STANDING COMMITTEE ON
ESTIMATES AND FINANCIAL OPERATIONS

2012–13 BUDGET ESTIMATES HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 7 JUNE 2012

SESSION THREE
DEPARTMENT OF HEALTH

Members

Hon Giz Watson (Chair)
Hon Philip Gardiner (Deputy Chair)
Hon Liz Behjat
Hon Ken Travers
Hon Ljiljanna Ravlich

Hearing commenced at 3.30 pm

HON HELEN MORTON
Minister for Mental Health representing the Minister for Health, examined:

MR KIM SNOWBALL
Director General, sworn and examined:

MR WAYNE SALVAGE
Acting Executive Director, Resource Strategy, sworn and examined:

DR ROWAN DAVIDSON
Chief Psychiatrist, sworn and examined:

MS NICOLE FEELY
Chief Executive, South Metropolitan Area Health Service, sworn and examined:

DR DAVID RUSSELL-WEISZ
Chief Executive, North Metropolitan Area Health Service, sworn and examined:

MR PHILIP AYLWARD
Chief Executive, Child and Adolescent Health Service, sworn and examined:

MR IAN SMITH
Chief Executive, WA Country Health Service, sworn and examined:

DR ELIZABETH MOORE
Executive Director, Mental Health, South Metropolitan Area Health Service, sworn and examined:

The CHAIR: On behalf of the Standing Committee on Estimates and Financial Operations, I welcome you to the hearing this afternoon. You will have all signed a document titled "Information for Witnesses". Have you read and understood this document?

The Witnesses: Yes.

The CHAIR: The hearing is being held in public, although there is discretion available to the committee to hear evidence in private either through its own motion or at a witness's request. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session before answering the question. Government agencies and departments have an important role and duty in assisting Parliament to scrutinise the budget papers on behalf of the people of Western Australia. The committee values that assistance.

These proceedings are being recorded by Hansard. A transcript of the evidence will be provided to you. It will greatly assist Hansard if, when referring to the *Budget Statements* volumes or the consolidated account estimates, members and witnesses give the page number, item, program, amount and so on in preface to their questions.

If supplementary information is to be provided, I ask for your cooperation in ensuring that it is delivered to the committee clerk within 10 working days of receipt of the questions. Should you be unable to meet that deadline, please advise the committee clerk immediately. The committee reminds agency representatives to respond to questions in a succinct manner and to limit the extent of personal observations.

For the benefit of members and Hansard, I ask the minister to introduce his advisers to the committee, and for each adviser to please state your full name, contact address and the capacity in which you appear before the committee.

[Witnesses introduced.]

The CHAIR: I give the call to Hon Sue Ellery.

Hon SUE ELLERY: I want to ask about nursing rosters, and I think the best place is probably on page 128 under service 1, "Public Hospital Admitted Patients". My question is about Rockingham General Hospital. Can the minister confirm that nurses who take annual leave for two weeks or less are not currently being covered or replaced on wards while they are on leave? The minister would be aware of a dispute, I suppose you would call it, at Rockingham hospital over nursing staffing rosters. Can the minister confirm the things that nurses are reported to have said publicly that hospital management is requiring nurses in the high dependency unit and the intensive care unit to operate below the requisite number of nursing staff as stipulated in the hospital policy guidelines?

Hon HELEN MORTON: I will ask Nicole Feely to respond.

Ms Feely: As I understand the question, it is in two parts. The first relates to non-replacement of staff taking less than two weeks' leave. I am not aware of that. That is not a stated SMAH policy that I am aware of. In fact, I would reinforce that making sure we meet all award conditions and our nursing hours per patient day is the guiding principle for employment of nurses across all the wards, so I am surprised to hear that. I can take that on notice, but it is not something I have ever authorised as a position.

Hon SUE ELLERY: Have you heard of the practice?

Ms Feely: No, because I will not allow the nursing ratios to fall below what are the award and the nursing hours per patient day requirements. In relation to the second question on the ICU, as I understand it—I have the actual figures in here—the same considerations apply. We are reviewing all the nursing ratios across Rockingham, but, as I understand it, the nursing ratios were about 10 FTE higher than comparable hospitals. So, if there is any reduction in nursing hours, again, it is never to be below the award requirement or the nursing hours per patient day. Where there is fluctuation on a day-to-day basis, that could occur to meet those requirements; but, again, there is no direction from me or from any executive director or any management to reduce any nursing hours below those requirements.

Hon SUE ELLERY: If I may, through the Chair, are you aware of a dispute—I do not know if that is overblowing it—or an issue between nursing staff and management at Rockingham hospital?

Ms Feely: In relation to the nursing hours issue? I understand there are some nurses who have expressed concerns, and that does concern me also if I have nursing staff, whom we value very highly at Rockingham, being concerned about their future or what is happening with nursing hours. But I can reassure you here that we are looking at, from a good management perspective, what are the nursing hours per patient day and the award requirements, and I have asked my executive director to come back to me to justify where we have higher than peer hospital employment ratios. To that extent, though, all the senior nursing staff have been fully briefed, and there are daily meetings with the nursing staff and the executive director of the hospital. Each member of staff has been given a guarantee that if they have concerns, they should raise those directly with the hospital. We actually need our nursing staff and we want to make sure that we send the message that they are valued. But change can sometimes be difficult, and that is the process they are going through. But

the fundamental issue is the award. There is no threat to the award or the nursing hours per patient day requirement. However, where there is a higher than usual ratio for a peer hospital, I have asked my executive director to explain that and also to substantiate why it is we should continue to employ at those levels. On a day-to-day basis, there may be a requirement to do so, but not an ongoing one. It is just about good management of the hospital.

Hon SUE ELLERY: I turn to works in progress on page 144 of the budget papers, the QEII car park. I will just tell you that in August and September last year I had reason to say all of your names in vain, as I spent a lot of time trying to park at Charlies. I am very pleased to see that the multi-deck car park is coming along. I understand that nearly 900 bays are expected to open in October this year—I want to check that is on target—and a further 800 bays by April next year. I particularly want to ask about the fees that will be charged and what modelling you have done. Have you set the fees? Will the fees at QEII be different from those in any other public hospital; and, if so, why?

[3.40 pm]

Hon HELEN MORTON: Dr Russell-Weisz.

Dr Russell-Weisz: In relation to your first question in relation to the bays going up, the car park is progressing well. We will get 876 bays back by 12 October this year, and then in excess of 800 bays in April next year—it may even be as high as around about 1 000 extra bays, which is the second phase of the car park. Phase 3 of the car park will come on line about a year before the new children's hospital is completed, and that will give 3 000 multi-deck bays at the QEII Medical Centre, and there will be an additional 2 000 bays at grade; so around about 5 000 bays at the QEII Medical Centre. So the car park is progressing well.

In relation to fees for staff and visitors at the QEII Medical Centre, the fees for staff are set by the WA metropolitan access and parking strategy, which applies to a number of hospitals across the metropolitan sites. Under the current strategy, they are in three tranches—they are in category A, category B and category C. Clearly, QEII, and hospitals like Royal Perth, are in category A because they are central city hospitals; category B, an example would be King Edward or PMH; and category C, something like Rockingham, where fees are not charged. In relation to QEII, the strategy foresees fee increases to $7.50 a day for staff at 1 April 2014; and visitor fees currently at the site for short-term car parking, under three hours, are $2 50, and by 1 July next year will be around about $3, and then going up by CPI.

Hon SUE ELLERY: Of the configuration that you referred to, how many of those bays will be available for patients and visitors and how many will be for staff?

Dr Russell-Weisz: There will be a preponderance, obviously, of staff bays out of the 5 000.

Hon SUE ELLERY: What is the technical term?

Dr Russell-Weisz: If I could take that on notice, just to give you an exact breakdown of the 5 000, because as the 876 come on line, the same proportion of staff bays will come online as visitors. We have been very careful not to bring down our patient or visitor bays during this year, 2012, too much. We have reduced them by about 200. They will come back online very quickly. Staff car parking will come back online, and we imagine that we will move around about two-thirds of those staff who are currently parking at Graylands back in the first and second tranches, which is October and April next year. But I could take that on notice to give you an exact breakdown.

[*Supplementary Information No C1.*]

Hon SUE ELLERY: I think Graylands is the temporary parking. So my question was: will you cease using that once you open stage 1?

Dr Russell-Weisz: No, we will not. We will continue to use Graylands at stage 1 and through to stage 2. We will reassess the situation coming up to stage 2 to see how many staff we actually still

have parking at Graylands or at Shenton Park. We are doing both. We may consolidate around one of those hospital sites. But obviously it is clear that we want to provide as much car parking on site for our key clinical staff as early as possible.

Hon SUE ELLERY: If I may, still on the same issue, what, if any, additional or enhanced public transport arrangements, such as new routes or frequency of services, or encouraging alternative modes of transport, have you looked at for when the new car park opens?

Dr Russell-Weisz: There are a number of things we have actually put in place already. For the last two or three years we have put in place encouraging car-pooling, so people do get an advantage if they car-pool in relation to our priorities, and also assistance in relation to TravelSmart cards. We are providing some transport around the site now. Also, we are currently providing two extra bus services through the PTA; that is bus services 97 and 79, which go through to the university. Clearly, the Department of Health is in discussions—has been for some time—with the Public Transport Authority in relation to providing more public transport to the site, because it is not only the site that is being redeveloped but it is also UWA, so there is a lot more traffic coming to both areas.

Hon SUE ELLERY: Thank you. Before I move off car parking, so that I am absolutely clear in my head about the fees, as I understand what you explained, there is a separate fee structure for staff, and that is in three categories, A, B and C, and those fees are set by that body that you named.

Dr Russell-Weisz: It is under the WA metropolitan access and parking strategy, which was endorsed in 2009 between the Departments of Health and Planning.

Hon SUE ELLERY: That is setting fees for staff. For patients and visitors, is there some mathematical formula? How do you determine that it is $2.50 now and it is going to go to $3, and then after that it will go up by CPI? What takes it to $3 from $2.50 now?

Dr Russell-Weisz: There are two answers to that question. Number one, not just at QEII, but going back to 1992, there have been very few fee increases since that stage. This strategy with the Departments of Planning and Health sets to put a proper fee structure in place for staff and visitors. In relation to the visitors' fees, that was part of the financing arrangement in relation to the new multi-deck car park at QEII.

Hon SUE ELLERY: So some sort of cost recovery; is that what you mean?

Dr Russell-Weisz: Absolutely cost recovery. But that was actually part of how the car park was bid.

The CHAIR: I might just indicate that I will give Hon Sue Ellery a couple more questions, but just so that members know the order that I have got people in, and the time frame that we have got, and again prioritising committee members, I have Hon Philip Gardiner and Hon Ljiljanna Ravlich, followed by Hon Alison Xamon, Hon Adele Farina, Hon Linda Savage, Hon Max Trenorden and Hon Jim Chown, and Hon Liz Behjat, who is indicating as well. That is why I did that, so that I could double-check. I will put Hon Liz Behjat up the list. We have until seven o'clock, but I was going to propose that we have a 10-minute break at 5.15 pm. So that is the time frame. Hon Sue Ellery.

Hon SUE ELLERY: Thank you. I now want to turn to Midland health campus. I think the place to talk about that is at page 131, in the infrastructure dot point, which is where it appears. I understand that some of the land that Midland health campus will be set on is now to be set aside for a private health provider other than St John, to provide those clinical services in a day-surgery setting that St John is not prepared to offer. There has been some attention to those matters. My question is: how much money has the government set aside to enable that bit of land to be put aside for that purpose? Will it come out of the existing $360 million for the Midland health campus, or will the allocation of that separate land and the building of that separate private facility require new and additional funding?

Hon HELEN MORTON: The director general.

Mr Snowball: There are a couple of issues there. Firstly, the contract negotiations with St John of God Health Care, the preferred proponent, have not been finalised as yet. However, the intention is that in terms of those restricted procedures, of which there are around about 250, there is a decision to excise part of the land, which is part of the Midland health campus site, for a number of purposes, including the provision of those services. The intent at this stage is to examine a variety of options, including doctor groups and private developers, to construct a day hospital–type service, which has the potential then to encompass restricted services, and potentially other services as well, that we would like to see provided out of the Midland health campus.

[3.50 pm]

The entirety will mean that all services that are currently provided at Swan District Hospital will be provided at the Midland health campus site. I should add that a number of these procedures are procedures that would normally not be done in a hospital but in the community and other settings. It is quite appropriate and reasonable to for them to be provided not in a hospital but in a day-hospital-type service.

Hon SUE ELLERY: Do you require any additional funds at all above the $360 million to give effect to this new plan?

Mr Snowball: Not at this stage. As I said, the contract negotiations have not been concluded, bearing in mind that this contract includes the design and construction of the facility itself. We have a budget of a little over $360 million for that purpose. Until those contract negotiations are finalised, we will not know whether or not it is in budget, but ultimately the provision of the total service at Midland encompasses the total service within the price that we have available to us.

Hon SUE ELLERY: What are you anticipating will be the way that patients will go to this day-surgery facility? How will they get there? What is the referral process? Do they need to go to St John and they say, "We are not able to provide you with that service but we will refer you to the service provided across the car park"? What is the process by which they will go into that service?

Mr Snowball: Through the minister, these are essentially elective services. The normal process for a referral to those sorts of services is through a general practitioner. The expectation would be that they will see a GP and be referred for those services, and obviously the GPs know exactly where the services are provided in Midland. In fact, there are other options in the Midland area that provide these services.

Hon PHILIP GARDINER: My first question—I do not quite know where it is in the budget papers—concerns the Bidi Bidi program. It is in there somewhere but I cannot find it. Is anyone familiar with the Bidi Bidi program? It is under the Department of Health. Do not worry; I will move onto the next one and come back to you privately.

Hon LJILJANNA RAVLICH: It is amazing you do not know about the Bidi Bidi health program; everyone else does!

Hon PHILIP GARDINER: It is not listed as a line item on its own because it is probably such a small amount. It is a very important part of early childhood development that is being run at Cue or Wiluna.

The CHAIR: We will do an electronic search for it and get back to you.

Hon PHILIP GARDINER: I will get back to you privately.

On the famous efficiency dividend that we have had some evidence from Treasury about, on page 127—this is a much bigger number than the Bidi Bidi program. The second dot point on page 39 of budget paper No 3 states —

- a general government sector efficiency dividend — a 2% efficiency dividend will be applied to general government sector appropriation agencies … based on cash service appropriations.

That is the definition. Treasury advised this morning that that cash services appropriation is the number on page 150 of budget paper No 2 under "Service appropriations". It is a percentage of that item. There may be some adjustments, but what I have calculated based on the efficiency dividend on page 127 is that it is 2.6 per cent in the first year, 2012–13, and then it goes up by one per cent each year up to the last forward year. It goes to 3.4 per cent, 5.6 per cent and 6.75 per cent—if it is the figure in "Service appropriations" under "Cashflows from state government". Treasury advised us this morning that that was the calculation. The question I have is: given Education had a concession down to one per cent, at least for the first financial year in 2012–13, and given that in your papers you talked about the health system coping with unprecedented demand for its hospital and health services—maybe we can always write that every year; I am not sure—why does it appear to be higher than what is spelt out in budget paper No 3?

Mr Salvage: It is correct that the two per cent efficiency dividend is intended to be applied to state appropriation funding. When the efficiency dividend was applied to health, there were some commonwealth payments that may have been captured within that calculation and there is a footnote that I can refer you to at the bottom of page 127 that acknowledges that we may have to do some further adjustment to the efficiency dividend post the budget being handed down.

Hon PHILIP GARDINER: The other evidence we received this morning is that part of the underlying rationale for introducing the efficiency dividend was related to the full-time equivalents that state government agencies have got. I was referred to a table under Public Sector Commission. You will not have this, but I have it on my computer. The Department of Health has a full-time equivalent ceiling. Can you tell me what that ceiling is for full-time equivalents?

Mr Salvage: There might be a calculation difference between the numbers we refer to —

Hon PHILIP GARDINER: I do not have the ceiling here. I have put a question on notice. What I am leading to is that there is a difference between what the ceiling is and what you are actually applying in terms of full-time equivalents, which is part of a gap that will allegedly realise this efficiency dividend more easily. I want to see whether this applies to the Department of Health as well as other agencies, so I need to have the ceiling number for a start. I have the paid FTE number for December 2011.

Mr Salvage: I understand. If I can refer you to the income statement on page 147 of the Health budget, there is a footnote to the income statement that provides some information about the FTE ceiling that will apply to Health both in the current financial year and in the 2012–13 financial year. What that indicates is that the ceiling for the current financial year is 33 334 FTEs, increasing to 34 646 in 2012–13. What that recognises is that in handing down the efficiency dividend, the Treasurer was clear that a freeze would be applied to public service positions in agencies like the Department of Health but operational front-line service delivery would continue to grow. In fact, we have some growth in the ceiling demonstrated in the budget papers.

Hon PHILIP GARDINER: I think I heard you. The figure of 33 334 happens to be one more person than you had in December 2011, which was 33 333. That is interesting. If the difference going to 34 646 is the ceiling—are these numbers in the footnote what you call the ceiling?

Mr Salvage: Yes. To be clear, the number you are looking at for December 2011 might have been a month-to-date position, whereas —

Hon PHILIP GARDINER: I understand.

Mr Salvage: These numbers are full-year average FTEs, so at any point in the year it will be a different number from the full-year average for that year. The 34 646 that I referred to for 2012–13 is the full-year average FTE ceiling for the Department of Health.

Hon PHILIP GARDINER: Okay; I have the full-year average here as well. What I would like to know is in achieving the $94 225 000, which is in the budget papers, is there going to be a difference between the ceiling in the budget papers—the 34 646 full-time equivalents—and what you expect to have as the average paid full-time equivalent during 2012–13?

[4.00 pm]

Mr Salvage: The 34 646 will be the number that we will be managing to and should align to the funding available for paid staff in WA Health during next year.

Hon PHILIP GARDINER: So that should be aligned to what is in the budget already.

Mr Salvage: Correct.

Hon PHILIP GARDINER: Okay; so that means there is no gap, so it is going to be relatively easy to fulfil this efficiency dividend for your agency.

Mr Salvage: The efficiency dividend will obviously pose the Department of Health some challenge in relation to its delivery—understand that—but what I am pointing to is that there is an FTE ceiling for next year that accommodates growth in our FTE for service delivery, excepting that the Department of Health agency is expected to maintain its current numbers.

The CHAIR: The minister is indicating that Mr Snowball might have something else to add.

Mr Snowball: The purpose in trying to align our *Budget Statements* and our FTE within Health is particularly to ensure that we have sufficient nurses, doctors and others to provide for that additional activity in our hospital and health services. So the growth that you are seeing in terms of these targets allows for employment of those staff in order to meet the growth in activity. There is a ceiling, particularly, and a freeze on our Department of Health staff numbers. So our FTE in the Department of Health—that is, policy planning areas, and corporate and finance and so on—will be pegged at a level, but this provides for continued growth in FTE to meet demand in our hospital system. This is an attempt to make sure they are very closely aligned between our salary appropriation—our employment cost—with our FTE numbers.

Hon PHILIP GARDINER: But notwithstanding that explanation, realising the dividend is going to be challenging. I suspect it is going to be more challenging because I think it is at variance with what I heard—maybe that is too strong a term—but there is some difference between the impression I gained from the evidence this morning compared to what I am hearing this afternoon in your agency.

Mr Snowball: If I can refer you, though, to page 127 and footnote (a)—which was referred by the executive director, resource strategy—it basically indicates further discussions are required, particularly between ourselves and Treasury about the efficiency dividend setting, given that we obviously also rely on a significant commonwealth contribution in the provision of our services. So that flags further discussions to occur with our state Treasury around that final position in terms of an efficiency dividend.

Hon LIZ BEHJAT: Page 144, "Works in Progress", under "Equipment", the third line item down, the "Simulated Learning Environments Program", we have the funding for that disappearing at 2012–13 and then nothing going into the forward estimates. Can you just talk me through what happens with that program once that funding stops? What will happen with maintenance of the program? I am assuming that this is software and hardware sort of programming that we are looking at here. Where are the areas that it services and what happens when the money is not there?

Mr Salvage: I can provide some background detail to this project. The aim of the project is to purchase assets to expand the current amount of simulation equipment available to WA Health in the form of things like mannequins, part-task trainers, audiovisual equipment, e-learning and those sorts of things. This specific funding allocation has come to us via Health Workforce Australia, a

national body that funds clinical training across the nation. The flow of funds reflects the period of that funding agreement with Health Workforce Australia.

Hon LIZ BEHJAT: So who is going to be taking that on? After the funding through Health Workforce Australia, what happens?

Mr Salvage: We would be looking to have further conversations with Health Workforce Australia about continuation of funding after this period, but what is reflected in the budget papers is reflective of the current term of the agreement.

Hon LIZ BEHJAT: On the same thing, under "Works in Progress" is "Osborne Park Hospital—Reconfiguration Stage 1". We have got no moneys coming into that then until 2014–15, after expenditure finishes at the end of this year. Was that a change in program there?

Mr Snowball: Throughout this budget process there were a range of capital programs that we deferred for a number of years, and Osborne Park stage 1 was one of those projects that was deferred by three years.

Hon LIZ BEHJAT: I guess you had to sort of look at the bucket of money and see how much you had and how far it was going to go and which projects would get deferred and put onto the backburner. How did Osborne Park end up being one of those hospitals that it was determined?

Hon HELEN MORTON: These were some replacement mental health beds that were going to be developed at Osborne Park in place of beds that are existing at Graylands Hospital. Where it was necessary to find a deferred project, it would appear that this would be one that could be deferred given that it is not making a difference to the number of beds available. So, the replacement beds are being delayed.

Hon LIZ BEHJAT: Okay; so the services that are currently offered at Osborne Park Hospital are not going to be affected in any way?

Hon HELEN MORTON: Under this particular project, no, because, as I say, these were beds that were going to be built at Osborne Park and then closed at Graylands as a result of that. So there are no new beds in this project; it is just a replacement of beds.

Hon LIZ BEHJAT: As there are with several hospitals in the metropolitan area, there are parking issues at Osborne Park Hospital. I am assuming the department is aware of those issues and I am wondering what might be in the pipeline there to address those issues at Osborne Park?

Mr Snowball: There are a number of works continuing at Osborne Park, including other development of two extra theatres, so in the course of the next two years as part of the surgery centre. That is national partnership agreement–sourced funding, so that is separate to the deferral of this specific project around the establishment of the mental health beds. There will also continue to be work around master planning for the Osborne Park campus site, so that is about future plans in terms of developing an approach to support the sort of needs in that area through developments at Osborne Park. This is obviously the position, so we continue to provide the services that have already been announced and recognised at Osborne Park, with the exception of the mental health project.

Hon LIZ BEHJAT: The car parking?

Hon HELEN MORTON: Could you just repeat the question on car parking, please?

Hon LIZ BEHJAT: I only know this because my electorate office is very close to this area and I have constituents coming to me talking about these issues. There is not enough parking at Osborne Park Hospital and people are now parking in the streets. The streets are not built for it. It is quite dangerous. There are some issues with rat-runs and things happening there as well, but I am just wondering what the hospital, or the department in fact, is doing to address those, which is only going to get worse.

Dr Russell-Weisz: There has been an issue with parking at Osborne Park ongoing. The prime issue was that there really was not enough parking for the patients and visitors, so we have actually focused on that.

[4.10 pm]

That has, unfortunately, spilled some staff into the streets, but what we are trying to do there is actually prioritise like we do at other sites for staff car parking—our key clinical staff having priority for parking—but also having that right balance for patient and visitors. What happened, as I understand it, is that there has been some spillover into the streets, and there is a limit on local car parking now in the streets of about three hours, I think. We are going to address that, in making sure we do have adequate car parking for staff and patients but with a focus on patients as well because there has not been enough. That means we will not be able to provide, as we cannot do at most sites, parking for absolutely everyone, but we will do our best to provide enough parking for the key clinical staff.

Hon LIZ BEHJAT: What is your time frame for that?

Dr Russell-Weisz: That is happening at the moment. We are doing some reconfiguration at Osborne Park, and that will continue over the next few months.

Hon LIZ BEHJAT: So, by the end of the year?

Dr Russell-Weisz: Certainly we hope, well before then, to have enough parking for patients and visitors, and enough for key clinical staff.

Hon LIZ BEHJAT: You might like to put a Give Way sign as you are leaving the car park to enter onto the street. There is not one, and no-one wants to take responsibility for putting it there. Maybe Health might do that because it is about the Health people leaving the campus.

There is a line item on page 146 of budget paper No 2 for "QEIIMC – WA Institute for Medical Research North", with an allocation $25 million in 2012-13 for the construction of their premises at QEII Medical Centre. It is my understanding that there are two centres being built for WAIMR, and one is at Fiona Stanley, but I do not see a separate line item for that. Is that just bundled up in the whole Fiona Stanley $1.7 billion budget?

Ms Feely: May I just have a word with the director for a moment, please?

The CHAIR: Sure.

[Witnesses conferred.]

Ms Feely: I understand that it is yes.

Hon LIZ BEHJAT: You do not want to expand on that?

Hon HELEN MORTON: The director general might just expand on that a little.

Mr Snowball: In terms of the Fiona Stanley site, that includes a contribution from the universities towards that facility on the Fiona Stanley site, but the state government contribution is from the wider Fiona Stanley campus total budget of just over $1.7 billion.

Hon LIZ BEHJAT: I understand there was, I think, $100 million from the state government; was that for the building at QEII?

Mr Snowball: It is $25 million each, so it was a total of $50 million not $100 million. As an addition to that, it is a combination —

Hon LIZ BEHJAT: But wait, there is more!

Mr Snowball: That is right; sorry. The addition is that the commonwealth government is also contributing. The commonwealth contributed $50 million, the university $25 million, and the state $25 million as the matched contribution.

Hon LIZ BEHJAT: That is for the works of both the south and the north campuses?

Mr Snowball: That is right.

Hon LIZ BEHJAT: I understand that Fiona Stanley is on track and that will come online probably at the same time as the thing. With relation to the north facility, construction is well underway, I think, already, from my discussions with Professor Klinken. What is an expected finish date for that project?

Mr Salvage: The expected completion date for the WA Institute of Medical Research at the QEII campus is April 2013.

Hon LIZ BEHJAT: We are just doing the capital works for that thing; we do not provide ongoing funding to the research facility there for the works they do, do we? If, yes, where is it in the budget papers?

Dr Russell-Weisz: There are a number of researchers who are going into the WAIMR facility—some from the current site, the QEII site, and some new researchers—and we do provide ongoing recurrent funding to some of those researchers, but usually through an application process that is run through the Department of Health by the individual research institutes.

Hon LIZ BEHJAT: So if you are doing Duchenne muscular dystrophy, that will get that thing of funding there?

Dr Russell-Weisz: Yes.

Hon LIZ BEHJAT: I understand. Thank you.

Hon LJILJANNA RAVLICH: I refer to the first dot point on page 129 under "Significant Issues Impacting the Agency" that states —

> The Western Australian health system is coping with unprecedented demand for its hospital and health services. Maintaining the present health budget sustainability remains an ongoing challenge …

I do not want to read the rest of it out, but, given the unprecedented demand and the fact that there is $716.3 million over the forward estimates to be harvested in savings, I wonder whether you could give us at least some indication of what some of those savings might be in the 2012-13 financial year?

Hon HELEN MORTON: As is the case with most of these portfolios, these are ongoing discussions at the moment. The final decision will be made by the Minister for Health, and there is a broad range of initiatives being considered. I think that, as I say, the final decision of that will be made by the Minister for Health, but none of those decisions has been made yet.

Hon LJILJANNA RAVLICH: Madam Chair, can I reserve the right to come back to the health department within a three to six-month time frame, requesting a schedule of all the savings to be harvested in the 2013 financial year?

The CHAIR: I guess you can.

Hon LJILJANNA RAVLICH: Thank you.

At the same time, minister, I am also very keen to find out where the savings have been harvested in the last two financial years, because quite clearly there would have been, and there have been, tens of millions of dollars harvested over the last two or three financial years. What I am going to ask is that the Department of Health provide to the estimates committee the three per cent dividend harvested in 2009-10, the three per cent in 2010-11, and that which was harvested in 2011-12. There should be documents within the department so they do not have to redo the work—they know where they got the savings from in those last three financial years—and I ask that that information be provided to the committee.

Hon HELEN MORTON: I will just ask the director general to make some comments about that.

Mr Snowball: It is certainly true, as outlined in the budget statements, that we have had significant demand growth within our hospital system. One of the good features of our healthcare system is that we have managed to keep pace with that growth in terms of development and response and in terms of activity levels. As you know, two years ago Health went through a transformation by re-basing its budget to align with activity and projected activity into the future, so that was under the clinical services framework. We have managed, indeed, the last two years, and those activity projections have been within less than one per cent in terms of outcome, so they are very accurate predictions of activity going forward, and our funding aligns with that in terms of our forward estimates. We are able, now, to be in a position of planning to meet the growth in that demand that is coming through. In terms of productivity improvement in particular, one of the things we have seen is a significant growth in emergency department presentations—roughly eight per cent a year for the last three or four years—and through things like the implementation of the four-hour rule, it has meant that we have been able to accommodate that growth. So, in fact, we have been able to provide that growth within the resourcing that we have, in terms of the entire system, through better management of patients coming in and flowing through our emergency departments.

[4.20 pm]

I think it is a good news story in terms of a health system that is now able to properly plan for the growth we are predicting and know will come through growth in population as well as an ageing population, who need our hospital and health services more often.

Hon LJILJANNA RAVLICH: Director General, I have to disagree with you. You may think that is a good news story. I have to say, having a look at your quarterly reports in terms of the level of activity in the health system, it seems to me that the system is under considerable pressure. When I look at the number of mental health patients, for example, who present to emergency departments, that has increased by some 20 per cent. Quite clearly, the system is under considerable strain. If we have a look at elective surgery—and you make a note of this—which is the last dot point on page 129, you make the point that in the nine months to 31 March 2012, 60 094 patients were admitted for elective surgery, and whilst this is 1 034 cases higher than reported for the same period in the previous year, the real question is: how many people are still out there waiting to get their elective surgery and how long have they been waiting for? I wonder whether you can provide the answer to that question.

Mr Snowball: The best measure of our performance around elective surgery is how long people wait for that surgery. Rather than simply raw numbers of people waiting for surgery, it is how long they wait that is the important part. As a system, to give you an example, and comparing us with other states, through the period 2006–07 to 2010–11 we had the highest annual average increase in admissions from elective surgery wait list of any state.

Hon LJILJANNA RAVLICH: Director General, it is about what is happening in Western Australia. This is one of the two states that is doing very, very well in this nation and, quite frankly, why would we want to compare ourselves with states that are in financial difficulty? Anyway, having said that, I am interested to hear the figures that I have asked for, not the comparisons. If you want to put the comparisons on the public record, I do not have a problem with it, but I do not know that it says much.

Mr Snowball: The comparison to other states is that we have had the highest annual average increase in admissions. There are more increases than there are in any other state and at the same time we have seen our equal lowest median wait times for elective surgery, which is now 29 days, down from a national average of 36. For mine, that is a system that is not only dealing with the pressure of the number of people coming through on our wait list, but we are doing those cases more quickly, and more quickly than any other state. We have gone from being one of the worst states in terms of how long people wait for elective surgery to now being one of the best.

Hon LJILJANNA RAVLICH: Can you give me the figure of how many people are waiting?

Mr Snowball: In terms of the total number on our waitlist, if you can bear with me for a few moments—while we are waiting to get those numbers, I have a couple of other examples in terms of how our system performed. Of the proportion of people who waited more than 12 months for elective surgery in WA, which is 1.6 per cent, it is almost less than half —

Hon LJILJANNA RAVLICH: Yes, but how many in real numbers? How many people waited more than 12 months to get elective surgery?

Mr Snowball: It is just over 16 000. I do not have the exact number, but I can provide that. The key issue is how long people wait for that elective surgery, and, as I have described, our system is coping. Despite the continual increased demand for elective surgery, we are actually admitting people and dealing with that surgery much quicker than we did even four or five years ago, which is a sign of a system that is able to manage that growth; albeit, yes there are pressures in our system for a lot of our staff, but I think it is a tribute to our hospital staff that they have been able to achieve what I think are remarkable results for Western Australia compared to the results in any other state in Australia.

Hon LJILJANNA RAVLICH: Can you take on notice, through you, minister, the number of people who have waited for elective surgery for more than 12 months, between 12 months and 18 months, between 18 months and two years and over two years? I would appreciate that.

The CHAIR: Are you asking at this point in time, as a snapshot, for how many people have been waiting for those different times?

Hon LJILJANNA RAVLICH: On the waiting list for a year, between one year and 18 months, between 18 months and 24 months, and over two years.

Hon HELEN MORTON: Yes, we can take it on notice.

[*Supplementary Information No C2.*]

Hon LJILJANNA RAVLICH: I want to ask a question in relation to the question asked by Hon Sue Ellery about increases in parking fees, because one of the areas where savings will be harvested is in the area of parking fees. Through you, minister, I would like a schedule of proposed fee increases for all the public hospital car parks for the 2012–13 financial year. If that information is available and if you can you provide that to the committee, that would be great. If not, you can take it on notice.

Hon HELEN MORTON: We can take it on notice, but if you want that information more quickly, although I hate to tell you, it is on the website. But we will print it off for you so that you can have it in hard copy.

Hon LJILJANNA RAVLICH: If it is on the web site—no, you can bring it. Since you are so keen to share, why do we not have all the car park fee increases for each public hospital in the financial years 2009–10, 2010–11 and 2011–12? I am sure they are all on the website.

Hon HELEN MORTON: That is absolutely fine.

Hon ALISON XAMON: I want to pick up on some of the issues raised in relation to St John of God, Midland referred to under “Infrastructure” on page 131. The director general made the comment that in terms of the services intended to be made available in the public area of that hospital, they would ordinarily be referred through by GPs. Because emergency services will obviously be provided through St John of God, if, for example, a woman were to present at emergency having just been raped, and may need to be offered, among a number of crisis services, a morning-after pill, how is that intended to operate considering St John of God has made it abundantly clear that it will not be involved in any contraceptive services? Likewise, if a woman who is suffering from an ectopic pregnancy appears in emergency, how will that be managed? I am

aware there will be circumstances in which people will have to appear in situations of dire emergency where either contraceptive or reproductive services will need to be made available regardless of the ideological constraints of St John of God as the provider. Can you tell me, please, how it is envisaged that that will be managed and how people can be assured that the referral services, if that is what is required, will be patient-centred?

[4.30 pm]

Hon HELEN MORTON: I will direct this to Dr David Russell-Weisz. However, I would also like to make available for photocopying all the car parking fee increases from 2009 upwards, so that we do not need to take that on notice any longer.

The CHAIR: Thanks very much, minister.

Dr Russell-Weisz: In relation to the question, clearly we are still in contract negotiations with St John of God, but, as you stated, there will be a significantly enhanced emergency department services provided by St John of God at the new Midland health campus site as well as inpatient services. In relation to the two examples that you gave, which was if a lady had been raped and presented to St John of God, they would actually be seen and they would have all emergency treatment that was required by that provider.

Hon ALISON XAMON: How is that the case when St John of God has made it unequivocally clear that contraceptive services will not be part of anything they will contemplate?

Dr Russell-Weisz: What normally happens in these circumstances, for any advanced or complex sexual assault, is that all the treatment gets provided. Then they are referred onto the Sexual Assault Resource Centre. For any other complex procedures, they can be referred on to King Edward memorial hospital, which is the standard practice around other hospitals in the state. If somebody is presenting with a medical emergency such as an ectopic pregnancy—which can be a medical emergency—they will be treated as a medical emergency and treated at that site as a medical emergency.

Hon ALISON XAMON: Even if it requires the foetus to be terminated as part of that process? Again, St John of God has made it clear that they will not, under any circumstances, entertain termination processes.

Dr Russell-Weisz: I am talking as a clinician here: in an ectopic pregnancy, which ultimately will not be viable and may threaten the life of the mother, then it will be treated as a medical emergency and treated by St John of God.

Hon ALISON XAMON: They will not be referred through to another hospital to undertake that?

Dr Russell-Weisz: No, they will not refer through. We have been very clear about this: you would not refer through unless there was a complication that required that person to be treated at the tertiary centre, but that would be the same as if they were seen at Joondalup, Rockingham or Armadale.

Hon ALISON XAMON: Going back to the issue of contraceptives in the case of crisis, it may be that someone does not present as an emergency until maybe eight hours or so after the assault has occurred. A subsequent referral may be too late in terms of being able to deal with the immediacy of needing to ensure you can have the contraceptive administered immediately. There are instances where basically patients may end up missing out on essential services because they happen to present at this particular hospital if it is a matter of time.

Dr Russell-Weisz: That is not the case. We will make sure that patients receive timely treatment. In this case there are certain tests that you would have to perform—this is at any site—before you actually prescribe the morning-after pill. You have to find out if the lady is pregnant first, not from potentially that sexual assault but earlier. You have to be very careful before you prescribe the

morning-after pill. That could all be done. We would make sure that no woman is disadvantaged by being seen at that site.

Hon ALISON XAMON: I will be waiting to see what the eventual contractual arrangements are because I think that people in the eastern suburbs certainly need to be assured they will get the necessary services.

Moving on to other things, I refer to "Infrastructure" on page 131. The third dash from the bottom refers to the construction of a $28.9 million mental health inpatient unit at Sir Charles Gairdner. It is expected to commence in late 2012. How many beds will that be? Are the beds only for adults? When is it expected to be completed?

Dr Russell-Weisz: There will be 30 beds at the new Sir Charles Gairdner Hospital mental health unit. There are currently 36 beds but they are all voluntary beds. We will have the ability to have involuntary beds in the new unit. The new unit, we aim to start construction towards the end of this calendar year.

Hon ALISON XAMON: How many voluntary beds is it anticipated will be in the new centre? Of the 30, how many are anticipated to be involuntary?

Dr Moore: The process is the authorisation of all the beds. All the beds can treat either involuntary or voluntary patients. There is no specific number.

Hon ALISON XAMON: Okay. So that is how the facility was set up. Is it anticipated that adolescents and children will be able to be incorporated within those beds?

Dr Moore: I will have to pass that back to Dr Russell-Weisz.

Hon HELEN MORTON: The answer is no.

Hon ALISON XAMON: And the expected completion date? You said when it will start; I want to know when it is likely to finish?

Dr Russell-Weisz: The expected completion date is towards the end of 2014. At this stage, the construction completion is expected in February 2014.

Hon ALISON XAMON: Moving on to page 142, "Contracted Mental Health". I am interested in the trend in the number of admissions to specialised mental health units.

Hon HELEN MORTON: Sorry; I could not hear what page it was.

Hon ALISON XAMON: Page 142, "Contracted Mental Health". I am interested in the trend in the number of admissions to specialised mental health units. How many more admissions were there this financial year than last financial year?

Hon HELEN MORTON: Whilst we have a percentage, we cannot actually find the number that you are looking for. We will get that on notice.

[*Supplementary Information No C3.*]

The CHAIR: To avoid confusion, I allocated a previous C3 but that one was answered, so this is the new C3.

Hon ALISON XAMON: I now move to page 145. This question also pertains to something on page 146; I will explain. It refers to "Completed Works", line 17 "Graylands Hospital—Redevelopment Planning". It says that $600 000 has already been spent. I would like to know what that money has been spent on. It seems to be a lot of money on planning if the minister is still unsure about what is going to happen at Graylands. You knew I would ask this question! On page 146, the fourth item under "New Works' is "Graylands Hospital—Development Stage 1". Sixteen million dollars has been allocated for some time in the future, starting with $500 000 in 2015–16. It is clear that the government recognises something needs to be done and that there are

plans. I was wondering if the minister could advise what those plans are, as well as what the money has already been spent on? What is the future for Graylands?

Hon HELEN MORTON: Those discussions and considerations are underway at the moment, as you are aware.

Hon ALISON XAMON: But you have money in the budget for it. I am thinking, if it is being released in the budget, you have obviously made some decisions and now is the time to actually tell us. You are right; I have been trying to get this information for a long time. What has the $600 000 already been spent on?

[4.40 pm]

Hon HELEN MORTON: An amount of $350 000 has already been spent on consideration about the future of Graylands Hospital. That has been done in conjunction with the planning, for example, around the beds at Osborne Park and additional beds going to Joondalup. A fair bit of work has been done in determining how services can be provided closer to where people live. Osborne Park is an example, and some of the beds went to Joondalup, as you know. The overall future of Graylands Hospital is still under consideration.

Hon ALISON XAMON: You have spent $350 000 already, presumably on consultants' fees to assist this.

Hon HELEN MORTON: Yes on fees, principally for a site master plan, and we are getting information around the facility at Graylands.

Hon ALISON XAMON: Can I request that that report be tabled?

Hon HELEN MORTON: Which report are you referring to?

Hon ALISON XAMON: You said $350 000 was put towards consultancy fees, reports, pulling together documentation, and a master plan.

The CHAIR: I thought I heard the minister say "site master plan", just to be helpful.

Hon ALISON XAMON: It would be good for us to see what that $350 000 has gone on, because it is a lot of money and it would be great to see the outcome.

Hon HELEN MORTON: The answer is that a range of initiatives have been undertaken to develop the position where it is at the moment. There is not a single consultancy or a single report, but there is advice that has been received et cetera. So those are the things that make up that $350 000.

Hon ALISON XAMON: Is the minister able to list those initiatives?

Hon HELEN MORTON: I can probably take that on notice.

Hon ALISON XAMON: I am happy to take that on notice.

Hon HELEN MORTON: I can certainly provide a breakdown of those things and provide them to you—for example, heritage listing and all sorts of things like that.

Hon ALISON XAMON: I would appreciate the breakdown of that $350 000.

The CHAIR: As I understand it, that would be an acquittal of that $350 000, what it is spent on and what the product is; is that right?

Hon HELEN MORTON: Absolutely.

[*Supplementary Information No C4.*]

Hon ALISON XAMON: What has the remaining $250 000 of that $600 000 been spent on?

Hon HELEN MORTON: That is currently under consideration between the Mental Health Commission and the Department of Health. The precise amount of fees or what precisely is the next

step that is to be taken is the subject of discussions within the next fortnight, so I cannot give that precise detail to you at this stage.

Hon ALISON XAMON: Can you give me some detail?

Hon HELEN MORTON: No. I do not have it. There is not any. That discussion is scheduled to take place in the next fortnight.

Hon ALISON XAMON: It is $250 000. It is a lot of money.

Hon HELEN MORTON: I can assure you it will be spent primarily on planning fees and to further the discussion that we are having, but we do not have the definitive outcome of what those fees will be spent on at this moment.

Hon ALISON XAMON: Madam Chair, in the same way that Hon Ljiljanna Ravlich was able to ask that future decisions be tabled, is it possible that I could also request that maybe in two or even three weeks I am able to receive that breakdown of that $250 000?

Hon HELEN MORTON: Any member of Parliament can put a question on notice about this matter any time throughout the 12 months coming.

Hon ALISON XAMON: I have been asking for this for ages, so I am keen to get it.

Hon KEN TRAVERS: We can call you back on Monday, if you like!

Hon HELEN MORTON: You can do that, Hon Ken Travers. I will be thrilled to be here!

Hon ALISON XAMON: Going back to the $16 million for “Graylands Hospital—Development Stage 1” on page 146 under new works, are you able to give any detail as to what that huge sum of money is intended to be allocated for?

Hon HELEN MORTON: The only item of that reflected in these budget papers is the $500 000 in 2015–16. All of the carryover amount of $15.584 million is going to be spent on what we might need to do in the redevelopment of Graylands—or otherwise.

Hon ALISON XAMON: Are there any plans to sell the Graylands site?

Hon HELEN MORTON: There are no plans at this stage.

Hon ALISON XAMON: Are there any plans to sell any portion of the Graylands site?

Hon HELEN MORTON: Not that I am aware of. There are definitely no plans at this stage to sell any land of the Graylands site.

Hon ALISON XAMON: I refer to the second dot point under “Activity-Based Funding” on page 132 of budget paper No 2. This point raises the measurement of teaching, training and research. I am interested in funding provided by the health department for targeted research, specifically whether any major research initiatives are planned; and, if so, what they are. I am happy to take that on notice if there are a lot. Importantly, also, is there any intention to fund the Telethon Institute for Child Health Research to undertake a child development survey to provide more up-to-date data or is any funding planned for research into FASD?

Hon HELEN MORTON: The director general.

Mr Snowball: Through the minister, there is a significant amount of resource and work going into research. As you are probably aware, we have clinical academics in all of our teaching hospitals who, as well as teaching, undertake research as clinicians; so there is a value to be ascribed to that. But there are also funds that are directed both to commissioned work and to targeted research, basically to help us answer some of the questions we need answered, as well as support to the institutes, including the child health research institute, as well as obviously developments around infrastructure. The new children’s hospital will have significant research capacity built into it, as will, as you have heard, QEII and Fiona Stanley Hospital as well. It would be very useful and we

would be delighted to provide a breakdown of that research and the value of that research going forward. In fact, I thought I had it with me.

Hon ALISON XAMON: I am happy to take that on notice, and if I can have a breakdown of that, that would be particularly useful. But you cannot indicate at this point whether any of that money is going specifically to the Telethon Institute or to specific research into FASD. Are you able to indicate either of those at this point?

Mr Snowball: Not at this point. I would prefer to take it on notice because then I can be accurate.

[*Supplementary Information No C5.*]

Hon ADELE FARINA: I refer to the general appropriations. What is the funding allocation in the 2012–13 budget for child and adolescent community health funding; that is, funding for children who are dependent on technology and who are being cared for by their parents in their home?

Mr Aylward: The CACH program is very important initiative. It currently looks after six children in the community in the metropolitan area. It is a joint-funded arrangement between the health department, the Department for Child Protection and also the Disability Services Commission. At present, I cannot recall our specific allocation. It is a three-party amalgam of funds. It will continue at the same level, plus escalation will be provided into next year for 2012–13, so there is no expected change in the overall allocation that is currently provided in there at the moment. There is a matching of resources and efforts. As you may be aware, there is a very good non-government organisation provider, Perth Home Care Services, that provides excellent services for families and these young people, as well as support from Princess Margaret Hospital for Children and the two other departments in ensuring we can keep those children better placed not only in the home environment, but also in the school environment, because we are finding that some of these children are able to progress into school; and of course the Education Department assists with looking after those children when they attend school hours.

[4.50 pm]

Hon ADELE FARINA: Can I have that question taken on notice? Can I have the department's allocation for CACH funding for 2012–13—I would like the dollar amount—and how that compares with the 2011–12 budget allocation?

[*Supplementary Information No C6.*]

Hon HELEN MORTON: I was just wanting to make sure that the figure you are looking for is the Department of Health figure.

Hon ADELE FARINA: Yes. If you can provide the overall figure as well, that would be great, but I appreciate that might be beyond the jurisdiction of the department. But if you can provide both, that would be great.

Just following on from that, how many people whose permanent place of residence is in regional WA currently have access to CACH funding?

Mr Aylward: The criteria for access to CACH funding are quite specifically related to children who are technology-dependent—they tend to require ventilation services, oxygen therapy and the like. There is no universal restriction or sort of identification of where the funding specifically goes. What we try to do, in conjunction with my colleagues here from country health services, is match the needs of each individual child. So if we can successfully, in conjunction with the parents—the carers—get the child home, depending on where that is, and if the circumstances are clinically appropriate and the family structure—the carer structure—is able and willing to support the child, then really we are working on the principle that it is best that they are at home, not in hospital, no matter where they are, whether it is in the metropolitan area or in the rural sector.

Hon ADELE FARINA: So there is no restriction to CACH funding being available only to people who live in the metropolitan area?

Mr Aylward: Certainly not. The funding is available for the children who meet the criteria. At the moment there is a balance between available funds and demand. So the balance is being maintained at the moment and has done so for the last three or four years.

Hon ADELE FARINA: My next question is to the minister: will the minister please advise members in this chamber why the Minister for Health has publicly stated in recent days that CACH funding is restricted to people living in the metropolitan area, and why the CEO of Princess Margaret Hospital has confirmed those comments, when Department of Health staff for the past six months have been working to secure CACH funding for Eden Turner?

Hon HELEN MORTON: I am aware of the case for the young person at Bunbury, and I have not heard the minister make those comments, but I will follow that up.

Hon ADELE FARINA: My next question is in relation to page 130 and the second dot point, the expansion of community child health services. I have a few questions in relation to this. The budget papers state that an additional $58.5 million over four years has been made available, including new funding of $40.5 million over the four years. If only $40.5 million of this is new money, what is, or where is, the balance of the money coming from?

Hon HELEN MORTON: You are going to have to give us the question again.

Hon ADELE FARINA: Sure; no problems. It is page 130, the second dot point. The budget papers state that an additional $58.5 million over four years is being made available for expansion of community child health services. It then goes on to state that this includes $40.5 million over four years of new money. If only $40.5 million of that amount is new money, my question is: what is, or where is, the balance of that money coming from?

Hon HELEN MORTON: The director general.

Mr Snowball: It is a combination. Of the balance, the balance is within the growth allocation to Health. So there is a combination here of new funds to basically boost the numbers so that we are better able to meet the demand coming through. Of course, we had a significant increase in birth rates a few years ago, and this will help us to respond to the gaps in terms of our child health services. So it is $40 million of additional money through this budget process, as well as accommodating the provision of growth for Health. So, as I mentioned in an earlier question, Health now has a re-based budget so that as population grows and demand for services grows with it, whether it be in the hospital settings or other settings, we have the funds that match that projected activity growth. So part of the contribution is from future growth funds already funded in the estimates going into this budget.

Hon ADELE FARINA: The budget papers also state that the intention is to provide additional community child services. Will the minister explain whether the intention is that these additional community child health services positions will be community child health nurses, or will other specialist services also be provided out of that new additional money that has been made available?

Mr Aylward: The funds are totally dedicated in the coming years to child health nurses solely; so no other specialists are being involved. However, in our negotiations and discussions that we have with a variety of stakeholders, NGOs in particular, there may be elements where some of the care in particular circumstances may be in remote areas, or in fact in other circumstances where that could be provided by other specialist workers. But at this stage, we are targeting these services to be provided purely by child health nurses.

Hon ADELE FARINA: The budget papers indicate that it is intended to make these additional community child health positions available through the not-for-profit sector. What I would like the minister to explain is how this will work; how continuity of service and standard of service between

the government sector and the not-for-profit sector will be assured; and how duplication, or people accessing both services, like double-dipping, will be avoided.

Mr Aylward: The actual service delivery model, in looking at the needs of children in all different areas, has got to be worked through with the NGO providers and ourselves. We plan to hold meetings with what we see as key NGO providers, and other stakeholders, over the next two to three weeks, to sit down and talk to them and work through what it is that they can provide in terms of increasing what will be a 50 per cent uplift and increase in nursing resources in this space. Clearly, the avoidance of duplication is going to be crucial to those discussions, as will the transfer and exchange of information as well that is pertinent for continuity of care. None of these things we think will be insurmountable, and it is part and parcel of what we do in other sectors. A good example is how we work in collaboration with the not-for-profit and NGO sectors in the provision of child development services at the moment, and that is a mix of both professional staff that we employ and professional staff that other NGOs employ, and it has been for us a highly successful partnership.

Hon ADELE FARINA: Is there any intention by government to shift all community child health nurses from the government sector to the not-for-profit sector?

Hon HELEN MORTON: I think that is a policy question and I do not think the agency would have the answer to that.

Hon ADELE FARINA: No, but you should have it, minister.

Hon HELEN MORTON: No, I do not have it either. On behalf of the minister, I do not know the answer to that.

Hon ADELE FARINA: Can you put that on notice then, please?

[*Supplementary Information No C7.*]

The CHAIR: I might go with one more question to Hon Adele Farina and then I will change.

Hon ADELE FARINA: My next question is: how many additional community child health nurses will be made available to the south west?

Mr Aylward: There are approximately 100 child health nurses to be allocated across the metropolitan and country areas. The precise allocation in terms of towns and locality has yet to be worked out. We are going to focus on the areas of greatest need and where we have the greatest potential to close the gap, particularly around achieving the screening milestones that we want to deliver upon and ensuring that we can meet our obligations in ensuring that we have comprehensive care provided in this space.

[5.00 pm]

Hon ADELE FARINA: When will those decisions be made and how do you allocate a funding figure without having actually figured some of this stuff out already?

Mr Aylward: We certainly allocated, notionally, a split between the whole of the metropolitan area and country areas based on population. I think that is a reasonable basis, and has been a reasonable basis, to go forward on. Decisions about specifically where individual child health nurses will be placed, in some regards, will determine the types of NGOs and partners we will get, but I envisage that that will become available over the coming months.

Hon HELEN MORTON: I ask the director general to make some additional comments on that.

Mr Snowball: Part of the process we are on now, following the budget being brought down, of course, is to firm up our service agreements with all the area health services, including the WA Country Health Service. The service agreements will include activity at our hospitals and where the new investments go. That will occur over the course of the next four to six weeks. We will then

have a more definitive response to say here is what will go to the south west and here is what will go to the north west or the metropolitan area.

Hon MAX TRENORDEN: I thought that it would all go to Northam!

Hon ADELE FARINA: I will make a pitch and say that not one additional child health nurse has been provided to Bunbury for perhaps 10 or 20 years, so I am looking forward to a significant number of additional child health nurses be being made available to the South West, reflective of the enormous population growth we have experienced in recent years.

I would like just one more question, please. This arose out of the budget estimates hearings in relation to education when I asked questions about the new Carey Park parenting centre and was told that a community child health nurse would be provided as part of that parenting centre. When I asked whether that would be one of the new additional community child health nurses to be made available under the budget announcement, I was told, no, it would be a community child health nurse existing within the service that was being relocated from a community centre to Carey Park Primary School. I was told that the decision as to which position that would be would be made by the Department of Health. My question to you now is: how many community child health nurses will be made available at Carey Park parenting centre, where are they coming from and why are they being relocated out of the community where we have a shortage already rather than additional nurses?

Hon HELEN MORTON: Mr Smith.

Mr Smith: I am expecting that the community child health nurses will come out of our child health facility. Your question around the need is a particularly good one, and that is the process we will go through now that we have this funding committed and we will actually do the prioritisation. Carey Park has obviously been chosen because the concept of having a joined-up service is attractive to all the agencies to deliver a better service. I do not think there is a problem with the philosophy. We will work with our individual staff to see which ones want to relocate to that facility and we will do an assessment of need and see whether another new person will come in and whether they will do that and what they were doing elsewhere as part of their normal duties.

Hon ADELE FARINA: But we actually need additional community child health services in the South West; shuffling the deckchairs on the *Titanic* does not stop it from sinking.

Hon LINDA SAVAGE: I would like to ask questions in regard to the $58.5 million. Perhaps to begin with, a point of clarification. I understood Mr Aylward made the comment that the funding was solely for child health nurses. I would like him to clarify whether we are including in child health nurses also school nurses or whether when you talk about child health nurses you are talking solely about the 150 child health nurses we are short of that provide the seven tests up until school entry.

Mr Aylward: Certainly the increase in funding of 100 child health nurse FTEs will deliver us a 50 per cent increase in staffing across the state, so it is quite a substantial increase. The investment does relate solely to child health services, as defined through the provision of screening services, but also a whole gamut of very important services that child health nurses provide to parents and carers in the early years of a child's life. The number that also is thrown about for this investment will be comprehensive and will cover all the areas where we think we can make a difference. Bearing in mind that in terms of child health screening, not all the screening is undertaken by child health nurses, as you would be aware. Some of that screening is provided by other primary care providers. As screening is not compulsory, a lot of parents who have had multiple children decide to opt out and not avail themselves of those services. We are very confident that this investment will provide a very significant improvement in the screening rates across the state.

Hon LINDA SAVAGE: I am very glad to hear that because a press release went out on 17 May that referred to the fact that the additional $58.5 million would be for additional child and school

nurses, so I am pleased to hear that it is just child health nurses. Although it is not in the budget papers, in press releases and in the budget at-a-glance pamphlet it does refer to the figure of 100 over the next four years. Minister, can you give an undertaking that at least 25 additional child health nurses will be employed in the next financial year?

Hon HELEN MORTON: Mr Aylward.

Mr Aylward: The opportunity the funding gives us is to provide the ability for us to employ some additional child health nurses immediately from 1 July through state employment arrangements, and then allows us to also negotiate the other components relating to engaging NGOs. In terms of numbers, the phasing is not evenly spread as 25, 25, 25, 25 across the four years of the forward estimates. As my colleague here mentioned, part of the very important work we need to do is match up the areas of highest priority and try to put those resources into those areas first, but we do not have a specific total number right across the years. We will certainly have that available once the allocation has been made to us from the Department of Health in the next month.

Hon SUE ELLERY: You did not do that in your budget bid?

Hon LINDA SAVAGE: I will ask again—and perhaps to the minister—will the minister give a guarantee that at least 25 will be employed in the next financial year, or, if not that, will there be at least one employed in the next financial year?

Hon HELEN MORTON: What I understand about this particular project is that the target is for 25 nurses to be employed in year 1. What you are asking for is a guarantee that the target of 25 will be met.

Hon LINDA SAVAGE: At least an additional 25 child health nurses, not school nurses, to be employed in the next financial year. I wonder if I could perhaps ask that as a supplementary question to go to the minister —

Hon HELEN MORTON: What you are asking for is for the minister to give you a guarantee that the target of 25 will be met.

Hon LINDA SAVAGE: If it is the intention of the minister to —

Hon HELEN MORTON: I am telling you right now that that is the intention; I am just not prepared to give you a guarantee that it is going to happen, but it is definitely the intention.

Hon LINDA SAVAGE: Could you alternatively put that there will be at least 10?

[5.10 pm]

Hon HELEN MORTON: I am sticking with the target figure of 25.

Hon LINDA SAVAGE: I ask this not because I am being flippant; there is a high expectation, given the shortage, and 100 over four years does lead, I suppose, to an expectation having been set up that there would be at least 25 in the first financial year.

Hon HELEN MORTON: I will just stick with the target of 25.

The CHAIR: I think if the member wants to put a question on notice to the Minister for Health —

Hon HELEN MORTON: Sounds like it, but it is hard to know what precisely she is asking for, over and above the information I have already given her.

The CHAIR: Yes, I am just seeking clarity there. Perhaps you would like to rephrase what the question is.

Hon LINDA SAVAGE: My question is: will there be at least an additional 25 child health nurses employed in 2012–13?

[*Supplementary Information No C8.*]

Hon HELEN MORTON: Okay, but I know that the answer is that that is our intention.

Hon LINDA SAVAGE: I have lots more questions on this topic. In light of the promise then for there to be approximately 100 additional child health nurses over the next four years, has advertising started to employ additional child health nurses?

Mr Aylward: Certainly, we have had an internal project team that has been developing job descriptions and putting in all the necessary arrangements to see a very rapid advertising process and recruitment process. Our assessment of the workforce and testing of staff is that there is a ready workforce available that will take up permanent positions within Health. So, no, we have not sort of physically pressed the button on the advertisements; we cannot actually yet because the final funding arrangements have not come through in a technicality, but we are ready to go from 1 July.

Hon LINDA SAVAGE: Just to follow up, because I have got in front of me on the online Department of Health website to 31 May 2012, four advertisements, or four positions, for child health nurses ranging in salaries from $66 000 through to approximately $72 000. So are you saying then that, given that the commitment is to significantly increase that number, you will not start advertising that process until after the beginning of the new financial year?

Mr Aylward: We can start the recruitment through the issuing of temporary contracts, because we do have a network of nurses that work for us in the metropolitan area. Maybe my colleague will want to talk about the country in a minute. We can readily bring them on board from 1 July. The broader recruitment campaign is ready to go and we will be using nursing recruitment pools to allow us to increase the workforce in a fairly rapid way. I think we have demonstrated in the past our ability to gear up and make sure we have nurses on the ground and other clinicians in a fairly quick way. To the extent that now we are in early June that we are going to have advertisements out before the end of the financial year, probably not in relation to this, but it certainly will not impede or inhibit our ability to get nurses in a timely way.

Hon LINDA SAVAGE: So how long would it normally take between the placing of an advertisement and bringing a child health nurse on to begin to provide the service?

Mr Aylward: I guess it would depend on whether they have to be released from somewhere else, but I would consider between six to 10 weeks would be the time period of recruitment from placing the advertisement.

Hon LINDA SAVAGE: Bearing that in mind, when do you think that we will see some of these additional child health nurses in the system—before the end of the year?

Hon HELEN MORTON: I ask the director general to make a few comments.

Mr Snowball: In terms of the timing for recruitment, it needs also to align, of course, to where they are going, what are the accommodation arrangements, so you are doing some of that preparatory work first before you get somebody obviously into those positions. But, as the chief executive has explained, they are ready to go. It is really a case of make sure we decide what the priorities are; in other words, the first 25, if you like, as our target, go to the most at-need and at-risk areas, and we are able to accommodate them quickly and get them working quickly.

Hon LINDA SAVAGE: Thank you. Last year I asked a question in estimates about the percentage of the child and adolescent health service budget that was going to child and adolescent community health services. So, again, do we know yet exactly what child and adolescent health services will be receiving in this budget—the exact amount?

Mr Snowball: Once the budget is brought down, we go through a process with all of the area health services and the department and basically allocate the resources against the activity, need and, of course, what is committed in terms of the appropriation. That process is underway now. It will not be finalised, though, until probably late June, but I am hopeful that we will have budgets for all of our area health services by 1 July and that will be very clear.

Hon LINDA SAVAGE: So you think that that allocation will be available late June as to what the amount of the child and adolescent health services budget will be?

Mr Snowball: That is right. That process will then give you a clear picture of the funds that are going to the child and adolescent health service for the provision of those services including child health services. From that, you are clearly able then to work out a percentage.

Hon LINDA SAVAGE: So is that information that could come back to the estimates committee—the amount that will be going into child and adolescent health services for 2012–13—or is that a question that I need to ask? Because last year when I asked, it took until September, I think, to get that answer.

Hon HELEN MORTON: Again, that is a question that you can ask of the Department of Health any time after —

Hon LINDA SAVAGE: And that would be probably available in the early part of the new financial year. Thank you.

The CHAIR: Sorry, member; I am mindful that I said we would take a break for 10 minutes at quarter past, and it is quarter past now. I indicate that I have the following people on the speaking order, so you know I have not forgotten you. Next is Hon Max Trenorden, Hon Jim Chown, and then I have got Hon Sue Ellery, Hon Ken Travers, Hon Liz Behjat and Hon Phil Gardiner who have indicated that they have further questions.

Hon LJILJANNA RAVLICH: And me!

The CHAIR: And Hon Ljiljanna Ravlich. I am sorry. I will put Hon Wendy Duncan somewhere a little bit up that list because I did not realise that she was seeking the call. We will adjourn for 10 minutes.

Proceedings suspended from 5.17 to 5.27 pm

The CHAIR: Hon Max Trenorden has the call.

Hon MAX TRENORDEN: First of all, I will make a statement. I want to put on record my appreciation of your efforts, minister, in my patch in the past, and particularly yours, director general, in my electorate over the past. It is fantastic currently, and there are pages of activity in my electorate popping up in the budget and I really appreciate that significant change. I just want to say that both of you put personal effort into that prior to your current positions.

Minister, can the health department assure this room that when the annual report comes out, it will not be qualified?

Hon HELEN MORTON: The director general can answer.

Mr Snowball: I cannot speak for the Auditor General, but obviously —

Hon MAX TRENORDEN: What I am really saying is: have you got some things you are worried about?

Mr Snowball: We always worry about things, but I am confident we have a very strong team here. Where issues are identified through audits, we respond as quickly as we can when those issues are identified or unknown to us. We have a very strong internal audit program as well, through which we continually look at areas of risk. We are a big system of 40 000 people, over 100 hospitals, and a big spend in terms of $6.7 billion. So, yes, there are risks in our system, but the answer to that is that we are certainly responding to those risks with good risk-mitigation programs, but also responding when issues are raised with us.

Hon MAX TRENORDEN: I asked that question because over the years you will be aware that, historically, the health department has not been flash, and being that the health department is one of the major agencies, it would be good to see that actually occur. I wish to ask a question about the

dot points under "Preparing for the Opening of the Fiona Stanley Hospital" on page 130 of budget paper No 2, which are about your patient administration system. Could you please tell me what the total cost of developing your current IT system has been to this date? Minister, if it is not instantly available, I am happy to get it on notice.

Hon HELEN MORTON: This question was expected, Hon Max Trenorden.

Hon MAX TRENORDEN: Fair enough.

Hon HELEN MORTON: So while one person is looking for it —

Hon MAX TRENORDEN: I can ask the next question, if you like.

Hon HELEN MORTON: No, I think the director general wanted to make some general comments about it.

Mr Snowball: The patient administration system has been a long time coming for Health. This system is designed to replace what called is called TOPAS in the metropolitan area and HCARe in the country —

Hon MAX TRENORDEN: That is the one I was thinking of.

Mr Snowball: — to the extent right now that in fact patient information cannot easily be transmitted between hospitals, to the extent in fact that when we transport a patient, they have their records essentially on their chest as they are transported. The patient administration system will allow for communication across our hospitals and access a whole range of clinical systems. Once you have that patient record—it has a unique identifier—you will be able to draw on all the diagnostics, past presentations, and all the information around our hospital presentations for that individual. It is a big step up. It is already operating and live at Fremantle Hospital, synchronised with TOPAS. Basically, it is live testing, it is running now, and it includes a whole range of other features that our old TOPAS does not have. We are very keen to see this rolled out very quickly right across our system. It will be the system that sits at the heart of the new Fiona Stanley Hospital and the new Albany Hospital, when that is finalised; so they are the two big ones to come. It has what is called a unique health identifier contained in it. That allows us to record information once on a patient, not multiple times, which currently occurs as you move through a hospital system.

Hon MAX TRENORDEN: It is obviously critical. On that point, director general, are you confident that that system will be available by the time Fiona Stanley Hospital opens?

Mr Snowball: We are very confident. There is a critical path for its delivery, and now that we have tested it and got it live running at Fremantle Hospital, we are actually able to hand it over fairly quickly to the Fiona Stanley Hospital team so they can start to connect it up as well with all the support services that are going to be provided at Fiona Stanley through Serco. That system, again, will be the heart of the arrangements within Fiona Stanley, and they are absolutely on track to deliver that outcome in terms of the patient administration system.

Hon MAX TRENORDEN: Do we know the answer to the previous question?

Hon HELEN MORTON: It would be appear that we do not have here the total figure you are looking for. You are looking for the cost of the total —

Hon MAX TRENORDEN: The total cost from design to current.

Hon HELEN MORTON: We do not have that. We will take that on notice.

[*Supplementary Information No C9.*]

Hon MAX TRENORDEN: You might want to take a couple of others, too; I have about four or five questions, Madam Chair, and then I will finish.

Who designed the IT system—all parties? I know there is an internal group, but who were all the parties that consulted internally—including Treasury—who designed the system?

[5.30 pm]

Mr Salvage: It has been a fairly long endeavour for Health. The main contract for the delivery of the PAS system is with a company called iSOFT, and there have been user groups principally around the Fremantle Hospital, where we have put the system in place first up to make sure it works in the hospital setting. The delivery of the program is through our health information network, which is part of the Department of Health, and there has been strong engagement with procurement agencies of government and certainly with Treasury in relation to the delivery of key milestones in implementing webPAS.

Hon MAX TRENORDEN: Anymore?

Hon HELEN MORTON: Some additional information.

Mr Snowball: This particular product was coming out of iSOFT. It is the responsibility of our own internal team to deliver and implement it. It has to do two things. It has to be capable of talking to all our clinical systems, and there are about 22 of them that have grown up over time. Our internal team is the one that ensures all those connections work and are effective. Secondly, while we put it through this phase, it must be connected and synchronised with Topaz, so if something untoward happened with it at this testing stage, you do not lose all the important health information. In terms of the procurement processes we have gone through, we have a very clear contractual arrangement with iSOFT that has gone through central agencies for validation and to ensure we have ticked all the boxes. Ultimately, it is in Health's hands to see it implemented right through our system.

Hon MAX TRENORDEN: The reason I asked the question was that just before you came in, there was another group and we talked about a little failure of what is called Shared Services. I have some nerves about IT procurement within the Western Australian government. I want to know who are the players in all this. My next question is: who won the contract?

Mr Snowball: If I can add a little to that, now you have asked further to that question, we have had an expert panel evaluate all of Health's ICT strategies and priorities that comprised interstate and overseas experts to provide that overview for us. That overview was provided to ourselves, Treasury, Department of Finance—all the key groups—to say, "What are the risks for government in moving to these; do we have capacity; do we have the wherewithal to deliver on what we are saying needs to be delivered; is the ask appropriate for what we are seeking to deliver for the state?" In terms of oversight to make sure we have got that stuff right, that was the external review of that process. Under the health executive group, I have also established a subgroup focused specifically around ICT in terms of what it is delivering and what its processes are to identify the priorities and strategies. So in assuming that part of the question is that there is a risk around ICT, yes, there is—so a lot of the effort of the department is to remove that risk as far as we are able in terms of external review and our own internal organisational arrangements to elevate ICT on the agenda for this health leadership team.

Hon MAX TRENORDEN: You and I had a conversation about that a while ago, so I understood that was happening. Who won the contract?

Mr Snowball: iSOFT won the contract.

Hon MAX TRENORDEN: They designed it and won the contract?

Mr Snowball: No; several other contractors are involved in this project. iSOFT was the developer of the software, so it is a package designed by iSOFT that is in place in other states as well. We did not design and build a purpose-design-and-built system. We looked around at what systems were working elsewhere that we could pretty much adopt without doing all the build and design of our own system. That was a change from where we were some years ago, which was trying to design a specific system for Western Australia. We looked more broadly and got a product that is already on the market. But the contract with iSOFT includes some variations to that product to accommodate our specific issues in Western Australia. The basic product is out there in other hospital systems in

other states and in the private sector. That is what they won the contract to provide—as well as working with us to add those modules and other changes to make it work in our hospital environment in WA.

Hon MAX TRENORDEN: It sounds awfully like the start of Shared Services. I am not going to pick you on that. We will worry about outcomes and not the journey, but that is precisely how Shared Services started with Oracle. We will watch your development and I hope you can smile at me and tell me when Fiona Stanley Hospital opens that the process is working. I gather that the same individual will therefore maintain the contract and do any technical changes to it?

[5.40 pm]

Mr Snowball: The contract itself has maintenance components to it, yes, as you would expect, but also Health essentially takes ownership of that product so we are not continually paying licence fees and the like for it. It is all contained within that total contract.

Hon MAX TRENORDEN: Even though you are supplying me the answer on notice, is it running above expected design costs?

Mr Snowball: It is working to budget. We are satisfied we have a product that works —

Hon MAX TRENORDEN: I am really talking about when it was set down, when the concept and design was put together, and the projected costs at that time—is it running to that cost?

Hon HELEN MORTON: Sorry, Hon Max Trenorden; we are having a little difficulty working out precisely what you are asking for. Are you saying: is it tracking against projected costs?

Hon MAX TRENORDEN: Yes—the original design cost.

Mr Snowball: We have revised the actual —

Hon MAX TRENORDEN: Another word that makes me nervous, director general!

Mr Snowball: Some time ago, as you may recall, we had an initial allocation for the design, build and delivery of a patient administration system. Having got to this point, at the time we revisited what we were getting in terms of delivery out of a patient administration system, that is where we then took the view we were better off looking at a product that is already out there and operating in the market. That is what we now have. We are no longer designing and building our own, which has a different budget construction to it, to the one where we are buying a product already in the market and amending it to deliver what we want to do with it. The price tag for that—the budget that was assigned to that—we are on track and within that budget.

Hon MAX TRENORDEN: I want to be sure that we are talking about the same thing. My understanding of what you are talking about is that your own team will design your own program, which is what you were discussing; I am talking at that stage, not at the time you decided to go for the current program. I am talking about from the time the health department—before the time you were director general—decided it wanted to take this program on. That is the timing I am talking about. I know you have changed the program in the meantime, but we deserve to know what have been the costings and the movements in that process from the time the concept first arrived four or five years ago or whenever it was.

Hon HELEN MORTON: Madam Chair, what we are going to do is take that on notice and provide the details from the start.

Hon MAX TRENORDEN: I am happy with that.

Hon HELEN MORTON: The expectations of cost and where it is now.

[*Supplementary Information No C10.*]

Hon JIM CHOWN: My question regards the southern inland health initiative. I refer to pages 131 to 132 of the budget. The question relates to your program of recruiting doctors into the footprint of

the initiative. I see here you have found seven doctors for certain areas in the agricultural area, especially. How many vacancies exist for GPs, how do you intend to fill them, and how is the program going in regard to recruitment?

Mr Snowball: I will ask my colleague from the WA Country Health Service to elaborate as well. In terms of total vacancies across country WA, you are looking at around 90, but, of those, they are by and large filled by either locum or agency, or other arrangement. They are not vacancies as in there is no-one there but they are not permanent —

Hon JIM CHOWN: They are not permanent either.

Mr Snowball: That is right. There is not a permanent doctor in those areas. What the southern inland health initiative does for us is set up a much more attractive model for doctors to go into particularly those inland country towns which have been so difficult for us to fill. We are seeing that is much more attractive, as you have described. We have already got additional doctors. There are almost 45 doctors in the pipeline—they have shown an interest in it—mainly from the United Kingdom. We are seeing quite a bit of traction now. There is a different model and it is more financially attractive now to practise in those inland centres.

Hon JIM CHOWN: On the same subject, you are indicating there is a possibility that half of those vacancies, for want of a better word, will be filled if 45 applicants come from the UK through the recruitment program. How do you retain them in the area? If they arrive, what sort of contractual arrangements do you enter into to ensure they remain in situ?

Mr Smith: The payment regime, the incentive, we have, these are all about keeping the private GP practices viable in these areas so they do not come in and become employees of the state. To participate in the district emergency department roster, there is a significant payment of $40 000 a year, which really makes it very attractive for them to be part of the team which is delivering emergency care, and with the other doctors in the town. It has had the benefit of actually getting many of the doctors to join up who were previously operating as single-town doctors in isolation from one another. This model, having $40 000, is allowing those doctors to come in, and to participate with the nurses and other people to do joint training and have some good clinical governance around the quality of care that is actually being provided. That has underpinned that process. There is also a payment there to encourage those doctors to have outreach services to the smaller towns as well and to maintain primary health care services. It is to incentivise those GPs to go and then bill Medicare in the smaller towns and provide continuity of service. In addition, we also have a payment regime for GPs who are proceduralists, so either providing obstetrics or anaesthetic cover to the main district centres—which is the only places we would be doing that type of work. They get an additional payment as well to encourage them to come and stay.

Hon JIM CHOWN: This $40 000 you are talking about, who actually pays that?

Mr Smith: WA Health.

Hon JIM CHOWN: The WA government; okay. How does that mean they are retained within the area they are employed for?

Mr Smith: That payment is to participate on the roster. There is an additional payment as well for them to actually be on the floor either 24 hours a day—not constantly 24 hours a day—but to have medical coverage on the major sites all the time or within immediately close call, as in within no further than five to 10 minutes away. That guaranteed service in Northam, Narrogin, Katanning and Collie—the range of sites—as they are getting that level of payment, it means they do not have to then open their practice the next day if they do not want to. They are far more responsive to servicing the emergency needs that we have in our major district centres.

Hon JIM CHOWN: I am glad you mentioned obstetrics because in your recruitment program I assume you would have a percentage of specialists as such that you would try to encourage to come into the area. What sort of ratio do you have between GPs and specialist doctors, because, for

example, there is a dire need for obstetrics at Katanning; they have virtually closed down the maternity ward.

Mr Snowball: There are two parts to that. One is Western Australia relies quite heavily on GP proceduralists to provide obstetrics and anaesthetics. In fact, in Western Australia, of our rural GPs, 25 per cent have proceduralist skills. The national average—other states—is around 12 per cent. When you say, "What is the ratio of specialist to general practice?", you have got to acknowledge and count the GP proceduralists in that as well because they will deal with the large bulk of deliveries and anaesthetics in those centres that they are able to accommodate. Others of course ultimately rely on metropolitan specialist services where you need to go to a tertiary facility for that service. We operate very much as a network. Generally speaking, you will see anywhere between 50 and 70 per cent of hospital services can be provided in their local hospitals, with GP proceduralists essentially the backbone of that service. The specialists generally operate out of the larger centres where you have economies of scale and size.

Hon JIM CHOWN: Sure—Northam, Narrogin and Katanning.

Mr Snowball: That is right. You have to imagine, too, we are trying to recruit new doctors. What are the new breed of doctors looking for? Often, they are not looking to work alone. They are much keener to be working in group-type practices. The approach the chief executive of the WA Country Health Service outlined provides that kind of group practice and support.

[5.50 pm]

They are not on call 24/7 in single doctor towns any more. They are on call less often, but they are busier when they are on call. They can get away, take their family and have a weekend off and go to the city or whatever they want to do. That is making practice much more attractive. At the same time, from a community perspective, you are now guaranteed that you have an emergency service and a doctor available to you at that centre, and there is much more of a guarantee you will have GPs through your centre. Notwithstanding that, we can still have issues with particular locations in this state. Although all those broad things are happening, we will still have areas where we run into risk. Katanning is an example of that. But we are not prepared to offer a service that is not a safe service; we have to guarantee the safety of those services. We are obviously doing everything we can to recruit, support and re-establish those services in Katanning.

Hon JIM CHOWN: The southern inland health initiative has been underway for about 12 months now. It had a bit of a rocky start, which is what I am hearing from my electorate, but it seems to be travelling reasonably well at the moment. I refer to infrastructure programs on page 131. What sort of expenditure are you expecting on residential aged-care and specialised dementia areas, which is a significant issue in rural Western Australia?

Mr Smith: The budget process allows for a $20 million capital contribution to improve aged-care services.

Hon JIM CHOWN: Is that this year or over the five-year program?

Mr Smith: On the cash flow, it will be in the last couple of years, not in the first two years, because we will need that amount of time to deal with the shires, the communities and everyone else on the best place for that funding to go. The intention with that money is to try to sponsor a private aged-care provider to come in and deliver those services, which is the commonwealth's responsibility but which the state is doing. It is actually a bit of seed funding to see if we can get a better solution in some sites. So we have not progressed that at this stage, to take the member's point; we have put all our focus in the first year on getting the additional primary health care practitioners in place and also getting the doctors in the pipeline to fix that workforce shortage.

Hon JIM CHOWN: I wonder how you assess the spend on some of these district hospitals et cetera. For example, $45 million of expenditure has been allocated to the Katanning Hospital.

Having visited it a number of times and talked to staff there, a lot of people locally and professionally do not believe that expenditure is required.

Mr Smith: The first part of this process is completing the service planning. So we are doing the profile of what that community is going to need.

Hon JIM CHOWN: That announcement to spend $45 million at Katanning Hospital has already been made.

Mr Smith: I appreciate that. I was trying to describe the process we are going to use to determine what will be spent on the priorities within that $45 million and what are those services that are going to be most at need. The other part of that process is that we are just conducting a condition audit of all the facilities in that southern inland area—we do not have the results back yet—which will give us a good indication of how much of this money will have to be spent to upgrade the basic infrastructure—electrical and whatever—to make sure the buildings are suitable and fit for purpose, for whatever the purpose is in the future going forward.

Hon WENDY DUNCAN: I will just follow on from Hon Jim Chown on the southern inland health initiative. I note, and you have already advised, that there has been an audit of the infrastructure throughout the area. Can you tell me whether any of the capital will be spent on the Menzies nursing post?

Mr Smith: No, I cannot at this point. The original allocation was for $104 million for the smaller hospitals upgrade and refurbishment. We used some fairly blunt measurements to get that number nominated at the beginning of this program. Until we get that condition audit to get an understanding of how we can maximise the use of the money for the benefit of all those sites, I cannot tell you what the quantum will be or where it will go.

Hon WENDY DUNCAN: I will continue on from that. Under the southern inland health initiative, how much has been spent on the recruitment of nurses and nurse practitioners? With that in mind, is there an intention to staff the Menzies nursing post with a full-time nurse?

Mr Smith: At the moment we think we have spent around $80 000 on the recruitment of the nurse practitioners. The intention is to have 11 nurse practitioners, of which seven will be in the emergency departments and four would be primary health care nurse practitioners. Of the four for primary health care, one has already been contracted via Silver Chain for Merredin, so that has been quite successful. The second half of your question was around the Menzies nursing post. We have had some difficulty staffing that since the occupant left in December. We have a drive in, drive out service at the moment, which is not satisfactory for anybody, and we have to find a solution to getting a long-term permanent appointment there. That has not affected that process; that is just one of those difficulties we constantly have in remote sites in maintaining staff in some of these facilities and environments.

Hon WENDY DUNCAN: In relation to the community child health initiatives—congratulations on that excellent initiative—I note that you said the division of those resources will be between regional and metropolitan areas according to population. Is that division based on the number of nurses or is the funding divided according to population? I guess the issue I am getting at is that it costs more to place a child health nurse into a remote place, so if you divided the number of nurses up according to population, you might find that it is not the same cost-wise, if you get my drift.

Mr Aylward: The division of funding allocation between metropolitan and country was derived both on issues of population, gaps in service provision and, of course, recognition of the extra cost associated with provision of those services, which far outweighs the cost of providing those services—as those who operate and work in the country are well aware, whether it be accommodation or other things. The calculation at this stage has attempted to take into account all of those factors. The final resource allocation will be undertaken, as the director general has already said, over the coming weeks and probably month; but the initial bid was using those criteria: basis

of need, population, and the cost of providing those services, and in particular staff in very remote areas of WA.

Hon WENDY DUNCAN: I refer to “Patient Transport” on page 139—the jargon name escapes me. I have had it brought to my attention that one of the biggest challenges when trying to send a patient out of a regional or district hospital to the nearest large hospital or to Perth via the RFDS is that often the doctor is also trying to phone the RFDS and undertake all those management issues as well as deal with the patient. Has any funding been allocated to put in administrative services to help manage the movement of patients out of hospitals?

[6.00 pm]

Mr Smith: There is a project that we are undertaking, and have for the last eight months, about improving our clinical care coordination for patients. That was an internally funded arrangement where the WA Country Health Service decided that we needed to see if we could find a better way of ensuring that doctors could focus on treating the patients whilst at the same time dealing with all the other arrangements for getting those patients to where they are going to end up and all the care that is required. That is still in progress, and that actually will not be finished until the end of the year, and we will then have a very good understanding of what we need to do in the future to get a better system for those patient outcomes. The issue here has been driven by one of our emergency specialist doctors, and he is doing a lot of consultation with the metros and the RFDS and St John Ambulance to design a model that will allow us to have a seamless process that hopefully should improve the patient’s journey.

Hon WENDY DUNCAN: Excellent. Thank you. I notice that on page 144, towards the bottom, you have an item relating to strengthening cancer services, and you itemise several regional locations there. Could you give me some more detail as to what those services are and how they will be delivered, in particular in Kalgoorlie, of course, which is of interest to me?

Mr Smith: This is a contribution from the commonwealth government, and it is predominantly around improving chemotherapy services and providing us with a facility and a building to join up all of the cancer services in those communities to work out of the one co-located environment. So that is what it is. It is not about the recurrent funding for delivering more services. It is actually a building solution, which will allow us to join up with services in those regions.

Hon WENDY DUNCAN: Thank you.

Mr Snowball: In terms of more specifics around that, this will provide for 28 chemotherapy chairs and 21 accommodation places for patients and carers at Albany, Geraldton, Kalgoorlie, Northam and Narrogin. So this is actually about providing access to chemotherapy services closer to where people live. As you can appreciate in terms of these programs, after you have had chemotherapy, and the nausea that goes with that, the last thing you want to be doing is travelling. This provides those sorts of important services much closer to where people live.

Hon KEN TRAVERS: I want to ask some questions regarding the issue of replacing fabric sheets with paper sheets. Can you tell me where, particularly if it is at Sir Charles Gairdner Hospital, as an example, but it may apply elsewhere, you currently use paper sheets in clinical procedures?

Hon HELEN MORTON: Can we have a page number, please?

Hon KEN TRAVERS: Yes. It is actually page 127, major spending changes, efficiency dividend, $94.225 million to be saved.

The CHAIR: Touche! Minister, the ball is in your court.

Hon HELEN MORTON: The director general will obviously put that to bed.

Hon LIZ BEHJAT: No pun intended!

Hon KEN TRAVERS: Yes, but what type of sheet will be on the bed, minister! That is what we want to get to!

Mr Snowball: As a system, we are constantly, obviously, looking for ways in which we can improve our services to patients. We actually use quite a lot of disposable linen in our system in terms of our theatres and so on. This particular issue that was raised in the media recently was an evaluation of other products that are now coming onto the market, to say, "Is this something we want to be using in our hospitals?" There was a working party formed, particularly at Sir Charles Gairdner Hospital, to have a look at and evaluate that and come forward with a recommendation for the executive. So, no decision around it, but it is pretty normal practice for us to explore these new products as they come on the market.

Hon KEN TRAVERS: Yes, and that is why I was asking. My question was actually: where do you currently use paper sheets in the clinical sections; are you able to tell us where you currently use them?

Dr Russell-Weisz: From a Sir Charles Gairdner Hospital point of view, we do not currently supply any wards and departments with disposal bed linen or patient gowns. All clinical areas use normal linen for beds and patient clothes. We do keep a contingency supply of some disposable items in case of laundry breakdown, potential industrial action or any other emergency situation, as any hospital would do. The theatre does use disposable drapes, and they changed over from linen last year, as is the industry standard. All three tertiary sites have actually changed over to disposable in theatre, and we would have the same sort of disposable for emergency situations. But we are not changing over onto the ward or any other areas.

Hon KEN TRAVERS: So you do currently use them in the ED department—is that what you are saying?

Dr Russell-Weisz: No. We have a supply if we need them. We do not use them, but you never know what happens; we obviously have to have emergency supplies.

Hon KEN TRAVERS: So outpatient clinics and those sorts of things—you are not using them in any of those? So it is only in the theatres that you currently use them on a regular, ongoing basis?

Hon HELEN MORTON: The director general.

Mr Snowball: There is routine use of paper materials, particularly in outpatients where there are examinations and so on. I am sure that if you go to GPs and others and there is an examination, you will find that for hygiene for the next patient, and for your own benefit as well, there is usually disposable material used in association with those examinations. So it is pretty routinely used, particularly in environments where you want to keep hygiene and prevent soiling.

Hon KEN TRAVERS: That is why I wanted to find out where they are currently used. I am trying to get a list of where they are currently used.

Mr Snowball: They are used in all sorts of settings in different ways. That includes outpatient settings, emergency department settings, wherever there is diagnostics, whether it is examinations, radiology, theatres. So it is part and parcel of our hospitals. In fact, whilst adopting the disposable linen in our theatres, for example, fairly recently, other hospitals—many of the major teaching hospitals—have done this five and 10 years ago. So really it has been a routine use across hospitals for a very long time. This was a particular review, though, that was focused in on wider use of a particular product that has come on the market.

Hon KEN TRAVERS: What products was the review looking at, and in what locations was it looking at using them?

Dr Russell-Weisz: Really, initially it was just an overview of where we could potentially use these. It never got down to any intricate detail, because in the initial stages of this review we found that we wanted to continue the same practice that we had on the general wards and the same practice that

was going on in the emergency department and radiology and the areas the director general has outlined—that was the practice we wanted to continue with. So we have not actually made any changes over the last few weeks in relation to that.

Hon KEN TRAVERS: No, I am not asking about whether you have made any changes. I am asking about what areas you have examined and what products. The director general just referred to looking at different products. So what were the products you were looking at, and what areas were you looking at whether or not they would be suitable?

Hon HELEN MORTON: It would appear that the member is looking for a level of detail that is not here at the moment, so if you were wanting that level of specific detail, we will take it on notice.

Hon KEN TRAVERS: If is not here today, I am happy to have that taken on notice.

Hon HELEN MORTON: Can I just confirm that what you are looking for is the different types of products that were being considered—or reviewed, rather?

Hon KEN TRAVERS: Yes, and in what locations were they being considered?

Hon HELEN MORTON: And in what locations they may or may not have considered?

Hon KEN TRAVERS: Yes, and whether or not any modelling was done of the savings that could be achieved by using that product.

Hon HELEN MORTON: I understand it did not even get that far; so the latter part will not be considered.

Hon KEN TRAVERS: And maybe, as part of what you are taking on notice, if you could give us a list, if there is one, of where you currently use paper products.

[6.10 pm]

Hon HELEN MORTON: Can I just confirm, again, looking at the specific level of detail you are looking for, can we take a typical hospital, for example, Sir Charles Gairdner Hospital and talk about it in terms of Sir Charles Gairdner Hospital?

Hon KEN TRAVERS: Yes.

[*Supplementary Information No C11.*]

Hon KEN TRAVERS: The third dot point on page 133 talks about activity for state public inpatients, EDs and outpatients and the increases that have occurred in the 2010–11 financial year. I was wondering when you will have the figures for the 2011–12 financial year and whether you have the capacity to break those down by hospital—so what the increases in each of those three areas are on a hospital-by-hospital basis.

Hon HELEN MORTON: The answer is yes. You are asking me if we are capable of it and I am saying yes.

The CHAIR: It is getting late and I do not think that is a good idea.

Hon KEN TRAVERS: Is it on the website anywhere, minister?

Hon HELEN MORTON: It is.

Hon KEN TRAVERS: Are we able to get it broken down? Do we also have the 2011–12 figures yet, or when will we get those?

Hon HELEN MORTON: Not until the end of the year.

Hon KEN TRAVERS: Do you have a year-to-date figure for 2011–12 of where we are tracking?

Hon HELEN MORTON: It is a year-to-date figure and although—you think it is a joke—it is on the website, too. Are you looking for us to pull that off the web for you?

Hon SUE ELLERY: You do not have it in front of you now?

Hon HELEN MORTON: No.

Hon KEN TRAVERS: My experience is that some of the websites like Health are so large and expansive —

Hon HELEN MORTON: I ask the director general to provide additional clarification on whether this will save you and others the time that you are seeking because that information is already done as a comparison from the previous year's activity, and that information is here—the percentage difference.

Hon KEN TRAVERS: I am particularly interested in Joondalup Health Campus and how that compares with the other locations.

Hon HELEN MORTON: We have those figures.

Dr Russell-Weisz: In relation to Joondalup Health Campus, obviously when the new emergency department opened, it opened with an 18 per cent increase in emergency department presentations. That has been retained. We have seen some spikes of up to 22 per cent over certain months and it has been maintained at around about 16 to 18 per cent. I cannot give you the figures exactly to date for the last month.

Hon KEN TRAVERS: Is that for ED?

Dr Russell-Weisz: It is. I would need to take on notice the current inpatient figures. I would say that is not all translating into inpatient separations. The increase has been significantly more in ED than in the inpatient sector.

Hon KEN TRAVERS: I suspect you would not be able to fit them into the inpatient section of the hospital with an 18 per cent increase in ED presentations at the moment. That takes me to the next point. It strikes me that those figures well and truly exceed the predictions in the "WA Health Clinical Services Framework 2010–20". Are you doing any work to remodel your predictions in terms of the 2010–20 clinical services framework in light of that sort of significant jump? Again, I am particularly interested in the north metropolitan region.

Hon HELEN MORTON: Director general.

Mr Snowball: We in fact remodelled the CSF—clinical services framework—and the population growth in particular last financial year. That increased our predictions around a higher level of population growth than originally had been assessed. As you can see, that statement talks about a growth of 4.6, 8.9 and 7.3 this year so far compared with 2010–11. We have been able to do that within our existing budget parameters. This activity growth has been accommodated within the existing budget, which is based on the CSF predictions. Overall, although there are significant increases across the health system, particularly at Joondalup, we have seen the growth in activity basically right on our CSF projections, which at least gives you some confidence that the CSF is a pretty accurate predictor of activity across the system.

Hon KEN TRAVERS: At the macro level but not necessarily at the hospital level.

Mr Snowball: Correct. What this budget gives us is the funds to deliver the activity globally across the system. Over the course of the next few weeks we will convert that into activity area health service by area health service and hospital by hospital. For example, Joondalup will see a significant response to their activity growth. Other areas have not grown at the same pace. In fact, some have reduced their activity, so it has drawn work away from some hospitals to others. We track that across the system and convert it into their budgets. The budget for this coming financial year will be on activity, ED and inpatients in particular, with a weighted value to that activity so you get a budget that allows you to provide the activity we are expecting to deliver on. Through this activity-based funding arrangement with the government and Treasury, we now have a system that says if across the board we see growth far and away in excess of our clinical services framework, that becomes a trigger for us to basically go back and talk to Treasury in particular and say, "Hang

on, the population is growing faster than our clinical services framework suggested it would and we need to recognise that activity and see some funds follow." That is what happened in the last financial year. We got that adjustment. It flows right through the forward estimates, so it not just in that year. We now have that matching year on year.

Hon KEN TRAVERS: Are we able to get that information provided to us—the updated modelling you have about the projections? You said you have remodelled the clinical services framework. Is that something you can provide to us as supplementary information? I am particularly interested in Joondalup.

Hon HELEN MORTON: I think if you are looking for the modelling system, it is an entire system that does that, but what we can provide you with is the actual outcomes of adjustments against the clinical services framework.

Hon KEN TRAVERS: What I am looking for is in the clinical services framework you have projections out to 2020 of what you expect patient demand to be and their number requirements and the rest of it. I assume that if you have redone the remodelling, I am interested in the new modelling of the future demands for Joondalup Health Campus.

The CHAIR: I have six more members who have indicated they have questions, so I will have to move on and if we have time we will come back to this.

Hon KEN TRAVERS: Can we just get an answer as to whether they can provide that information?

The CHAIR: Fair enough.

Hon KEN TRAVERS: I am happy for it all to be taken on notice. I just want to be sure they are clear about what will be taken on notice.

Hon HELEN MORTON: Dr Russell-Weisz has the information for Joondalup in that form if you want it now.

Hon KEN TRAVERS: I am in the hands of the Chair as to whether we get that as supplementary information.

Dr Russell-Weisz: I can read out some facts and figures of Joondalup to date—as of March this year. They are accurate year-to-date figures about the actual activity and Joondalup's performance, if that is what you are seeking.

Hon KEN TRAVERS: I am happy to have that as supplementary information.

The CHAIR: Is it something that you can table?

Dr Russell-Weisz: Not this as such today because there is additional data, I think —

Hon SUE ELLERY: We want that, too!

The CHAIR: Rats—they are onto us!

Hon KEN TRAVERS: We promise to look after it!

The CHAIR: In the interests of time, I would suggest that we take that on notice as C12.

Hon KEN TRAVERS: What I am also interested in is the modelling in terms of the prediction. Can we have that as supplementary information as well? When do you predict that the current expansion of Joondalup will actually be at capacity again?

The CHAIR: That is all on notice.

[*Supplementary Information No C12.*]

Hon HELEN MORTON: That is supplementary. That is fine.

Hon KEN TRAVERS: If there is any doubt, give me a call and I will tell you what I want.

The CHAIR: Hon Sue Ellery is next on the list but I will, if I could, take the liberty of going to Hon Liz Behjat because she has question on this particular topic.

[6.20 pm]

Hon LIZ BEHJAT: On that clinical services framework and the ABF and the modelling that you do in relation to changes that might happen, is it only just population growth that you look at? What I want to know is—and in that information that you are going to provide to us—have you done any modelling or crystal ball gazing or whatever with regard to what pressures might be placed on our public health system when the federal government stops the 30 per cent rebate on private health insurance as to people that might leave that system to then come into the public health system and how that might affect us in Western Australia?

Mr Snowball: Basically, what will happen as your percentage of private health insurance falls—and there are different models out there about whether or not that will have an impact and how substantial that impact will be. Our CSF includes different levels of modelling and it now includes that one as well, so it includes things like we know we have got too few GPs in this state, about 15 per cent less than the national average, so that has an impact on the department in our ED. We have too few nursing home beds in Western Australia, which in turn sees we have got longer lengths of stay—patients who would otherwise be in residential facilities are in our hospitals. So likewise we also look at the impact of reductions in private health insurance. We can only really do that as modelling predictions at this stage until we can see some real trends, and you will not see those real trends for at least 12 months. Obviously, people hold their private health insurance for up to 12 months until they get a renewal or whenever their renewal becomes due. The broad basic analysis is—nationally this is—for every one per cent drop, you see about $100 million required in the public system. We have one of the highest levels of private health insurance in this state compared to other states, so it will be interesting for us to see just how quickly that percentage actually falls. The private system does an enormous amount of elective surgery, not so much in terms of emergency, so our modelling says there is not going to be a significant impact in terms of emergencies because most of our private hospitals do not have emergency departments, so it is really honed down to medical, obstetric and elective surgery. They do almost 54 per cent of elective surgery in this state. In some areas, like orthopaedics, it can be as high 72 or 73 per cent. So they are big partners, if you like, in responding to elective surgery and other demand in our system. So the short answer is, yes, we do model that but we really cannot give you a firm conclusion until at least 12 months down the track.

Hon LIZ BEHJAT: But if after 12 months down the track there was a spike, that is something you could go back to then on the activity-based funding and say, "You have to give us more money because this is what's happened"?

Mr Snowball: We review our clinical service framework every year, basically, and we do that in conjunction with Treasury and with government. So if there are material changes, yes, we would go back, as we did in that prior year. This year, for example, despite those increases that we have talked about, we have managed to deliver the activity within our budget. We have not had to go back to government and say, "There's been this extra activity, we need more money." We have been able to accommodate it. In fact, one of the good news stories out of this current financial year and last financial year is, in fact, that we have done more elective surgery in particular than we have been funded to deliver. So, that is telling you within our budget settings, we have been able to accommodate more activity through productivity and other measures to actually deliver a better result for the community than was anticipated 12 months ago.

Hon LIZ BEHJAT: Good outcomes.

Hon SUE ELLERY: Budget paper No 3, which you may or may not have with you, page 190, in respect of the capital works review, identifies that $229 million worth of capital works projects have been removed or deferred. Can you please provide a list of each of the projects that have been

deferred or removed, identifying whether they have been deferred or removed, and in each of those cases the rationale that you were able to reach the decision that that could be deferred or removed?

Mr Salvage: I can give you a breakdown of the $229 million to begin with. There are four components to that. There were cash flow changes to a number of projects. These were projects that did not have current business case approvals to proceed, and we spoke earlier in the session about the Osborne Park and Graylands projects, for example, where there was a budget allocation but no approval to proceed with the building until we worked out what we were wanting to do. So across the forward estimates period, that contributed $131 million in savings. These were not project cancellations; these were deferral of projects to a later period in the forward estimates or past the forward estimates period. There was a minor cash flow change of $2.9 million for the southern inland health initiative. Again, no change to the overall total funding commitment, just a repositioning of that cash flow to the post–forward estimates period. The decision to defer the start of a Karratha health campus pushed out $88 million across the forward estimates. There were small tender savings on a couple of projects, accounting for the balance of $6 million. That is the composition of the $229 million that you saw in budget paper No 3.

In terms of the decision-making process, essentially, we looked at those projects which had not commenced in terms of there being a commitment to spend the capital that was available. So there were projects that did not have current business case approvals or current approvals to proceed; they were projects that were still in the planning phase and those sorts of things. The judgement was made that we wished to retain those projects within the overall capital works program, but in order to deliver the savings sought, we would defer the cash flow to a later period. I can go through the projects where that has occurred, if you would like?

Hon SUE ELLERY: Given the time and that there are other members that want questions, I wonder if that is something that you could table, because I just know that there are other members.

Hon HELEN MORTON: What are you asking to be tabled now?

Hon SUE ELLERY: It is a list that he just referred to. He just identified there are further items on the list that he could go through.

Hon HELEN MORTON: I am just wanting to make sure that they are not still subject to decisions, that is all. I think they are.

Hon SUE ELLERY: He knows what is on the list; I do not. So —

Hon HELEN MORTON: Yes, I know. We will not table that paper, but we will provide the information as a supplementary.

[*Supplementary Information No C14.*]

Hon SUE ELLERY: Are there any capital works projects beyond what you have identified in the $229 million that are being considered to be deferred or cancelled?

Mr Snowball: In terms of this budget outcome, this is simply the allocation in the appropriation. It incorporates all the changes at this point. Like any budget process, during the course of the financial year things come and go as well in terms of priorities and so on, so there may be future changes. But this is the budget; this is the allocation.

Hon SUE ELLERY: So the capital works review has completed?

Hon HELEN MORTON: That is always ongoing, is it not?

Mr Snowball: It is, but in terms of what has been brought down in this budget and what is in the budget papers, what you have heard in terms of those projects that are deferred and the basic recommendations we have made to government and the kind of rationale for making those recommendations, ultimately it is a government decision as to what does and does not get deferred, of course in terms of capital programs. So this is a point in time, this is the budget brought down,

this is the locked-in capital program that we have. There is no expectation, I have no direction, that there is further analysis of that, but that is something governments will do from time to time during the course of any financial year.

Hon SUE ELLERY: Sure. Budget paper No 2, "Employee benefits" is the kind of reference. I have not written the page number, but I am sure you will assist me. Can you provide a list with all of the salaries of non-operational staff where those salaries are over $150 000 across the agency—so that is in head office, including in the area health services and any other health agencies? So, it is a list of the positions where the salary is over $150 000 per year, across the department, and what that salary is.

[6.30 pm]

Hon HELEN MORTON: I am going to say that this will not be gathered within the normal time frame that you want responses from estimates hearings. So it can goes on notice, or understand that you need an extension of time to gather that information.

Hon SUE ELLERY: Thank you.

The CHAIR: How long would you estimate you would need?

Hon HELEN MORTON: Nine parliamentary days.

Hon SUE ELLERY: Let us think about that, because I do not want us to go beyond the July break. We have nine parliamentary days, and that means you are committing to get it to me on the last day that Parliament sits. I hope there is not an extension beyond that.

Hon HELEN MORTON: The director general would like some further clarification of what exactly what you are after.

Mr Snowball: It would actually be quite helpful to us to clarify a few things particularly about the $150 000, and particularly about the positions you are looking for us to come up with; that may shorten the process. Are you able to elaborate?

Hon SUE ELLERY: Yes. I guess non-operational, non-clinical positions are what I am talking about. Over $150 000 in salary, so I do not want where the total package, with all the oncosts, is over $150 000, because that is much bigger. So it is where the salary is $150 000 or over, and where we are talking about non-clinical positions. The reason I said I wanted it across the agency is that I do not want it just out of head office; I want it across the area health services and whatever other names you call the other elements of the agency these days.

Mr Snowball: Are you happy for us to make the definition of non-clinical?

Hon SUE ELLERY: Yes, and if I have an issue with it, I guess I will ask a question on notice or something.

The CHAIR: Yes.

Hon SUE ELLERY: But if you think you need further clarification, I am happy to have a conversation with the minister behind the chair or something.

Hon HELEN MORTON: I am just thinking, when you are saying that, that there are a number of positions—an example I would give is the chief medical officer, who is clinical by nature but does not provide a clinical role in the health system.

Hon SUE ELLERY: I would include him or her because he is not hands-on, let us say that; he is not operating and he is not treating patients in his capacity as chief medical officer.

Hon HELEN MORTON: Okay.

Mr Snowball: I am sorry to focus on it, but clarity is really important here because we have lots of positions where you have a clinician who also does research and would have to home in and say, "What percentage of your duties are clinical versus research or teaching?" It would be helpful if it is

a cleaner, clearer definition. The Department of Health, for example as a whole—that is the role—and in a hospital and health services we have a range of positions that I have just described that have that sort of feature to them. In order to help get the question right, if we can define administrative positions—we have a definition in our payroll system that says "clerical administrative staff"—and if we can accept that that is the definition, it would make it so much easier for us to comply within the time frame.

Hon SUE ELLERY: Sure. If you use that definition, and if I am not satisfied that that gives me what I want, then I can ask a further question on notice about it later.

The CHAIR: I might just go to another member; I will come back if I have time. The next person I have is Hon Phil Gardiner

Hon PHILIP GARDINER: At the bottom of page 129 of budget paper No 2 reference is made to the four-hour rule. A very dear member of my family was in the emergency department of a hospital for 16 hours, and I just wanted to really inquire about whether we know where the problems are for the 15 per cent who are not catered for under this four-hour rule, so that we know how this $40.9 million that we have allocated here is going to be spent. Do you get reports back, for example; and, do we really have a fix on where the problems are? Because it was totally unnecessary that my dear member of my family was there, we were there as just public people, we did not disclose anything or that I had a keen interest in health, until someone did actually blow the —

The CHAIR: Blew your cover guard.

Hon PHILIP GARDINER: Blew my cover—thank you, Hon Giz Watson! But that was after about 10 hours. I just want to know whether we understand where the problems are for the 15 per cent who are not getting through the system.

Mr Snowball: There certainly are circumstances when people wait too long in our emergency departments. Part of how we manage this process is that we get regular reports from all the hospitals, real-time, so each of my chief executives could in fact tell you now how long you would wait in their emergency departments. We monitor that real-time. That includes so that we are able to direct ambulances to the right hospital to make it quicker—all those things that go with it. But we do have surges as well, and you can get surges across the system. I do not know the circumstances of your particular case, so I cannot respond to that other than to say we monitor it very closely across the system. There are still things to be done to improve our performance in the four-hour rule. We in fact are about to release information around particular solutions for particular hospitals, so that each of the hospitals have come up with further solutions in their particular circumstances, and we can fund those initiatives out of the four-hour rule program funding we have available to us. So that is one that the hospital identifies a particular area that is a problem to them, and they can initiate new approaches in that area.

Hon PHILIP GARDINER: It is an individual hospital thing? They did come down and apologise, but it is just that $40.9 million is going in there and I just wanted to be confident about whether it was a systems problem or a computing problem, or whether it is a personnel or just a management problem. Anyway, that is where I am happy to leave that so that it is on notice—not a question, just that it is on the record.

The CHAIR: On the *Hansard*.

Hon PHILIP GARDINER: I want to go back, if I may, to Bidi Bidi, which I mentioned at the very beginning; my good colleague Hon Liz Behjat has helped me understand where it was, and it is the WA Country Health Service area. I raised it because it was such an innovative early childhood program. I understand it is located at Mt Magnet and it is working in conjunction with the Geraldton Aboriginal groups up there. My concern, from what I understand about it, is whether the human resourcing—not the financial resourcing, because a lot of that comes from royalties for the

regions—is right for what we are trying to get as an outcome from this early childhood program, which is a very innovative program.

Mr Smith: When you said that earlier, it triggered something in my memory but I could not exactly picture exactly where Bidi Bidi was; I think I said to my colleagues as we walked that I think it was around about Sandstone or Cue, so I was in the vague area. I thought it was royalties for regions funded as well. I have not had a chance to confirm those items beyond which you have actually just described to me. Again, I am comforted because the model we are trying to create in Mt Magnet, in particular—in conjunction with Geraldton Regional Aboriginal Medical Service—is a very cooperative solution for that area of the country. Exactly what the model is, I cannot describe it, but the relationship we have with GRAMS and the intentions we share about trying to get a much better service for Mt Magnet, Cue and Yalgoo, in conjunction with GRAMS, would put us in a good position, but I cannot give you the detail.

Hon PHILIP GARDINER: Can I have something on notice then? Maybe just a brief summary of what the human resourcing is; the skills you have in that human resourcing; and, the progress you might be making, because I think it was initiated in 2009, against whatever baseline you have and whether you are able to measure a difference. That may be hard, I know, given the short time frame. Also, can you get something back to me on the points of learning we might extract from this program?

[*Supplementary Information No C16.*]

[6.40 pm]

Hon PHILIP GARDINER: Can I have one more quick question?

The CHAIR: Yes; sure.

Hon PHILIP GARDINER: It relates to some research that has been done about Naltrexone. I think money has been allocated in the budget somewhere for next year for Naltrexone implants. I understand that one of the problems we have is that there is a Therapeutic Goods Authority issue that I think needs to be overcome, but I suspect that would need the support of the Department of Health, ministers and so on. There is pretty clear research about the merits of implant Naltrexone for addicts, in a publication called *Addiction*—I regard drugs as largely a health problem—where, in the first four months after treatment, the death rate for oral Naltrexone is something like 24 times what the death rate is of implant Naltrexone. That seems to be a huge cost, but the paper is there. Does the Department of Health take part in seeking to have drugs put on the Therapeutic Goods Authority list?

Hon HELEN MORTON: I am going to answer this question myself because it is covered in the mental health drug and alcohol budgets. The funding for Naltrexone is covered in the Mental Health Commission's budget. That is the budget that comes after the dinner break.

Hon PHILIP GARDINER: I am happy to leave it there.

Hon HELEN MORTON: You can leave it until then but I am happy to give you information now if you are not staying.

The CHAIR: He is rostered on tonight!

Hon LJILJANNA RAVLICH: I refer to "10: Contracted Mental Health" on page 142. I go to the memorandum of agreement between the Mental Health Commission and the Department of Health mental health services 2010–11. Have you signed the 2011–12 agreement?

Hon HELEN MORTON: Yes.

Hon LJILJANNA RAVLICH: Can you forward a copy to the committee of the 2011–12 agreement? I am assuming you have not signed the 2012–13 agreement yet. Is that correct?

Hon HELEN MORTON: No; certainly not. I have a feeling that the 2011–12 agreement has been provided—not to the committee. but I thought it was a question you asked on notice.

Hon LJILJANNA RAVLICH: No, I have not got it; somebody has overlooked it. You have been denying me again!

[*Supplementary Information No C17.*]

Hon LJILJANNA RAVLICH: I go to the heart of the agreement for a sum of $426.9 million, $8.43 million of that was 2010–11 growth funding to cover the operation of the new specialised mental health inpatient beds in Rockingham General Hospital and its consultation liaison services. When we move to the next page, page 5, of the agreement goes into what might be an issue of conjecture.

Hon HELEN MORTON: Are you reading from the agreement?

Hon LJILJANNA RAVLICH: Yes, I am.

Hon HELEN MORTON: I thought you said you did not have it.

Hon LJILJANNA RAVLICH: I have got the 2010–11 agreement; I do not have the 2011–12 one. I need 2011–12 so I can compare it to 2010–11. In this agreement that I have, there is some $8 million. Clearly, there was an issue between Health and the Mental Health Commission in terms of whether this $8 million in growth funding should automatically be provided or "relied" on—is probably a better word—for committing the commission to a similar amount of growth funding every year and then handing that over to the health department for the delivery of those goods. I am not going to get stuck there. Can you explain what went on in terms of a response on notice so that we do not take up too much of the chamber's time and to see whether there are any issues that are outstanding on that issue?

Hon HELEN MORTON: Are you talking about what is outstanding in terms of the 2010–11 agreement?

Hon LJILJANNA RAVLICH: You can give me what is outstanding but there is a provision there about important funding caveats and I want to know whether this is still an issue, whether it is in the subsequent agreement or whether it is a matter that has been resolved.

Hon HELEN MORTON: I do not think it is an issue, but I will have a look and if it is I will provide the member with something.

[*Supplementary Information No 18.*]

Hon LJILJANNA RAVLICH: I am interested in the provision of information between the two agencies because, obviously, it is important in terms of knowing what is going on, making decisions and so on and so forth. I understand there are a number of data sources, if you like, that are provided from the health department to the Mental Health Commission. Some is provided through access, for example, into the computing systems—so through online access—but there is other information that may or may not be provided in that form and may in fact be provided in hard copy. Minister, can you, for example, provide the committee with the director general's report or mental health KPIs, which are apparently provided on a monthly basis, for the last 12 months?

Hon HELEN MORTON: If this is the Mental Health Commission, would you not want this question coming up in the following session?

Hon LJILJANNA RAVLICH: I can do, but I can just as quickly –

Hon HELEN MORTON: If you are asking for Mental Health Commission outcomes you will have to wait until the Mental Health Commission is here.

Hon LJILJANNA RAVLICH: It is not in your budget. The problem with it is that the contracted mental health is in the budget. If you are asking me whether I can —

Hon HELEN MORTON: If you are asking for some information from the Mental Health Commission, ask it of the Mental Health Commission.

Hon SUE ELLERY: You do not want to say then, "What is the budget paper reference?" Because if the budget paper reference is now —

Hon HELEN MORTON: I do not think that is the point that —

The CHAIR: Sorry; Hansard is having trouble with people talking over the top of each other, so one at a time is really helpful.

Hon HELEN MORTON: I understand you are asking for some information that is provided by the Mental Health Commission on a monthly basis.

Hon LJILJANNA RAVLICH: No; it is provided to the Mental Health Commission from the Department of Health, as I understand it. Clearly you are not across this agreement.

Hon LIZ BEHJAT: Oh!

Hon LJILJANNA RAVLICH: That is the transfer of information. You should know whether you are in fact —

The CHAIR: Member, we are very close to teatime and the blood sugar is getting below optimum.

Hon LJILJANNA RAVLICH: With all due respect, I would think that if the information flow is from the health department and it is in the health budget, clearly it is appropriate to seek copies of this data from the health department. I might have it totally wrong, but I do not think so.

Hon LIZ BEHJAT: It would not be the first time.

Hon HELEN MORTON: It did sound like you were talking about the Mental Health Commission. We are happy to provide the aggregated data. The health department can provide that aggregated data.

The CHAIR: Is that on notice, minister?

Hon HELEN MORTON: On notice.

[See next page.]

Hon LJILJANNA RAVLICH: Now that we are back onto this, there are a number of data information sources. Some of the them may be easier to provide than others; for example, the director general's report on mental health KPIs on a monthly basis might be easy to get. There should be 12 of those. Clinical modelling—you do regular updates to the minister, as I understand it; is that correct?

Hon HELEN MORTON: Not really. They are to the Mental Health Commission.

Hon LJILJANNA RAVLICH: I want the four-hour rule reports, which are provided to the commission on a monthly basis.

Hon HELEN MORTON: All of this information is provided from the Department of Health to the Mental Health Commission on a monthly basis.

[6.50 pm]

Hon LJILJANNA RAVLICH: I am wondering whether I can have the four-hour rule reports for the last 12 months—is that possible? You should be able to; it is only data transfer.

Hon HELEN MORTON: Let me clarify. This section about contracted mental health services is about specialist mental health services contracted by the Mental Health Commission to the Department of Health. The emergency department information around four-hour rules is not something that comes under this contracted area.

Hon LJILJANNA RAVLICH: The four-hour rule reports are listed in this agreement —

Hon HELEN MORTON: As information.

Hon LJILJANNA RAVLICH: Yes. So whatever is provided, if I can have the monthly reports in respect of those. Likewise, with the workforce division, the area health services' vacant FTEs are provided on a quarterly basis—if I can have that information, please. I will satisfy myself with those, Madam Chair. Can I leave the option open, if I need additional data, to be able to go back to the agency and seek that information, please?

The CHAIR: We have a list of things that you have requested, which I can give a number to. I am looking at the minister.

Hon HELEN MORTON: I think the best way to do it is exactly as Hon Ljiljanna Ravlich said. We will provide that information. If it is not satisfactory, or not comprehensive or whatever, she can ask for additional information.

[*Supplementary Information No C19.*]

Hon LIZ BEHJAT: I refer to page 135, "Outcome: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care". I have been looking at the table headed "Loss of life from premature death due to identifiable causes of preventable disease or injury (in Western Australia)". I want some further explanation about the figures. It is fairly obvious; we all know about preventable and identifiable causes such as lung cancer, breast cancer, cervical cancer, ischaemic heart disease and melanoma, but the interesting one for me is "Falls". I had no idea that falls would come into a category so high up. If you look at the figures that we are talking about, premature deaths identifiable due to falls is almost the same as cervical cancer in Western Australia. I have a couple of questions. It says —

> This indicator is based on long-term outcomes, as the effect of interventions may not be seen for decades. Success is measured by gradual downward trends over a number of years. Age standardised Person Years of Life Lost (PYLL) up to 74 years of age per 1,000 population.

In that area of falls, are we looking at people who suffer a fall and die immediately, or is it people who have some other underlying disease and then fall and eventually die? Is there a cut-off at 74? I would imagine that falls probably after the age of 74 increase greatly. Are we talking about falls that are happening all the way through Western Australia and the community, or is this mainly people who are already in hospitals or in care facilities or things like that? It is just an extraordinary figure to me. I want to know a bit more information about it.

Hon HELEN MORTON: I think the director general will start and then probably Dr Russell-Weisz will continue.

Mr Snowball: Without going to the detail, because it is quite a detailed question you have posed there in terms of what entirely fits into that category, in terms of the falls, we can provide that information. In broad terms, falls are preventable. Part of our effort, particularly in our hospitals, and also for people who have been recently discharged or have had a stroke and who have issues of balance, and mainly in the older cohort—as the community ages, falls have become an increasingly prevalent event and often trigger other events. For example, a fall and a fractured neck of femur, when you are elderly, is very difficult to recover from—to get your mobility back quickly, to have the fracture repaired and so on. So our hospitals have specific initiatives to identify fall risks for our patients, so we actually categorise them as they are admitted into our hospitals. You will often see, if you are going to a hospital, there will be a sign on a particular patient's area saying "Falls Risk". All of our nurses and others recognise they need to be assisted to the toilet and the like to prevent those falls.

We also run lots of programs in the home, whether it is Hospital in the Home or other programs through Silver Chain and others, similarly assisting people in their own homes around preventing falls. That is giving people skills about how to navigate around objects, particularly around steps, and making sure that there are highlighters on the steps. There are all sorts of prevention things you

can have just around the house, which can be quite risky for somebody who may be under medication or, as I said, has issues with their balance. Even standing quickly, for an elderly person with a heart condition, you are at risk of a fall. A lot of effort goes into trying to prevent and provide safe environments in the home for people. That is starting to be borne through. As you can see, over the last few years—we have no more recent data than 2009, mainly because cause-of-death data takes quite a long time to validate and come through. But the effort that has gone in here, both in hospitals and in homes, is starting to pay off in terms of preventing that event that otherwise would see deterioration in terms of mobility and lots of conditions ultimately resulting in death, which is why it is a preventable condition. Whether it includes accidents, falls from ladders and the like, I need to take advice on that.

Dr Russell-Weisz: The director general has answered that very well. Just to add: one of the programs that we have both in the hospital and in Hospital in the Home in our community-based programs is in relation to medication, especially medication in the elderly, which can potentially lead to falls. It is really a two-pronged attack in our hospital system where you can get many elderly, or not necessarily just elderly patients, on multiple medications that can interact. One of the focuses in our hospitals at the moment when patients come in is to review that medication and make sure you do not have what we call an iatrogenic effect, which can actually cause the patient to suffer a fall because of a loss of blood pressure because of interactions between medications. We can talk not just about hospitals, but mental health facilities as well. What the director general was saying about the focus on reducing falls in hospitals—we know we get these falls, especially on our older patients with fractured neck of femurs, as a very common example. Often the actual cause can be their medication. The medication can be too heavy, and people can add to their medication, which can actually cause further problems. We now have systems that actually alert the doctors and the nurses to potential interactions with medications and therefore the likelihood of them suffering falls that can keep them in hospital longer and cause significant problems for them.

Hon LIZ BEHJAT: Thank you for that. My final question relates to a question I asked of a previous director general, so, Mr Snowball, you may not be familiar with it. It goes back to a question in October 2009 at the agency annual report hearings. At that time I spoke to the previous director general about a number. I was probably quite flippant, saying there were a large number of other sorts of doctors employed throughout the health service who were not necessarily medical doctors, and I called them the spin doctors! At that time I was led to believe there was something around 60 spin doctors employed throughout the health service, but I was very quickly put back in my place by the former director general when he told me it was not 60, it was actually 54! I certainly took on board that I got it wrong by six people. At that time, he said to me that there was a review being undertaken; there were a lot of people who perhaps were across the services duplicating things and that that service was being looked at and there would be a rationalisation of that undertaken.

[7.00 pm]

I asked that in October 2009, and we are now in June 2012. Did that rationalisation take place and are you able to let me know today, or take on notice, how many spin doctors we have today across the health service?

Mr Snowball: There are probably two things in that question, and I am happy to take it on notice. I am aware of the view that you referred to. You referred to spin doctors. Our communications branch is the area that employs people to ensure we have effective communication with the wider community. That area is also responsible for providing brochures and the like, and material around vaccination programs.

Hon LIZ BEHJAT: There is no denying you need some of them; I am not saying there should not be any.

Mr Snowball: It really is communicating with the broader community about their health service and their health system. Without going through whether that has been rationalised and what are the numbers now, I can assure you that in all of the areas and in all my interactions with that communication area, they are very dedicated to making sure that the community gets an accurate message about the health services that we offer as a state. In terms of putting a spin on it, that is not the business of the health department or health services; our business is making sure people understand the risk factors they face as individuals and how they can improve their own health outcomes. So it is good health information and education as well as information about our services, what we offer and where they are. That is all important information to people. I would hate to characterise it as spin, because it demeans a lot of hardworking, highly-motivated, well-meaning people in that area.

Hon LIZ BEHJAT: How many are in that area?

Mr Snowball: I cannot tell you.

Hon LIZ BEHJAT: If you take that on notice, that would be great.

[*Supplementary Information No C20.*]

The CHAIR: I am very pleased with the level of interest in this hearing; it has been excellent, but all good things come to an end. Some people are going to go home, but not everybody—yet. Just to conclude, the committee will forward any additional questions it has to you via the minister in writing in the next couple of days, together with the transcript of evidence, which includes questions that have been taken on notice. If members have any unasked questions still outstanding, I ask them to submit these by email to the committee clerk by the close of hearings. Responses to these questions will be requested within 10 working days of receipt of the questions. Should you be unable to meet this due date, please advise the committee in writing as soon as possible before the due date. This advice is to include any specific reasons as to why the due date cannot be met.

Finally, on behalf of the committee, thank you very much for your attendance this evening. We will close this hearing.

Hearing concluded at 7.03 pm