Australia.

Professor LIPTON: There have been a lot of developments in the field of mental health. A major capital works program was conducted over the past five years and it is still continuing. It has led to the presence of mental health services throughout the rural and metropolitan areas of the State. There are a number of government commitments in this budget. It would be worth discussing them, as they are quite important. They are in addition to the continuing reforms. I will touch on future capital works programs as well.

One commitment is for $1 million a year for four years for support, rehabilitation and accommodation. About a week ago, the minister approved a proposal the department has called Community Options 100. Its main purpose is to move patients who have been long-term patients in hospitals - who should not have been - back into the community with proper support. There needs to be respite care and home help. A committee of major stakeholders has been established to manage that program. It will continue over the next four years. It will do a great deal for the proper care of patients and will improve the economics and waiting lists of hospitals.

Many government commitments involve community self-help and non-government organisations. They include counselling and self-help for the families and carers of mentally ill people. An allocation of $650 000 a year for the next four years has been made to develop those programs.

Children and youth figure very strongly in the programs. We have doubled the funds for child and adolescent services over the past five years. Another $800 000 a year will be spent over the next four years. We are working out how to best spend the funds. A proposal to provide a very intense outreach treatment service is before the minister. It involves treating children in their homes and schools or wherever they happen to be. It will target the most severely disturbed children in the community - the ones that go to every agency but still do not get looked after. It will be a cross-agency program. It will involve the Departments of Health, Justice and Education. The program cannot be announced yet, as the submission is yet to be taken to Cabinet by the minister. It is a very exciting program.

Mr KUCERA: It arises out of a program that has been very successful in another part of the world. I cannot remember the name of the professor in charge.

Mr BOARD: He is unforgettable!

Professor LIPTON: It is an American project. The program is probably the most well-studied program in the world; it has been going for 20 years. It takes children from the bottom of the barrel and gets them back to school or work and to lead reasonable lives. In terms of social services over time, the program saves about $64 000 for each child. The department thinks the project is well worth doing. Approximately $100 000 a year is available for school-based programs. We are having discussions with the Department of Education and Curtin University of Technology. We will probably base the program on a well-tested program called Aussie Optimism, which has been developed by Curtin University. We will try to spread it through the schools.

Mr BOARD: We have learnt over the years that money spent at the beginning of the process is far less than all the money required at the end of the process. Is prevention a significant part of the department's policy?

Professor LIPTON: Yes. We have been running the positive parenting program. When parents of ill children who are three or four years old are put through a counselling program, up to 50 per cent of the children continue to be well. We have followed people for up to three years after they have completed a program. The children return to school as well children, not troublesome children. It has a huge effect on the future.

A lot of money is put into postnatal depression counselling services. The Government will provide $850 000 a year for four years. The department is currently spending about $360 000 a year. All the department's services deal with these things. Postnatal depression programs do not just treat mothers; they help establish proper bonded relations with their children. That is a very important and positive development. The positive parenting program will be run throughout the State this year. It has previously been run in selected areas on a trial basis.

A recently approved policy has been developed by three divisions of the department: ourselves, Aboriginal health and public health. It concerns health promotion and prevention. Developing the program will depend on commonwealth funds, which come as part of the national mental health policy. The program will establish a network between all health areas and put people in place to develop the extra capacity for a variety of projects that will pick up the sorts of things I have been talking about. The first thing we need to do is establish the framework.

Mr KUCERA: Is it a matched funding project?

Professor LIPTON: We get funds from the Commonwealth as part of the national mental health program. This year we will have funding for health promotion, quality assurance and partnerships. The funds have not come through yet.

With the rise of consumerism and advocacy by consumers and carers, the Government has provided $105 000 a year for four years to develop the concept of consumer advocacy. It will employ consumers or users of health services. We are currently working on a recommendation to the minister that we employ consumers of health services at the upper echelons to help with area management and guide policy development. I suspect that that will be very effective. For some three or four years we have supported training programs for consumers and carers to enable them to be effective in committees and to understand how their work can be effective. Some sophisticated consumers contribute a lot. We tend to use consumers on all our committees that are established in this State. This provision is an addition to that sort of activity. They are the main new initiatives, and other programs will continue.

[2.10 pm]

Mr BOARD: Are advances being made in capital works? Are the commitments from both sides of politics to this immediate area being met? Are you satisfied that we are well placed to deal with increasing demands?

Mr KUCERA: I refer that question to Professor Lipton.

Professor LIPTON: I will answer that question in a roundabout way. Five years ago, when I first came here, we treated 15 500 people. We now treat roughly 22 500, which is a 40 per cent increase. The demand on our services is greater now than it was then. That is to do with the fact that some 30 per cent or 40 per cent of people with mental health disorders do not access services. When those services are provided to areas that previously had no services, people access the services. By increasing services, instead of meeting the demand, it creates more demand. Although the demand is high, it is not due to the absence of a major increase in services.

Mr BOARD: I know that services are being increased and that demand is high.

Professor LIPTON: The demand is high, and we must continue to expand and develop services. We provide fewer beds for the elderly -

Mr BOARD: There has been some concern that some people have not been able to find appropriate beds when it is required. Is that situation under control?

Professor LIPTON: It is under control in the sense that we have not gone over the bed count since February, which is when the minister told us not to go over the bed count. We have set up a system to manage that. We have more beds now than when I arrived. Although people have the impression that we have reduced the number of beds, we have not. We have probably 30 or 40 more beds in the adult area; however, demand continues to be very high. We are always skating at the edge of our bed capacity and there will be occasions when the system is gummed up and we have to do the best we can.

It is important to provide more community services and for the quality of those services to improve. We must provide the capacity to deal with the sick people in the community. To be admitted now, one would need to have a fairly high acuity of illness. In another five years, if I were to sit before this committee, it would still be a problem but we must work on that issue and try to resolve it.

Mr AINSWORTH: I refer to dot point four on page 1257 of the *Budget Statements* and the expansion of the community mental health assessment and treatment services for young people across the coastal and wheatbelt regions, which I applaud. Will the minister indicate how much funding has been allocated and which locations will receive that funding? I do not know whether it is still in existence but what is happening with the Ministerial Advisory Council on Mental Health?

Mr KUCERA: I will defer both of those questions to the professor.

Professor LIPTON: The operation of mental health has created regions. The four health areas are combined into one mental health region. We provide a one-stop-shop; therefore, by agreement with the other regions, we relate to the lead general manager. The centre for mental health is based in Northam, although services are provided all around the region. It is a fairly new service, which has operated for the past year or two. It had teething problems but it is now going very well and we promised to provide additional funds of $220 000 for child and adolescent mental health once things had settled down. No doubt it will require more funds in the future. The service is essentially based in Northam, but that does not mean people sit in Northam; they are spread all around the region.

Mr AINSWORTH: What has happened to the ministerial advisory council?

Professor LIPTON: That was set up by previous ministers in accordance with the ministerial task force recommendations. I note that Mr Day is here. The task force advised him for a while. The Health Administrative Review Committee recommended that the ministerial advisory council be re-established, which is within the minister's prerogative.

Mr KUCERA: I confirm that there is a recommendation that the advisory council be re-established because it is a useful tool for the minister, and we will head into that as we change the processes.

The CHAIRMAN: I will exercise some prerogative as the chairman and ask a question. I refer to page 1255 of the *Budget Statements*. I am thrilled with the work that has been done in this area, including the interagency support and work with schools and community centres. The programs referred to are overdue. I ask not only for my own region but also for others: will the program that is being referred to include services to be rolled out to Joondalup and to the outer regions including Clarkson? I understand that it is intended to cater for the needs of young people in the outer metropolitan areas as well as the country regions.

Mr KUCERA: The Government intends to provide those services to the outer metropolitan area. All services will be rolled out. I will defer to Professor Lipton.

Professor LIPTON: It is apropos because, although the minister did not say so, he has just set up a review of the north metropolitan region that is based on the need to move the Selby Child and Adolescent Clinic, which is south of there, and take the opportunity to network that region, including Clarkson and Warwick clinics with other services including the children's hospital and the resources of the Selby clinic. The review will be a guide for the Government to set up services with a variety of bases that have outreach. The policy referred to by the Chairman, and I appreciate the compliment, was set up by meetings throughout the State with all the relevant stakeholders. We consulted with about 4 600 people, and it is their thoughts that evolved into the policy that exists, which I think is a good process.

Mr KUCERA: When I first took over as the minister, there was a deal of controversy about the Selby clinic. Members would be aware that the clinic must move from its premises. A great deal of discussion occurred about where it should be put. Part of the review process will consider how that issue should be dealt with. There was a lot of talk about shifting it to one place; however, the reality is that there are needs throughout the western suburbs and, as the Chairman recognises, to some of the far flung areas in the northern suburbs -

The CHAIRMAN: It is not that far flung, minister!

Mr KUCERA: It is a long way from my place. The outer limits of the city are at Wanneroo. There is a need for that type of service out that way, particularly for the younger families. It is not just a matter of having it in only one place, we must consider how the services are delivered.

Mr AINSWORTH: I refer to the decisions made prior to the state election on page 1239 of the *Budget Statements*. The budget provides an additional $6 million for the delivery of specialist services in the country. Is this new funding, or has it been sourced from other areas of health and, if so, from where? Will any regional hospitals lose specialist services to help fund this initiative in other areas? Will the minister give details of which health services or hospitals will benefit from funding? If there are any reductions in any other regional hospital specialist services, which might they be?

Mr KUCERA: An additional $6 million over four years will be provided for the delivery of specialist services in the country. I will defer that question to John Kirwan.

[2.20 pm]

Mr KIRWAN: The $6 million over four years has been allocated to the Great Southern, South West, Midlands, Mid West, Gascoyne, Kimberley and Pilbara Health Services, to allow those areas to attract medical specialist services they currently do not receive. It should be seen in the context of a couple of other initiatives. One is the telehealth program, which the acting commissioner can speak of. At the same time a review is taking place of

specialist services available in the country, with the aim of making sure that some areas are not underserviced, and others overserviced, although in remote areas that is rarely the situation. We are also focusing on those people who use the patient assisted travel scheme to come to the metropolitan area, when we can attract specialist services to the country to avoid that dislocation. Interestingly enough - not that we are not normally complimentary to the federal Government - the federal Government has allocated $562 million over four years for Australia-wide rural health areas, including retaining and extending medical specialist services. Of this about $6 million is allocated to Western Australia this year. This will be complementary to the work that is already being done. In answer to the member's question, all the services are new, and money is not being taken from elsewhere. They are all additional and recurrent, unlike some of our funding, which is non-recurrent, and will be maintained once the program is established.

Mr KUCERA: I met yesterday evening with a group of orthopaedic surgeons, who have recently taken advantage of this program to travel through the north. The estimated saving in that program is $64 000 to the health service. Otherwise the cost would have been borne by the health service to send people to Perth through the patient assisted travel scheme. Contrary to some reports in the newspaper that the changes to PATS are likely to deny service to the community, the exact opposite is the case. This is specifically designed to get specialists to visit country areas, rather than patients travelling to Perth. The other issue is that there is a degree of centralisation under the wait list period. Instead of all the doctors in the various country towns saying they need to send patients to different places, they can now be brought together. In the instance I described yesterday, it was far more sensible, and saved costs, to send the specialists to the people, rather than to bring the people to the specialist. It will save money in the long term

Mr D'ORAZIO: Did Mr Kirwan say that the federal Government has allocated $526 million, of which Western Australia is getting $6 million?

Mr KIRWAN: Western Australia is getting $6 million this year.

Mr D'ORAZIO: When that is multiplied by four, that makes $24 million. I suggest that $24 million out of $526 million is not a very attractive number.

Mr KUCERA: I agree with the member. It seems to be the case that Western Australia is still the cinderella State.

Mr D'ORAZIO: When it is considered that remote communities are far more relevant in Western Australia than they are in the eastern seaboard, someone should highlight this problem, if they have not already.

Mr KIRWAN: I will clarify the issue for the member. The specialist program on the commonwealth funding is a subset of the larger amount, so other money should flow to Western Australia. Broadly, we would normally expect to attract about 10 per cent of federal funding in those areas, on a crude, per capita basis. That normally applies in most commonwealth funding programs, except in some areas in which Western Australia actually attracts more; for example, in Aboriginal health and other initiatives for which Western Australia's needs are greater.

Mr KUCERA: This highlights an issue we have when negotiating any agreement with the federal Government - the tyranny of distance. That needs to be argued in the new agreements when they are brought up.

Mr D'ORAZIO: Ten per cent of $526 million is not $24 million. That figure is less than five per cent. In this case we are talking about remote communities, and this is far more specific to Western Australia than to any other State. This issue should be highlighted, so that Western Australia gets its fair share.

The CHAIRMAN: That was a comment, rather than a question.

Mr D'ORAZIO: My apologies to the Chair.

Mr QUIGLEY: I have a question on mental health, which the minister may wish to invite his adviser, Professor Lipton to answer. The question has to do with the overall purchase of the outputs of mental health. Given the amount of public awareness generated by the federal Government's Beyond Blue program dealing with community awareness of depression, and given that the treatment of depression will be an enormous public health problem within 25 years, is the number of people suffering the various forms of depression increasing? Is the Department of Health developing a public health strategy for the treatment of depression? I have seen trialled, by Dr Tannenbaum, a psychiatrist, an online program on the Internet for the use of remote area general practitioners for specialist support in the treatment of depression, and from which patients can monitor their own condition. Does this area of Internet support for the treatment of depression by general practitioners and patients have any merit in lowering the costs of this burden on the public health system?

Mr KUCERA: I will make some quick comments, before deferring to Professor Lipton. With regard to the Beyond Blue program, I met with the former Victorian Premier, Mr Jeff Kennett, and we had discussions about the involvement of Western Australia in that program. I raised some queries with him, which have not been answered, about the set-up of the company structure around that program. The Government is aware of Beyond Blue and it is negotiating possible involvement in that program. The third point the member for Innaloo raised was the Internet. I am aware of the program run by Dr Tannenbaum, and he has shown it to me. I cannot comment on its efficacy, other than knowing that I have worked out how to use his computer. I will now defer to Professor Lipton.

Professor LIPTON: Everything the member for Innaloo said is correct. Depression is now one of the major health issues, and studies show that by 2020 it will be the greatest cause of years lost through disability in the entire world, not just in Australia. It is a major public health and clinical problem. Hopefully, a lot of the health promotions work will assist to reduce the numbers, but at the moment, they are going in the wrong direction. I will discuss the Beyond Blue program, because I met Professor Hickey a week ago in Canberra, and we talked about the way Beyond Blue was working. Most States have signed up to it, except Western Australia and New South Wales. Our concern, because it is very much an east coast phenomenon, is how much Western Australia will get for the money it might put in. I will advise the minister shortly about that. I had some pleasant discussions, and useful things may come out of them. Apart from formal psychiatric services that treat depression, the most important strategy is to work with primary health providers - general practitioners. Western Australia is regarded as leading the country in coordinating mental health service with general practitioners. I established and chaired a task force between General Practice Divisions of Western Australia Ltd and mental health services. The Commonwealth is part of that task force, and we will probably be joined by the Department of Veterans Affairs. The Commonwealth has indicated that it might provide funding of $200 000. The outcome of this exercise is that every division of general practice is either negotiating, or has completed negotiations with the mental health services in its own area on protocols about how they will relate to each other. There is a lot of activity in the general health field dealing with education and the management of depression. The Perth division has been particularly active at a national level, producing booklets that are used nationally by general practitioners. That is important. The Commonwealth Government is about to effect changes to Medicare items to give general practitioners who are skilled in psychiatric and mental health matters some item numbers, which will enable them to work properly. The work cannot be done in six-minute consultations. The item numbers will enable them to make proper assessments for treatment and give them the opportunity to consult with family members, psychiatrists and so on. That is a fairly important move by the Commonwealth Government, and we support it.

On the issue of technology, I know of Dr Tannenbaum's system. He has demonstrated it to me and I have had my experts look at it. Superficially it is attractive. I do not say that to be negative. We have not gone into it in enough depth. We have a bit of a problem because we have organised an effective approximately 40-unit telepsychiatric system throughout this State. Clinicians are now consulting with people in rural and remote areas through telepsychiatry, interviewing patients and so on. It means better care because people do not have to travel to Perth. The number of people from rural areas who have been hospitalised has decreased considerably through telepsychiatry and the rooming-in centres. It is not cheap and neither is Dr Tannenbaum's system. We must think hard about what to do. That is currently being considered and it will be a while before we sort it out.

My view is that our telepsychiatry network is as good as any in the country; in fact, our rural and remote services probably lead the country. Telepsychiatry is now old hat but it is important that it work effectively. The next step must be the Internet, with general practitioners and patients having access to their own data and doing their own questionnaires.

[2.30 pm]

Mr QUIGLEY: That is what I understood Dr Tannenbaum's system to do.

Professor LIPTON: That is right but we would have to buy it en masse. We are not quite sure that it would meet our needs or fit in with our other systems. It is a good idea. I am quite positive about it but there are other issues to be considered.

Mr QUIGLEY: Has the Mental Health Division trialed the system at all?

Professor LIPTON: No, we have not. I have sent various expert staff to look at it. Dr Tannenbaum has slowed it down a little because he is not ready to roll it out for development. We will keep an eye on it. The use of the Internet for linking patients and doctors is the next step.

Mr QUIGLEY: Would that not be of benefit to the regions?

Professor LIPTON: It would be of particular benefit to the regions. That is the reason it is interesting.

Mr KUCERA: I am heartened to hear a senior clinician say that he wishes to test technology before he buys it!

The CHAIRMAN (Ms Guise): I have five questioners listed, which is practically each one of you, who could be added to by the member for Roe if he wishes to do so. I am aware of the time. Members might like to consider the possibility of each member asking a question in the time left.

Mr D'ORAZIO: Page 1266 refers to consumable supplies. The announcement was made that free needles and syringes would be supplied for insulin-dependent diabetics. It is a great scheme and is supposed to start on 1 October. Will it start on that date?

Mr KUCERA: Yes.

Mr D'ORAZIO: How will it operate? A couple of schemes already operate for the provision of insulin services. Will some of the private practitioners in the marketplace be able to tap into this supply of needles and syringes free of cost? Does the minister expect to expand the program in the near future?

Mr KUCERA: The provision of free needles and syringes for insulin-dependent diabetics was probably one of the most vexing questions from day one. I have been bombarded with letters pointing out that we provide them for drug users, why not diabetics? I requested the department, when it was framing the budget, to answer the question. I am not aware of the mechanics of the scheme.

Mr KIRWAN: The national diabetes needles scheme is commonwealth funded and is run in this State by Diabetes Australia-WA. Diabetes Australia runs it nationally. It provides needles to the approximately 11 000 insulin-dependent users in the State. We have contracted Diabetes Australia's state branch because it supplies the subsidised syringes to insulin-dependent diabetics. We will top up its funding, so there will be no extra paperwork or assistance. We will use the existing, in-place commonwealth scheme. Diabetics will get their needles through Diabetes Australia. We will pay Diabetes Australia, so it is cost effective and as efficient as possible.

Mr D'ORAZIO: Diabetes Australia already targets a few private outlets, as I know from my previous employment. Specific people being able to dispense these needles has always caused problems. Apart from the question of supplying the syringes at no cost, has the minister thought of making them available to all pharmacists in Perth who supply the insulin products? Diabetics must get insulin from one place and needles from somewhere else because they are free. Why not make the needles available to all retail pharmacists in Perth rather than being selective, which is causing problems for the patients and the retailers, because there appears to be a closed market for the select few.

Mr KIRWAN: The scheme to be introduced is similar to those in other States. We are the last State to do this for various reasons, including the view that it is a federal issue and not a state issue. We chose to do it for all the reasons the minister has outlined. The difficulty is that we are not providing them free but covering the additional cost of their provision by the Commonwealth. This is to ensure that the Commonwealth Government is not out of pocket. From memory, the co-payment is about $9. The option that the member is presenting of opening the provision to other pharmacies would create a difficulty for us because they would not be getting the commonwealth payment. We are trying to keep the scheme as cost effective as possible. As the member mentioned, money goes to other diabetes programs as well.

Mr KUCERA: The program is part of the overall diabetes program. It was essential that we went down this track because of the blossoming problems we had with diabetes. I am surprised that the decision was never made before.

Mr D'ORAZIO: I congratulate the minister on the decision, because diabetics are absolutely discriminated against. Injecting is not something they want to do but something they must do.

Dr WOOLLARD: On page 1261, the fourth dot point of the general health initiatives reads -

> The Department of Health will purchase activity for stroke through a special program in 2001-02.

I am obviously interested in this initiative for those south of the river. I was delighted to hear the minister say earlier that he would consider Duncraig House being used for a dental clinic.

Mr KUCERA: I am afraid that was a slip of the tongue.

Dr WOOLLARD: I hope the minister will refer that to the Minister for Planning and Infrastructure.

A report presented to the House from the Auditor General several weeks ago indicated that the level of facilities for patients south of the river who have had strokes was lower than that for patients north of the river. It applied particularly to patients of Sir Charles Gairdner Hospital and Royal Perth Hospital who are able to go to the Shenton Park Campus. I am interested in what will happen to improve services and facilities south of the river.

Mr KUCERA: Is the member referring to page 1261, the fourth dot point under "General health"?

Dr WOOLLARD: Yes.

Mr KUCERA: I shall refer that question to the Acting Commissioner of Health.

[2.40 pm]

Professor STOKES: It is important to appreciate that the stroke strategy, released some months ago, made a large number of recommendations that indicated we needed to make significant changes to the delivery of both acute stroke care and rehabilitative stroke care. Prior to that there was discussion on the development of a rehabilitative program, of which one issue was the management and rehabilitation of acute stroke patients. South of the river issues were pertinent because the main concern was the initial establishment of an acute stroke unit at Fremantle Hospital. That is one place at which neurologists will consider establishing a stroke program. The long-term rehabilitative aspects south of the river are still under discussion at this point.

Dr WOOLLARD: I thank the minister. I am pleased that south of the river will be considered in this important area.

Mr KUCERA: I referred earlier to a clinic in East Fremantle that also does a great deal to rehabilitate stroke victims. A lot of the processes being put in place there are aimed at that; and that is allied with what Professor Stokes spoke about.

Professor STOKES: That is allied with rehabilitation.

Mr WATSON: Have funds been allocated to address the increase in the number of youth suicides; and, if so, where are the services to be located?

Professor LIPTON: The issue of youth suicides is fraught. At the same time, although we have not done well, we have not done badly compared with the rest of the country. Our youth suicide program, thanks to the Youth Suicide Advisory Committee, is highly respected. The statistics on youth suicide have flattened out and are not currently rising. However, suicide is rising in young adults in the 20 to 35 age group. It is a distressing and interesting phenomenon and one asks oneself why that change is occurring. We would like to think it is because of the efforts that we have put in, but it is clearly much more than that. There has been a lot of activity in this area and it is hard to identify the funding. The direct funding is about $1 million. The department has conducted a few programs directly and we give money to the Youth Suicide Advisory Committee. Beyond that, of course, the issue of suicide prevention is an all-of-society issue, not just a health issue, and a lot of work has been done on that. The Aboriginal policy adopted by the Government about two years ago demanded that every department accept that it had certain tasks to do to assist the Aboriginal population, and many of those tasks have been done. The prime activity of our service is to treat people with depression and psychosis in the hope that it will limit suicide. We are negotiating with the Department of Justice on the prison population, which has a real problem with suicide. We hope this will lead next year to a major development in the forensic psychiatry service to help offenders with their problems. A deal of education has taken place, is taking place and will continue to take place. Every major hospital in the metropolitan area has a social worker in its emergency department funded by us who follows up any self-harm incidents. The only thing we know about the prevention of suicide is that a person who has attempted suicide is at high risk of another attempt and therefore at high risk of succeeding - if that is the right word - in dying.

A lot of effort has been put into the prevention of suicide. A major program was developed, called the gatekeeper program, which has a teacher or a number of staff in every school in this State who are trained through YSAC to deal with kids threatening suicide or with the rest of the school if a tragedy has occurred. There was an example in Wanneroo about three years ago when a school managed a very difficult and tragic situation when young people jumped off a bridge. The integration of the school gatekeeper with the local mental health service, the police and so on was absolutely brilliant. There would have been many more tragedies if that had not happened. There are many more matters I could talk about but I do not believe I could say any more that would be helpful.

I can say that a lot of funds are going directly into suicide prevention. However, much more activity is going into working with the infrastructure in other departments to try to set an all-of-government community approach that we hope will limit suicide.

Another aspect I should mention is that the committee should not forget the role of drugs and alcohol in suicide. Rarely does a young person die through self-harm who was not either intoxicated with alcohol - that is the usual one - or a mixture of drugs. The role of intoxicants, drugs and so on is enormously important in suicide prevention. There is an enormous amount of activity, some of which is funded and of which I could give the details, which is mostly just part of the work of various departments.

Mr KUCERA: Before we move off that subject, I have a good news story. The Youth Suicide Advisory Committee approached me this week essentially to wind down its role but to expand its role as a suicide advisory committee. As Professor Lipton said, it needs to move up a level. In addition, the Premier's social policy unit has been established under the Department of the Premier and Cabinet. This is a perfect opportunity now to bring together a whole-of-government approach to the issue of suicide. I have asked the department to develop a proposal by the end of next month to lift the level of the advisory committee to a ministerial council reporting to the social policy unit, which will bring into play all the issues of education, homelessness and the other key portfolios of ministers involved in that social policy unit.

Mr WATSON: I ask a supplementary question. Will these clinics be located in the city or the country?

Professor LIPTON: There are no clinics set up to prevent suicide. I may not have made myself clear. There are many services provided that include doing things appropriate to preventing suicide.

Mr WATSON: Where are they located?

Professor LIPTON: I will give the member a list of all the mental and public health clinics and general practitioners. What I am saying is that it is everybody's business. We have some educational programs, such as the youth self-harm program. The Perth GP division has a suicide prevention program, which is essentially educational.

Mr WATSON: There is also a mobile bus.

The CHAIRMAN: The member might like to talk to the minister and gain that information from him at another time.

Mr KUCERA: I am happy to supply supplementary information on that.

The CHAIRMAN: I ask the minister to clarify the information that he is prepared to supply?

Mr KUCERA: Some members want details of the location in the State of the mental health facilities dealing with youth suicide issues.

Professor LIPTON: They all deal with those issues, but we can give the member a list of them.

Mr KUCERA: The supplementary information will include a list of all those clinics. This matter relates to the general issues of mental health referred to on page 1261.

Professor LIPTON: There is one issue that would be good to mention and that is the youth counsellors, mainly in the rural areas, whose task is counselling in the hope that it will also lead to prevention. Counsellors have been established in Port Hedland, the mid west, Kalgoorlie, Perth, Mandurah and Esperance. That was half of the funds. The other half has been dedicated to providing Aboriginal youth counsellors. That will be set up this year in Derby, Moora, Carnarvon, Geraldton, Broome, Wyndham, Albany and Port Hedland. That is one among many. I cannot be precise, because this must be considered as a matter of joined-up government.

[2.50 pm]

Mr DAY: I refer to the section on community health services on page 1242 of the *Budget Statements*. I hope that the minister has become aware of the work carried out by community health services in the time that he has been a minister. My particular concern relates to services for young children who require speech pathology, occupational therapy or physiotherapist services as a preventative measure. I hope the minister has become aware of some of the needs in that area. Over the past couple of years, I became aware of unacceptable and excessive waiting times of up to a year for specific services. After a lot of difficult discussion, an additional $1 million was allocated on a recurrent basis to reduce waiting times within the metropolitan area for specific community health services. An additional $795 000 was allocated on a one-off basis to the special waiting list fund. Is the recurrent allocation of $1 million still in place to reduce the waiting times for those services? Has the $795 000 allocation been spent? If not, will the remainder still be available for expenditure in that area?

Mr KUCERA: I congratulate the previous minister on that initiative. As I said this morning to the member for Kingsley, there is no doubt that it was an excellent initiative and that it was needed. That question may have been answered this morning.

Mr DAY: If it was answered this morning, I am happy for it to be provided by way of supplementary information.

Mr KUCERA: I will ask John Kirwan to clarify whether the question was answered this morning.

Mr KIRWAN: The member has asked a slightly different question to the one asked this morning. The allocation of recurrent funding has been maintained this year. The additional money was spent and spent well. Some of the waiting list times were reduced from 18 months to weeks. It will be rolled again this year under the direction of the current minister. This issue will be supported.

Mr DAY: Is it expected that the $1 million allocation will continue on a recurrent basis past this year?

Mr KUCERA: Yes. Mention was also made this morning of a new community health centre in Clarkson, which I understand will take up some of the slack. The other point I made this morning was that there is a desperate need for staff in those specialist areas. My recent dealings with the Hospital Salaried Officers Association highlighted the general shortage of allied health professionals. As was pointed out this morning to the member for Kingsley, and as the previous minister has picked up on, it is not only a question of money but also of being able to get staff for those places. Does the member require any supplementary information?

Mr DAY: No, that is fine.

Mr BOARD: In view of the time, this will be my last question. I will take the committee back to where it started this morning. It is amazing how few questions can be asked in a six-hour period. I refer to page 1237 of the *Budget Statements* and to the major appropriations and forward estimates in the budget. The health budget will increase by three per cent this year, one per cent next year and two per cent in the following year. If adjustments are made for the consumer price index, real cuts will occur in the outlying years. Funding for health has gone from 25 per cent of the state budget to 23.9 per cent on a recurrent basis and 22.9 per cent of the total state budget. In overall percentages, the share for health is declining. This budget was brought down three months into a financial year. I have not been able to get an accurate picture of the cost of tertiary hospitals, but I understand that $120 million has already been overspent. I ask the minister to supply, by way of supplementary information, the cost analysis of the tertiary hospitals for July, August and September. Demand is still running high and the minister has not made the structural changes that are required to meet those demands. Can the minister assure us that massive problems, such as the closure of wards and beds, will not occur in the tertiary hospitals next year to meet an ever-increasing demand? Resources have not been placed and no plan has been implemented to meet that delivery in another way.

Mr KUCERA: As I said at the outset of the committee today, an extra $385 million has been put aside for health over the next four years. When I consider the amount of money that has come from other agencies to support health, policing and education in this budget, I am surprised when people say that the budget for health has not increased. There is an increase in the budget this year. I will defer to Alex Kirkwood in a moment. We have gone to a great deal of time and trouble to explain today the process of allocation and accrual for this year. I am not sure what the member for Murdoch exactly requires by way of supplementary information.

Mr BOARD: I am sure that the Department of Health is monitoring the individual monthly cost of running tertiary hospitals. I would like those costs to be provided to me, so that I can compare them with the amount that has been budgeted for those hospitals.

Mr KUCERA: The simple costs are the input in the budget. This is an output-based budget. I will defer to Alex Kirkwood. I will ask him to explain the issues relating to the construction of the budget. Which hospitals does the member require figures for by way of supplementary information?

Mr BOARD: All the tertiary hospitals.

Mr KUCERA: I do not believe that there will be any difficulty in providing that information, so long as we can get a clear indication of what is being asked.

Mr BOARD: I would like details of the expenditure of those tertiary hospitals on a monthly basis, compared with the budget allocations.

The CHAIRMAN: Minister, what we have noted is that the member has asked for a cost analysis of tertiary hospitals in July, August and September 2001, including the expenditure during that period and the monthly cost of running tertiary hospitals in relation to the budget allocation.

Mr KUCERA: I need to take advice on whether that constitutes a proper information flow from the estimates committee. I am happy to make the accounts available through the normal process. I am not sure whether that can be provided through the estimates committee process.

The CHAIRMAN: Minister, please take a moment to confer with your advisers so that you are clear about what you can supply.

Mr D'ORAZIO: The member for Murdoch has requested something that occurs outside the estimates process. It is not part of this process. The member is asking for actual spending, which occurs after the adoption of the estimates. That is not part of this process. I am happy for the minister to supply that information as part of a different process. This process is about estimates and the budget. The member has asked the minister to give him the actual expenditure that occurred out of this budget, but the budget has not yet been adopted.

Mr BOARD: Further to the point of order, this budget was brought down nearly three months into the new financial year. The minister and the department would be aware of the expenditure made by those hospitals at the time the budget was brought down.

The CHAIRMAN: I am sorry, member, but it is time, and the rules must apply. There is no point of order because time has run out. I suggest that the only option now open to the member is to put the question on notice.

Committee adjourned at 3.00 pm