STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2011–12 BUDGET ESTIMATES HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 15 JUNE 2011

SESSION ONE
DEPARTMENT OF HEALTH

Members

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

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Hearing commenced at 1.04 pm

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

MR KIM SNOWBALL
Director General, Department of Health, sworn and examined:

MR WAYNE SALVAGE
Acting Executive Director, Resource Strategy and Infrastructure, Department of Health, sworn and examined:

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

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

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

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

DR TARUN WEERAMANTHRI
Executive Director, Public Health Division, Department of Health, sworn and examined:

MS JENNI COLLARD
Director, Office of Aboriginal Health, Department of Health, sworn and examined:

MR BRAD SEBBES
Executive Director, Fiona Stanley Hospital Project, Department of Health, sworn and examined:

MS JODIE SOUTH
Acting Director, Health Infrastructure Unit, Department of Health, sworn and examined:

MR JON HARRISON
Executive Director, Corporate and Strategic Services, Department of Health, sworn and examined:

MR NEIL GUARD
Executive Director, Drug and Alcohol Office, sworn and examined:

MR GARY KIRBY
Director, Prevention and Workforce Development, Drug and Alcohol Office, sworn and examined:

The CHAIR: On behalf of the Legislative Council Standing Committee on Estimates and Financial Operations, I welcome you to this afternoon's hearing. Before we begin, I must ask the public servants to take either an oath or an affirmation. If you prefer to take the oath, please avail yourself of a bible that should be in front of you on your desk.

[Witnesses took the oath or affirmation.]

The CHAIR: You will have all signed a document entitled "Information for Witnesses". Have you read and understood this document?

The Witnesses: Yes.

The CHAIR: This hearing is being held in public, although there is discretion available to the committee to hear evidence in private, either on 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. 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, and the committee appreciates your assistance this afternoon. These proceedings are being recorded by Hansard. A transcript of your 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 please give the page number, the item, the program and the amount and so on in preface to their questions. If supplementary information is to be provided, I ask 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 this deadline, please advise the committee clerk immediately. An example of the required Hansard style for documents has been provided, minister, to your advisers. 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 her advisers to the committee, and for each adviser to please state their full name, contact address and the capacity in which they appear before the committee.

[The witnesses were introduced.]

The CHAIR: Members, I will give the first call to members of the committee if they so indicate they want to take the call and thereafter I understand that there are some lead speakers from the different parties. If anybody is the lead speaker from their party, please indicate and I will try to accommodate that.

Minister, do you wish to make an opening statement?

Hon HELEN MORTON: No, not really, thanks.

Hon SUE ELLERY: I will start with an item that I guess is broadly referred to in the income statement on page 149 of budget paper No 2, but before you all flick there, it is also referred to in budget paper No 3, *Economic and Fiscal Outlook*, in appendix 9, "Tariffs, Fees and Charges". Page 302 of budget paper No 3 states —

> **Department of Health**
>
> Existing hospital service fees will increase by 6.7% to maintain consistency with the Health Cost Index for Western Australian Hospital Patients Fees and Charges …

I want to ask some questions about that. Can you explain to me the assumptions that underpin the setting of the health price index? What particular services will be subject to those fees and charges? I have a couple of other questions on that same thing as well.

Hon HELEN MORTON: I think that the person most appropriate would be Wayne Salvage.

Mr Salvage: The figure of 6.7 per cent reflects our estimate of cost and demand growth in Health. It is derived through cost modelling that the department undertakes; it looks at the cost structure of our hospitals and the increase in costs going from year to year. It would include a factor for growth in salaries and wages—salaries and wages account for roughly 70 per cent of total health expenditure—but also a component for activity growth. So it is a modelled number that looks at the underlying growth in the cost of delivering health services. The way that it is applied in this context is that we have certain scheduled fees and charges that we are able to levy for inpatient services in public hospitals. What the note in the *Budget Statements* indicates is that the uplift factor that we apply to maintain the relativity of those fees and charges is by reference to this cost index—that is, approved through the budget process.

The CHAIR: Member, just before you continue, I omitted to say that, so that people understand the timing, we have until four o'clock, but I propose that halfway through we might take a 10-minute break for occupational health and safety reasons.

[1.10 pm]

Hon HELEN MORTON: There is another point that the director general would like to make on that as well.

Mr Snowball: It is really to clarify that a two per cent increase is not all cost related. It is also activity related. As you increase the growth in our health services, you will see a corresponding increase in revenue where private patients and other compensable patients are part of that service.

Hon SUE ELLERY: In terms of those services where you charge a fee as opposed to your level of activity, are you able to outline or table, or take it as a supplementary, which services will be subjected to increases as a result of that increase in fees and charges?

Mr Salvage: We issue an operational directive each year that shows the movement in fees and charges that this relates to. We would be very happy to provide that by way of supplementary information.

[*Supplementary Information No A1.*]

Hon SUE ELLERY: As I understand the modelling that you talked about in answer to my first question, have you done projections for that index over the forward estimates; and, if you have, what is that telling you?

Mr Salvage: The modelling that we have done is used by government to strike our forward estimates position. The uplift in fees and charges occurs on an annual basis because it is subject to —

Hon SUE ELLERY: Can I just clarify "uplift in fees and charges"—does "uplift" mean increase?

Mr Salvage: Increase in fees and charges. To put this in context, we are under an obligation through government policy to try to recover costs for those services that we can legitimately charge for. This indexation arrangement is an endeavour for us to identify what that cost increase ought to be for those relevant services. Each year, we advise government through the budget process of cost increases in health and the way that we would seek to apply that both in terms of setting the budget for health but also the increase in these related fees and charges: But the annual increase, or the annual adjustment, to these fees and charges occurs annually because it is subject to parliamentary determination.

Hon SUE ELLERY: The figures in the out years in the income statement in volume 1 of budget paper No 2 incorporates those projections you have done about the index over the out years?

Mr Salvage: In terms of setting our expenditure limit, that is correct, yes.

Hon SUE ELLERY: I might not be able to ask this question until I see the list of things you are going to table. I am looking for what increases are anticipated over the forward estimates. Is it

intended that fees and charges will be extended across any additional services to those which you have fees and charges in place for now?

Mr Salvage: There is no intention to extend charges beyond the charges currently prescribed. In fact we would have to look to whatever the capacity is under the hospitals act to vary that. There is currently no intention at this point to introduce new fees or charges.

Hon SUE ELLERY: The fees charged for people who park in the car parks at public hospitals, is that captured in this description of fees and charges—the calculation of the 6.7 per cent increase? It is a bit hard for me to ask this question without having that table you referred to. What I am trying to understand is to what extent will fees people pay when they go to park in a public hospital be impacted by this 6.7 per cent increase?

Hon HELEN MORTON: Dr David Russell-Weisz will answer that one.

Dr Russell-Weisz: Hopefully I am answering the question correctly; I can talk about the actual parking fee: it is my understanding that it is not included in those figures that you just alluded to. The parking fees are set as part of a whole-of-health government strategy across a number of hospitals which are tiered into tier A, B and C—tier A being the majority of the teaching hospitals; tier B being in the inner ring. The fee is going up to a set level over the next four years, which are higher, obviously, in the inner ring, up to $7.50, and slightly less in the outer ring, at up to $5.40. I can confirm they are not captured in the figures that Mr Salvage has been alluding to.

Hon SUE ELLERY: Thank you for that. I guess the best place for me to ask this question is on page 128 of budget paper No 2, which is a kind of catch-all. Under the “Services” summary, the first item is “Public Hospital Admitted Patients”. I am asking about the configuration of beds in each of the metropolitan hospitals, how that compares with the planned beds in each of those hospitals with reference to the clinical services framework 2010–20? It seemed to me that was the most sensible place to ask that question because I could not find anywhere else where I could neatly ask it. That is what I am looking for.

Hon HELEN MORTON: Both of us are not clear precisely what you are asking. You want to know how many existing beds there are in those facilities and what is to be achieved under the clinical services framework?

Hon SUE ELLERY: What is your current configuration—say, Royal Perth has 400, Charlies has whatever—a comparison of the planned beds for each of those hospitals against the clinical services framework to 2010–20? There were numbers in that document—are you still committed to those numbers, and what is the current configuration?

Mr Snowball: Excuse me if I give a bit of context around this. The way we now budget relates to activity in our hospitals. Regardless of the number of physical beds in a particular hospital or particular facility, this budget purchases a certain level of service across the system. That is then related to the needs area by area, on a geographic basis, so we make sure we have a good match of hospital services to community need. That has been a fairly recent event. The last financial year we were funded on the basis of that activity. In terms of its relationship to the clinical service framework, that is a different process. That does not directly influence our budgeting year on year; it is a planning tool. It is a vehicle for projecting planned activity or expected activity over the course of 10 years or more. The purpose of that is to guide our decision making around our capital needs, so where are we going to need additional infrastructure to provide the level of activity we expect will be needed.

[1.20 pm]

Our workforce, our ICTs and all the planning of all the things that make up an ability to deliver a service are guided by that clinical service framework. So, you will not find necessarily a direct link between our activities and a clinical service framework funded budget by budget. What that does, though, is give us a clear picture of what capacity will be required in our health system to meet

future needs, and to plan and budget for it into the future. In terms of individual beds per hospital, we are happy to provide that but it does not directly influence what we do in terms of activity-based funding.

Hon SUE ELLERY: If you are able to provide that and if you can do that for country hospitals as well, it will be of some assistance. If it is a long list, the minister might want to table it rather than read it out, but that is up to you.

Mr Snowball: Through the minister, I am able to go through the bed numbers, if that is helpful. These are available beds as at 24 May this year: PMH, 242; Graylands, 246; King Edward, 249; Royal Perth, 703; Sir Charles Gairdner Hospital, 626; Fremantle Hospital, 495; Royal Perth rehab, 169; Kaleeya, 76; Swan, 180; Rockingham, 162; Armadale, 198; Bentley, 209; Osborne Park, 165; Kalamunda, 33; Murray, or Pinjarra, 15; Joondalup, 328; and Peel, 177. Then for other contract services, of which we have a range, there are a further 146 beds or equivalent. For country services, there are almost 100 hospitals in the country, and I do not know whether we can table that.

Hon HELEN MORTON: We are not going to go through those.

Hon SUE ELLERY: If you could table that, it would be helpful.

Hon ADELE FARINA: Or take it as a supplementary question.

The CHAIR: Minister, is it possible to table the information on country hospitals or is it necessarily supplementary information?

Hon HELEN MORTON: Can you ask that question again; sorry?

The CHAIR: Do you have the information on country hospitals here?

Hon HELEN MORTON: Yes.

The CHAIR: Is it possible to table that?

Hon HELEN MORTON: Yes.

The CHAIR: Right, thank you. Is it okay to be made a public document?

Hon HELEN MORTON: I will just check to make sure it is comprehensive.

Hon SUE ELLERY: And that there are no secret notes written on it!

Hon HELEN MORTON: There are some additional hospitals that are not on this document. However, the director general has indicated that on the health department's website every hospital is listed and the number of beds they have. I think that it is probably more appropriate to access that information from the website than to table this document.

Hon KEN TRAVERS: What? That is the most outrageous thing I have ever heard! Peter Foss would have gone off his face at you for that sort of thing! If it is on the website, you should be prepared to table it! What a disgrace!

Hon HELEN MORTON: Why can you not look at it? Why do you not just look it up, if you want to know that information?

Hon KEN TRAVERS: This is the Parliament! Table it! It is a disgrace, that comment!

Hon HELEN MORTON: You can find that information on the website. This information is not comprehensive, so you will not get a full document if this is tabled.

The CHAIR: Before we continue, I want to check with the member who is asking the question whether you would like it as a hard copy provided to you. I understand it is not available right now but I will request that it be regarded as a supplementary question and that the answer be provided.

Hon HELEN MORTON: We have found the website.

The CHAIR: Whether it comes from the website or not, that is what I am suggesting. Minister, can we have that complete list as supplementary information A2? Whether it comes from the website or wherever, I do not mind.

Hon HELEN MORTON: I am so absolutely thrilled to tell the house that another member here has the website copy.

The CHAIR: Fantastic!

Hon HELEN MORTON: So, you may have it tabled today.

The CHAIR: Okay, let us all just take a deep breath. It is very early on in this hearing. That is, therefore, a public document; thank you, minister. The next question is from Hon Sue Ellery.

Hon KEN TRAVERS: Your members used to go off their face!

Hon LIZ BEHJAT: That was an outrageous outburst and you know it.

Hon SUE ELLERY: Madam Chair, if I may —

The CHAIR: Just bear with me. Can members just chill a bit?

Hon LIZ BEHJAT: If members would behave, perhaps I would not have to interject.

The CHAIR: Yes, we are working on this. Hon Sue Ellery.

Hon SUE ELLERY: I do not want to reopen the argument, but this is an important program for Parliament and it is appropriate for members of Parliament to ask for information, whether or not it is available anywhere else, and it is not unreasonable to ask for that information, whether or not it is available somewhere else.

Hon HELEN MORTON: Absolutely!

Hon SUE ELLERY: Maybe I am using the wrong language. I appreciate what the director general is saying when he talks about levels of activity. There is an argument in the public health policy debate about levels of occupancy and what an efficient level of occupancy is and what it is not. I want to understand that and where you are at today in terms of your capacity to meet demand and to understand the levels of efficiency in public hospitals. There is one argument that says—I think this was included in the Reid report and elsewhere—that 85 per cent occupancy is the maximum level of efficiency that you want to operate at. I am going to ask you to help me, as I am not sure that I am using the right language to get to that information when you talk about activity levels as opposed to bed levels. Can you give me some information about where the public system is now in terms of that level of efficiency; that is, your capacity to meet the demand and how you manage the demand for activity?

Hon HELEN MORTON: I will give the call to the director general, but I want to make a statement at the beginning that if members would like a level of detail that is not necessarily listed in one of the line items of the budget papers—that is, the list of all hospitals and their bed numbers et cetera—that information could have been relayed to us in advance and it would have been here. However, we are lucky that we have somebody with that information at hand. I want to allay the concerns of Hon Ken Travers and others that if you want us to provide information like that, asking for it in advance and making sure that we have it here is an easy thing to do.

The CHAIR: Mr Snowball.

Mr Snowball: Through the minister: we monitor very closely the occupancy levels. As you have described, there are optimum levels for our hospitals to operate efficiently in terms of optimum efficiency. It does not mean that you cannot operate effectively and clinically effectively at higher rates of occupancy; it is simply that the optimum efficient level, particularly for a secondary hospital, is around 85 per cent. Again, whilst we have all the information available—I am not sure if I can come up with that from the advisers at this point in time—on exactly the occupancy per

hospital, I can say that we monitor that on the basis that our key issue is capacity and we have peaks during the course of any given year. Winter, the flu season, obviously sees a greater level of demand in our hospitals; so, we need to make sure that we have capacity within our hospitals to accommodate that demand. That is why an initiative like the four-hour rule has been important to the health system because it has changed and sped-up the flow of our patients through our hospitals in such a way that we are able to accommodate more patients within the existing bed numbers that we have. So, on one hand it is about building capacity in the system knowing what our population growth is going to look like into the future so that we can accommodate those growths; but also to introduce and make sure that we have reform in productivity happening in our hospitals so that we can in fact accommodate growth. A good example is that our major hospital emergency departments this year had an average growth of roughly nine per cent, which is pretty extraordinary growth.

Hon SUE ELLERY: Is that nine?

[1.30 pm]

Mr Snowball: Roughly nine per cent, that is right. That is for the four major teaching hospitals. Whilst they accommodated that, the four were also able to improve their performance so that while more people were coming for service, they were actually being treated and seen quicker and were either transferred, discharged or admitted much quicker than in the past. We have some extraordinarily good examples where we have reduced access block, which is a measure of how long people wait for a bed once a decision has been made to admit them. We also have a measure of people who wait for a bed for longer than eight hours. That is now around six per cent in our hospitals. About 18 months or two years ago that figure was closer to 45 per cent. That is an extraordinary improvement in the way we are delivering the system. All those things are factors to consider when thinking about what is the right level of capacity and whether we can make sure that our hospitals are safe and can cope with the level of demand in the system. My absolute assurance is that the growth we have got planned in the system in terms of capacity plus the initiative reforms around productivity will see us able to match the growth that we are expecting to see in activity demand.

Hon SUE ELLERY: Do you subscribe to the theory of 85 per cent? Is that a reasonable benchmark? I appreciate you saying that you can be above and below that figure and continue to clinically operate absolutely safely. Is that the agreed benchmark?

Mr Snowball: Through the minister, it is a guide. It depends on the acuity in the system. A hospital could have 85 per cent of its patients who require intensive treatment, support and care, which is a lot more difficult than treating a mix of patients who require less complex care. A lot of factors come into it. The 85 per cent figure is a guide only. We would need to look at the other factors if we were to gauge whether a hospital was operating at the optimum level.

Hon SUE ELLERY: I think you just described to me before that it is not just about making sure you have bed numbers, for example, but also the other programs that you put in place to make sure that you are operating efficiently. That being the case, is it accurate to describe the level of funding as being your ability to meet that 85 per cent, or can you get to that 85 per cent if you have X amount of funding and you are having to do these other programs to get you to that 85 per cent? From what you have said, I understand that it is a combination of things. It is not necessarily the case that this budget presents you with everything you need to get to a benchmark of 85 per cent. That is the general aim, everything being equal, but you are also putting in place other measures to get quicker in area X and faster in area Y. It is not just about this budget; you have to have programs to address other potential blockages.

Mr Snowball: Through the minister, there are two things to look at. Under the clinical service framework, which is the guide of our projected activity levels, there are some assumptions about how the system can accommodate that. Those assumptions include how many GPs we expect to be

available—even outside the public hospital system; how many aged care beds there are and whether we need to accommodate more of that demand; and productivity initiatives like the four-hour rule are factored into our thinking about what infrastructure we will need, assuming those things occur, to deliver on the framework. Year on year, we look at where we are against those assumptions and projections and at what we expect to be able to deliver in the coming year. There can be different levels of demand on different parts of the system. Our mental health services might be growing more quickly than our ED services, for example, so you look at that as well. The basic message from our budget is that we sought a certain level of funding for the activity we expect in 2011–12, and that has been provided.

Hon SUE ELLERY: If I can—I think you referred to it earlier—I ask you to provide supplementary information about the occupancy rates.

Hon HELEN MORTON: In each hospital?

Hon SUE ELLERY: Yes, please.

Hon HELEN MORTON: We are going to provide it, but I would make the comment that if you want to find that information for yourself in the future, it is also on the website.

Hon SUE ELLERY: My colleague is whispering in my ear. Can I ask for supplementary information for country hospitals as well?

[*Supplementary Information No A2.*]

Hon SUE ELLERY: You referred to when the flu season might kick in. Sometimes the flu season is early and sometimes it is late. What is happening with the flu season in Western Australia?

Hon HELEN MORTON: I will ask Dr Tarun Weeramanthri to answer that.

Dr Weeramanthri: The flu season has not kicked off yet. We have weekly surveillance through GPs and emergency departments. Our latest news is that we have started to see an increase of cases from Queensland. Often the flu season starts in the northern part of Australia and tracks down. We are expecting a moderate flu season overall. A mix of influenza viruses is expected, both the pandemic strain from two years ago and the old influenza A-H3N2 virus. We are expecting a similar season to last year, but it has not started yet.

Hon SUE ELLERY: Correct me if I am wrong, was last August–September the critical point?

Dr Weeramanthri: Through the minister, it generally starts a little earlier than that but it peaks in August–September.

Hon LINDA SAVAGE: I refer to budget paper No 2, volume 1 at page 172, line 8, which is the total appropriations to deliver services. My first question is: what amount has been committed in the 2011–12 budget to deliver child and adolescent health services, including PMH, in the metropolitan area?

Hon HELEN MORTON: I will ask Mr Aylward to comment on that.

Mr Aylward: The government has committed, through the child and development areas, approximately $50 million over the next four years for child development services.

Hon LINDA SAVAGE: I am talking about the total child and adolescent health services budget. I ask that because I understood from the Auditor General's report on universal health checks last year that he said at page 14 that the budget was $285 million for child and adolescent health services, including PMH. I am asking what it is for this year out of the $5.353 billion budget.

Hon HELEN MORTON: The director general will comment.

Mr Snowball: Through the minister, we are going through the process of the allocations for each area health service. There are conversations happening right now around matching the funding with the activity and demand from each of our area health services. I cannot give you a definitive number

for child adolescent health services at this point in time, but I can give you a clear enough picture that it would be around $350 million, but that is subject to final negotiations from 1 July.

Hon SUE ELLERY: I do not know whether it is because of this configuration or the fact that we are not used to sitting here, but the three of us are struggling to hear people. I ask them to try to throw their voice a bit.

Hon LINDA SAVAGE: You think it will be around $350 million. I understand from reports in the press—I will stay with the total appropriations on line 8—that the child and adolescent community health services budget has increased to $76 million. My question in regard to that is: how much of that $76 million will be spent as a percentage and as a dollar allocation on child community health nurses?

Mr Aylward: Through the minister, if the question related specifically to child health service nurses in terms of the total expenditure, I did not bring that breakdown with me today. We are getting, subject to final discussions within Health, about a seven per cent uplift in our budget for the coming year. That is across the whole child and adolescent community health service and excludes the additional funding that has been provided for child development services, which is what I alluded to earlier and which is part of the approximately $50 million package that the government has commenced this financial year.

[1.40 pm]

Hon LINDA SAVAGE: Could I then ask that that question be a supplementary question as to what the allocation within the child and adolescent community health service budget will be for child health nurses, and that is out of what is reported as the $76 million budget? Perhaps that also could be clarified.

[*Supplementary Information No A3.*]

Hon LINDA SAVAGE: Staying with that, if I can, it has been reported that the minister, Kim Hames, has said that there was no additional funding for child health nurses in the 2011–12 budget, and it was also reported in April that he was going to go cap in hand before the budget—they are the words of the report—to ask for funding for child health nurses, which, of course, we are very short of. Am I able to find out what submission might have been made to get more funding for child health nurses, and also the amount that was sought?

Hon HELEN MORTON: I understand that it was part of the process through EERC et cetera, in which case it is subject to cabinet confidentiality, so you would not be able to access that information. You would not be able to get the submission, anyway.

Hon LINDA SAVAGE: I did not think so, actually. Perhaps this would need to be another supplementary question to clarify whether that submission was, as reported, unsuccessful. It has been reported as unsuccessful in the press in being able to get additional funds for child health nurses.

Hon HELEN MORTON: We will take that on notice. I do not really know the answer.

Hon LINDA SAVAGE: Perhaps just to clarify it, Madam Chair, could the question also include whether there is any additional or new funding for child health nurses in the child and adolescent community health service budget?

Hon HELEN MORTON: I think we would just like to clarify that, as has already been mentioned, there is a seven per cent growth.

Hon LINDA SAVAGE: Perhaps I could ask another question in relation to that.

[*Supplementary Information No A4.*]

The CHAIR: An additional question, Hon Linda Savage?

Hon HELEN MORTON: Can you just remind me now what A4 is?

The CHAIR: It is about the submission, as I understand it.

Hon LINDA SAVAGE: Yes. What money was sought? What additional funds were sought for child health nurses, and the outcome of the submission?

Hon HELEN MORTON: Okay.

Hon LINDA SAVAGE: It has been reported that there was an increase in funding in that budget, but the funding would be seven per cent for general cost and demand growth, five per cent for increases in previously announced priority funding for child development services, the anaphylaxis program, and the mandatory reporting of sexual abuse. That has been reported. So what I am asking and want absolutely clarified is: was there any additional funding for child health nurses?

Hon HELEN MORTON: Are you talking about over and above the seven per cent growth?

Hon LINDA SAVAGE: The seven per cent growth, as reported, does not go to child health nurses. That is what is reported. I am asking for someone to either be able to answer today—perhaps someone amongst this large group you have brought would know if there had been any additional funding for child health nurses in this budget. If not, you could get back to me on it.

Hon HELEN MORTON: I think the issue is that the budgets have not been allocated to the various area health services at this stage; they are in negotiation. I think the director general made that comment at the beginning of this conversation. So any information that was provided to you right now would be subject to variation as a result of the negotiations that are taking place at the moment. So I do not actually believe that this would be something that would be worthwhile providing an answer to, because it is not actually completed. The area chief executives have not got their budgets yet.

Hon LINDA SAVAGE: And when will that happen? I ask that because it has been reported that the money has already been allocated to the things I referred to previously.

Hon HELEN MORTON: The answer about when the budget finalisation is likely to occur is that it will be around about another two weeks. I would add that there has been some increase in child and adolescent services in the Aboriginal health area; that is, an additional 6.7 child health nurse FTEs have been employed statewide to deliver services to Aboriginal children and their families. That is an example, I guess, of one increase anyway. But probably in two weeks will be the finalisation of those chief executive officer budgets. I might add that this is an amazing improvement on previous times when most organisations working in the health sector did not get their budgets till around about September. So I think the fact that there is going to be a budget allocation within two weeks is absolutely amazing.

Hon SUE ELLERY: Let us hope there are some child health nurses out of that.

Hon LINDA SAVAGE: Could I just continue that? You referred to six new positions for child health nurses.

Hon HELEN MORTON: Yes.

Hon LINDA SAVAGE: Is that the funding that is coming through the Closing the Gap national partnership, which was to provide six additional child health nurses? Perhaps someone would be able to clarify that.

Hon HELEN MORTON: I am pretty sure that it is, and I will just give you the full information. An additional 6.7 child health nurse FTEs have been employed statewide to deliver services to Aboriginal children and their families. Additional resources have also been provided to the adolescent young mothers support program at King Edward Memorial Hospital, and additional funding is being committed to non-government agencies, including the Derby Aboriginal Health

Service, Ruah Community Services and the Hills Community Support Group, and additional funding to support Aboriginal families in the uptake of health checks for their under fives.

Hon LINDA SAVAGE: So that is the federal money through the Closing the Gap national partnership, not state money.

Hon HELEN MORTON: It is a mixture of funding.

Hon SUE ELLERY: I wonder if we can clarify: is there any state money in that?

Hon HELEN MORTON: Yes.

Hon SUE ELLERY: And how much is that? You cannot say it is state money and then say, "We don't know how much it is."

Hon LINDA SAVAGE: Perhaps that could go as a supplementary question: for the six child health nurses that you referred to, how much of that is going to be from the state budget?

Hon HELEN MORTON: We can find that for you.

[*Supplementary Information No A5.*]

The CHAIR: I will come back, but I will give the call to Hon Nick Goiran.

Hon NICK GOIRAN: Minister, my question is with respect to page 128 of budget paper No 2, volume 1, and in particular the line item relating to palliative care. I note that the budget estimate for the forthcoming year is some $33 million, as compared with an estimated actual for the current financial year of some $29 million, and I ask: is the difference between the two for any new initiatives that the government is putting in place for palliative care, or is that just a general increase in the cost of care?

Hon HELEN MORTON: I could not hear it; I am sorry. I really could not hear that.

The CHAIR: I wonder if you might check that the microphone is right in front of you. I am sorry; the minister did not hear the question.

Hon NICK GOIRAN: Sorry. The question, minister, is: is the increase of some $3.5 million in palliative care for the forthcoming budget period for new initiatives brought in by the government, or is it just the increase in cost of care or some other reason?

The CHAIR: Where in the budget papers is that? I missed the reference.

Hon NICK GOIRAN: It is page 128, budget paper No 2, volume 1.

[1.50 pm]

Hon HELEN MORTON: I will just ask Dr Russell-Weisz to answer this in the beginning.

Dr Russell-Weisz: Through the minister, there has been some increase in funding. We in the North Metropolitan Area Health Service have increased access to palliative care, specifically in Kalamunda Hospital, where we started with quite a low number of palliative care access or beds to palliative care. That has now extended to 10 beds over the last year, and we are maintaining that. We cannot actually expand any further, but we will have that for the whole year. Also we are expanding services in relation to another registrar there and some more medical consultant cover. We are also maintaining our services through Bethesda and other areas in the North Metropolitan Area Health Service, but if you want specific answers on that, we may need to take that on notice.

Hon NICK GOIRAN: I will continue on my line of questioning, if I can. Minister, last year we had a lengthy debate on the voluntary euthanasia bill, and although members of this chamber had differing views, I think the one common element was the need to properly resource the area of palliative care. One thing that probably was not discussed very much during that time was perhaps the need to educate the public about what palliative care is and also that it exists. Will there be any of that funding that has been set out attributed to those types of educational activities?

Hon HELEN MORTON: I will ask the director general to answer.

Mr Snowball: In Western Australia we endeavour to support people to die at home, and more often than not, it is the individual and the family's preference to do so. But there are occasions when people need additional support, particularly for pain relief or symptom control. That is why we need the backup of more specialised units and supported services in our hospitals. When I talked earlier on about activity-based funding, that also goes to the resourcing and support for palliative care services, so in each of the areas, they develop their own service plans around how they provide palliative care, both community and in hospital, and look to support that through that budget process. So there will always be resources where there is a requirement for additional support through the health system for that purpose, and we plan, as best we can, for that. The major emphasis in this process is to continually strengthen our support for those receiving palliative care in the home environment. We do that through not just our own services but, more often than not, non-government organisations like Silver Chain, and in combination with local general practitioners, to provide that community service. It is a service that Western Australians can be rightly proud of, because we have a very enviable service now occurring for people at home.

Hon NICK GOIRAN: If I can just continue, I agree that we have a system to be envied, but my concern is on the promotion of the service and the awareness that the service exists. I do not quite mind if there is not any funding under that particular item, but on that same page I notice that there is a heading entitled, "Prevention, Promotion and Protection". Might there be some funding available under that promotional heading, where we can alert Western Australians that palliative care exists, we have a system that is the envy of others, and how they can access it?

Mr Snowball: Through the minister, certainly there are promotions occurring. What tends to happen is when an individual comes to the stage where they are palliative—and that is a difficult conversation in the very first place—that is the time when there is a lot of emphasis given to their preferences, but also what services are available in our system and through the non-government community-based system as well, so it tends to be very targeted rather than being a broad campaign to the broader public, but it is very homed in on individuals and individuals' care preferences and options, that we are there to support. Of course, we have got other legislative support now around living wills and so on, that has provided even greater emphasis and, I think, community awareness as well, about being able to choose your continuation of treatment or not and being able to do so in a good environment, if you like: a good environment of understanding both what resources are available and what options are there for you. One of the good features as well in our system is we do not only concentrate on large population areas to ensure that service is available; this service and the way it is being delivered now stretches right across Western Australia, so if you are living in country areas, there has been a strong emphasis as well around developing our services there, providing support from specialist practitioners as well to local people in those regional and remoter centres, so that the level of support they are able to give terminally ill patients is the best possible. That has really been a terrific feature, alongside the development of our cancer services in country areas too, so that people receiving palliative care, whether it be for cancer or other reasons, have access locally to symptom control, pain management support and so on.

Hon HELEN MORTON: I think it is also worth mentioning that the paediatric palliative care service for children with non-cancer illnesses implemented by the Child and Adolescent Health Service has been operating for more than two years, and that is another area of work that is being undertaken that is quite specialised in palliative care.

Hon NICK GOIRAN: If I understand the answer correctly, promotion is not best done by way of a widespread campaign because of the nature of the service we are talking about; it is actually best done at a personal level, which presumably is done by general practitioners. I guess that brings me to the next question. Are there specific initiatives in place to make sure that our general

practitioners in Western Australia are aware about the level of palliative care services available, and in particular the improvements that have been made over the years?

Mr Snowball: Through the minister, the GPs are very much, as you said, the backbone of the palliative care service, particularly the community-based service and also in our regional centres. They are very active; there is a very active cohort of GPs in Western Australia who have a special interest in palliative care and providing palliative care services. The education is very much around alerting them where there are new services or the availability of more specialised support, as well as education and training, so there is an opportunity for professional development. In terms of palliative care, we have a very active palliative care association in Western Australia as well, made up of public and private clinicians, both specialists and GPs, who meet regularly, and they have their own education campaigns as well. I think we have a very active community around palliative care, which I think is serving us very well and it is very important for us to maintain a good balance between inpatient palliative care services—hospice-type services—and community support and resources to help people to die at home.

Hon NICK GOIRAN: Last question on this item. I just want to know if there is a difference in the level of funding between non-government organisations—for example, community hospices—and palliative care that is provided at a hospital level. For example, there might be what I think is referred to as bed rates or day bed rates; the amount of funding that is provided—is it the same across all of those providers, or is it different depending on the organisation in question? I am happy to take it on notice, if that is necessary.

[2.00 pm]

Hon HELEN MORTON: No, it is okay.

Mr Snowball: Through the minister, yes, there is a variety of settings in which palliative care is provided, including organisational settings. There is not a huge differentiation depending on the package of services that are offered by those services. We tend to focus in on ensuring good quality services. It is not generally a price-driven decision around palliative care. We are very careful to make sure that those services are providing the sort of quality when they are purchased by the public system. Of course, a number of those organisations are running their own services without grants from government. A lot of them are supported not-for-profit organisations that raise funds. One service that is very familiar to me is the St John of God hospice at Murdoch, which operates largely through the support of the broader St John of God Health Care group providing these services. But it also provides a public component, so it is not just private patients who access that service; we can also use it from our public system to access that service. There are very comparative rates in those services, so I would not make a distinction on who is running it; it is more a distinction on the service that they offer as part of that package. We particularly like those services that also support people at home, so it is not just a stand-alone hospice, but people are able to move in and out as required to receive symptom control or pain management.

The CHAIR: I have quite a few members who have indicated that they have questions. I am required to check first with committee members whether they have questions they want to ask. I will ask Hon Liz Behjat, but before I do, I just indicate that I have Hon Adele Farina, Hon Alison Xamon, Hon Jim Chown, Hon Brian Ellis, Hon Phil Edman and Hon Ljiljanna Ravlich all waitlisted, so I will try to get through those in roughly that order. Does Hon Liz Behjat have a question?

Hon LIZ BEHJAT: This is a relatively quick question. I refer to the dot points relating particularly to drug and alcohol on page 133. The third dot point states —

> The *Cannabis Law Reform Act 2010* will be proclaimed on 1 August 2011 repealing the *Cannabis Control Act 2003.* At the time the legislation is enacted, the DAO will implement the mandatory cannabis intervention treatment sessions for both adult and juvenile minor

> cannabis offenders and conduct a comprehensive public education campaign on the harms associated with cannabis use and the changes in the law resulting from the repeal of the *Cannabis Control Act 2003*.

My question may be perhaps a little premature given the recent announcements on this. I am pleased to see that there will be a comprehensive public education campaign in regard to these changes. But given the announcements just yesterday with regard to the banning of Kronic and other cannabinoid substances, will there be scope in this education campaign to include those substances while we are talking about cannabis and other cannabis-like substances, or am I a bit too soon in asking that question?

Hon HELEN MORTON: I will let Neil go for it.

Mr Guard: Currently, the Drug and Alcohol Office is working alongside Western Australia Police in planning for the implementation of the new cannabis law changes. We are currently looking at the beginning of August for those to come into effect. Currently, the thinking is that that will include two phases of campaign activity. One will be around the announcement of the changes to the law in the lead-up to the introduction of that particular date and probably for the next couple of weeks. Then there will be further campaign activity really promoting issues around cannabis and health. So there will be health-related campaign activity probably from around the middle of August for another month onwards and a couple of waves of that during the next 12 months and into the out years.

Hon LIZ BEHJAT: Is the education campaign targeted directly at schools?

Mr Guard: It is targeted at young people. It is primarily targeted at people who might be thinking about experimenting with cannabis—so, younger people. But it will also include people who currently use and others who are regular users.

Hon LIZ BEHJAT: When you say "young people", what I am more interested in is: are we going to be getting this information into primary schools?

Mr Guard: Are you talking about specific campaign activities targeting primary schools?

Hon LIZ BEHJAT: You said that the campaign is going to be targeted at young people. I am not sure what the department's definition of "young people" is. I think I am young, but I do not think you might think that!

Mr Guard: It is primarily targeted at people 14-plus.

Hon LIZ BEHJAT: Fourteen-plus? Might I perhaps suggest for future campaigns that we start looking at people a little younger than that? I think that cannabis and alcohol and other drugs are being used by a much younger age group than 14. I think the younger we can start these programs, the better off we will be. I think you found that over the years with sexually transmitted diseases and those sorts of education programs. I am not here to give you a lesson on where you should be targeting it, but I think young people really need to get the message very early on.

Mr Guard: Through the minister, I have one further comment on that. The primary target group is that group. We do expect other people younger than 14 also to be aware of that, because we will be using channels used by young people, as well as radio and other materials. We will certainly be building this type of thing within the School Drug Education and Road Aware program, which goes from primary through the school-based system.

Hon ALISON XAMON: I refer to the tenth line item "Contracted Mental Health" in the second table on page 128. What I want to know is whether that amount includes funding for costs associated with the maintenance and upkeep of mental health facilities.

Hon HELEN MORTON: The answer is: no, it does not. That is the funding that was allocated to the Mental Health Commission to undertake its functions as a commission.

Hon ALISON XAMON: Is there a line item in the health budget that refers to the maintenance and upkeep of mental health facilities—that is, the bricks and mortar rather than the delivery of services?

Hon HELEN MORTON: It is actually contained in the minor works program. I do not think that it is specified as a mental health area, but it is contained in that level of funding that is allocated to minor works.

Hon ALISON XAMON: Would you mind drawing my attention to where that is, because I was trying to specifically get that detail?

Mr Salvage: I refer the honourable member to page 146 of budget paper No 2. It is in the section at the top of that page. There is provision there for the minor building works program showing an allocation of $25.2 million in 2011–12.

Hon ALISON XAMON: Thank you. Is it possible to get a breakdown of the minor works budget? I am happy to take this on notice.

[2.10 pm]

[*Supplementary Information No A6.*]

Hon HELEN MORTON: As with the allocation for the budgets that I mentioned before, this is still going through the process of negotiating the outcomes for each of the area health services, in terms of what their allocation will be, so that has not been finalised for the coming financial year yet.

Hon ALISON XAMON: When are you anticipating that they should be finalised?

Hon HELEN MORTON: That will be in line with the previous answer of two weeks.

The CHAIR: Perhaps we could keep it as a supplementary question, but acknowledge that you will not get it until after, obviously, the time when it is available. Is that okay?

Hon ALISON XAMON: Thank you, Madam Chair. I did have a whole range of questions associated with that, so I suppose we will have to revisit it once the budget line item has been finalised. Page 146 of the *Budget Statements,* under "Completed Works", has a line item for "Graylands Hospital—Redevelopment Planning". Can I confirm—because there is nothing in the forward estimates—that that is because it is now under the Mental Health Commission budget?

Hon HELEN MORTON: I really am having difficulty hearing; I am sorry.

The CHAIR: Slowly, clearly, and loudly.

Hon HELEN MORTON: You will just have to say it a bit slower.

Hon ALISON XAMON: Page 146, "Completed Works", Graylands Hospital, and, underneath it, "Joondalup Health Campus Inpatient Mental Health Unit"; there is nothing in the forward estimates, and I wanted to confirm that that is because that has been shifted over to the Mental Health Commission, not because no more money will actually be put in there.

Hon HELEN MORTON: That amount shows the completed works, and so there is no funding going on into the out years because the final amount is the completion of that project.

Hon ALISON XAMON: Has the Graylands Hospital redevelopment planning been completed?

Hon HELEN MORTON: Is your question specifically about Joondalup?

Hon ALISON XAMON: No; I did ask specifically about Graylands Hospital and specifically about Joondalup.

Hon HELEN MORTON: Joondalup has been completed. In terms of Graylands, I will ask Jodie South to answer.

Hon ALISON XAMON: It is hard to think that it could be completed.

Ms South: Through the minister: the allocation for planning for Graylands was a once-off allocation for determining models of care around the facility. There is another line item for "Graylands Hospital—Development Stage 1" for $16 million; that is for the actual capital works component.

Hon ALISON XAMON: In the Health budget?

Ms South: Correct; yes.

Hon ALISON XAMON: Do you mind drawing my attention to where that was? I hope you understand that it is all a bit confusing.

Ms South: Sure; I will see if I can find it. It is page 146, and it is under "New Works", "Graylands Hospital—Development Stage 1", towards the bottom of the page.

Hon ALISON XAMON: I am sorry, I missed the page.

Ms South: Page 146.

The CHAIR: It is the same page.

Ms South: It is under "New Works", down at the bottom, "Graylands Hospital—Development Stage 1"; it is just over $16 million.

Hon ALISON XAMON: Thank you. Madam Chair, I have another question, if that is okay.

The CHAIR: Yes, Hon Alison Xamon.

Hon ALISON XAMON: I refer to the funding for the Council of Official Visitors.

Hon HELEN MORTON: Do you have a page number?

Hon ALISON XAMON: I do not have a page number; I have been trying to find a line item that would potentially pertain to it. I want to determine whether that funding is still in the Health budget. I mean, these are very short on detail, I am sure you would appreciate, and trying to find where the Council of Official Visitors was listed in it was not easy.

The CHAIR: I think the question is: is there a budget line item for the Council of Official Visitors?

Hon ALISON XAMON: Is there a budget line item for the Council of Official Visitors?

Hon HELEN MORTON: No, there is not.

Hon ALISON XAMON: But the funding for the Council of Official Visitors is coming out of the Department of Health; is that correct?

Hon HELEN MORTON: It is for the time being; that is the best I can say. I do not think it is intended to stay like that, but in this particular budget, yes.

Hon ALISON XAMON: The question then is: how much has been allocated for the Council of Official Visitors for this year?

Hon HELEN MORTON: The Council of Official Visitors has put a submission through to the health department. It is part of the same situation as has previously been mentioned; those negotiations are continuing right now. It will not be finalised until at least the two weeks that I have been referring to, but I can assure you that it will not be less, if that is of any concern—I do not know if it is. You will probably be looking to see how much more it will be.

Hon ALISON XAMON: I certainly would be keen to see not only more money going in to deal with the pay increases, but also for improved administrative support. I think we all recognise that they do a wonderful job and they probably need to have significantly more money. Madam Chair, can I take your guidance on this? I want to be able to put a series of questions pertaining to this on notice now. Is it that we are looking at, effectively, putting those questions on hold until the budget has been finalised?

The CHAIR: I suggest that you submit them at the end of the session. We will provide them to the department on the understanding that, obviously, they can only supply the answers once the decision has been made, so it might not be the 10 working days requested; it might take a little longer. I think that is the easiest way to deal with those.

Hon ALISON XAMON: On a related note then, I was going to ask, along a similar vein, about the Office of the Chief Psychiatrist. Is that in a similar situation, whereby the money is yet to be determined?

Hon HELEN MORTON: Yes, it is.

Hon ALISON XAMON: I will put my questions pertaining to that on notice as well.

The CHAIR: Thank you very much. We have 15 minutes before we take a break. I am aware that Hon Phil Gardiner, who is a member of the committee, has indicated that he has a question; I am sorry to other members who have been waiting. Hon Philip Gardiner.

Hon PHILIP GARDINER: Can I just go to page 128 of the *Budget Statements*? My question relates to a question asked earlier by Hon Nick Goiran about the service summary, and the line items "Palliative Care" and "Home-Based Hospital Programs". I am just really questioning what these figures mean in terms of future strategy, and whether there are efficiencies that are being obtained from the operations, or whether there are new innovations. I just wish to have an explanation. When we talk about palliative care we have to bear in mind we have an increasingly ageing population. I have a difference of opinion from Hon Nick Goiran; I think palliative care is a very holistic care service. From 2009-10 to 2010-11 there is an estimated actual difference of $5 million. I will keep on going along that line, and we find that between the 2010-11 estimated actual and the 2011-12 estimated actual, there is an allocation of $3.5 million, which is $1.5 million less. From 2011–12 to 2012–13, as shown in the forward estimates, there is an allocation of only $2.5 million. Then from 2012-13 to 2013–14, the allocation is even less; it is $2 million. In the final year there is an allocation of only $1.3 million. My question is: how come it is actually decreasing year by year, when I would have thought that the requirements for a palliative care service would have demanded an increase in expenditure? If the answer is that there are more home-based hospital programs, as the director general mentioned earlier, that line item follows a similar trend; it is decreasing. Are there efficiencies that we are getting out of the activity-based budgeting, or is something else happening there?

Hon HELEN MORTON: I will allow the director general to respond to that.

Mr Snowball: Through the minister: you are right on both counts. First of all in terms of palliative care, while there is a slowing in the growth, that is acknowledging an increasing percentage of home-based and supported palliative care. But, again, I should emphasise the comment that the funding is following our projection of activity required in that area, so that there are sufficient funds on the basis of that level of activity. Should that change during the course of the year, one of the jobs that the health department runs is to make sure there is sufficient to accommodate that growth.

[2.20 pm]

So in any particular year you might find palliative care services cost more than another year because it fluctuates year-on-year, but that is our best estimate of the expected demand. In terms of the Hospital in the Home programs, there is a combination; there are some that the department itself operates as Hospital in the Home, so it might be in association with one of the major hospitals, for example, where they are employed staff and so on, but we also use other NGOs. That is where a large part of the growth has been, not under that particular line item but in growing these services, in particular through Silver Chain providing a lot of those Hospital in the Home–type services. That is the explanation, I guess, for that shift, so you will find certainly a significant increase and growth in community-based services as part of the way we are reforming the health system.

Hon PHILIP GARDINER: That is helpful, thank you. Just in relation to Silver Chain and the other NGOs, are they funded entirely by voluntary giving by people or is there an allocation out of a government budget of some kind, which contributes to the service that they offer and provide?

Hon HELEN MORTON: There is actually a huge contribution from government. If you are looking for a specific number, by far the majority of their funding would be a contract from government.

Hon PHILIP GARDINER: So where is that in the budget papers if that is contributing, as Kim just said? Where is that in the papers, because that should be an additional amount, if you like, to the home-based hospital programs?

Hon HELEN MORTON: I ask Wayne Salvage.

Mr Salvage: You will not see it as a separate line item in the budget. If you look at the income statement—I might have to correct this subsequently—I anticipate it would be in the "Private sector contracts expense" line or possibly in "Grants and subsidies".

Hon PHILIP GARDINER: Sorry, which page is that?

Mr Salvage: If you look to page 149 of budget paper No 2.

Hon PHILIP GARDINER: I see it would be in there, okay.

Hon HELEN MORTON: If you would like some further explanation, the director general is going to give you some additional information on that.

Mr Snowball: Just to clarify, Wayne Salvage has outlined where it may be between those two items. There are two levels of support for non-government organisations. One of them is a grant to provide those organisations with the ability to provide the service that they do largely operate through philanthropic or other support. There are others where we do in fact contract a service. The Friend in Need–Emergency, or FINE, scheme is an example of that where we have contracted Silver Chain as a non-government organisation to provide a level of service. It is a contract, as you would expect, for service delivery and it is a formal contractual arrangement rather than a grant to an organisation to provide a service as they see fit, so this is actually specifying what we require them to deliver to public patients by way of a community-based program.

Hon PHILIP GARDINER: If you are looking at the money which towards home-based hospital programs to be more complete, it does need to have an allocation out of that private sector contract expenditure to give us a holistic view of what it is costing us. Do you do that? Do you actually manage the service you provide to palliative services and home-based hospital care as an activity like that? Do you aggregate it all up so we know what the whole cost is and how that is growing?

Hon HELEN MORTON: Yes.

Hon PHILIP GARDINER: Can we have the detail of that then, please? Is that possible?

Hon HELEN MORTON: So, what you would like is the detail of the total cost of the contract?

Hon PHILIP GARDINER: What I would like to have ideally, minister, is the home-based hospital program total cost, if you like, including the service from the hospitals, as well as the service from the NGOs, going out to the forward estimates so we can get an idea of the growth which is being planned for that area.

Hon HELEN MORTON: I want to see whether the information that I have got is what you are looking for and that is that the total cost of the contract to Silver Chain is $22 million.

Hon PHILIP GARDINER: It is not necessarily the Silver Chain contract I am interested in; it is the allocation to the home-based hospital care program which, if I understand the director general correctly, is covering part of the growth in aged care.

Hon HELEN MORTON: We will provide that for you as a total cost.

Hon PHILIP GARDINER: Okay, I will be interested in that.

[*Supplementary Information No A7.*]

Hon PHILIP GARDINER: Sorry, I know others have got questions, but if I can just ask this one as well. At the top of page 129 in the first dot point we have got reference to the commonwealth government agreement. It states —

> … rising to 50% in 2017–18, of the national efficient growth in public hospital services.

I do recall this being an issue in the negotiations. Have we got a definition of what "national efficient growth" is? Is that related to activity-based budgeting? How are we measuring it?

Hon HELEN MORTON: I ask the director general to speak on this.

Mr Snowball: Yes it is. What they are describing there is the development of an efficient price for hospital services nationally, so this is proposed as part of the heads of agreement under the national partnership agreement on health reform. That national efficient price will be used to fund the commonwealth's outlays to our hospital system for growth in service, so it will continue to fund at the level at which they were committed before. That growth will be on the basis of the activity levels established by the state, so if the state sees a growth of, let us say, five per cent in inpatient services in Western Australia, this is designed so that the commonwealth will provide its proportional share of 45 per cent from 2014–15 at the efficient price. Now, a lot of debate about what that efficient price will be and what it will incorporate is happening right now. It is based on activity-based funding, so you are working out a cost base for hospital procedures so that they arrive at an aggregated hospital weighted average for a hospital presentation in any state. There are two other things to mention under that efficient price. There will be an allowance for cost disabilities in that, which are yet to be described, but there is a general acceptance. For example, very small rural hospitals will not be the subject of an efficient price mechanism and also those that are very remote and have higher costs for power, water, employment and so on—acknowledgement of that as well within that efficient price. But there is a lot of work, obviously, happening to even reach the point where we have a national efficient price, but that is what it is referring to and that design is to achieve that by 2014–15.

Hon PHILIP GARDINER: Okay, and if I can just have one last question to do with the activity-based funding. Say, one of the hospitals in the city, on the basis of same beds and I guess same employees—a bit like having sales in retail where you have the same stores versus new stores so you have got a persistent thing—are you seeing the activity-based funding budgeting technique improving efficiency?

Mr Snowball: In short, yes we are. Activity-based funding recognises for a hospital—for example, we went through in the last financial year with an average price—if you like, an average cost, so they were able to very quickly identify where they were above and below that average; in other words, where have I got a problem and where am I doing well. That has helped to drive change and focus, whether it is areas like length of stay—how long people stay in our hospitals—it becomes readily apparent through the activity-based funding whether you are achieving an optimum level of support. But it is not activity-based funding alone in this process; there are also measures around quality and safety. It is not about the cheapest price equals the best outcome; it has to have that combination of "is this good clinical care" in terms of the process and safe care at the right level of quality and right level of cost.

The CHAIR: I suggest that we take a 10-minute break now and that we adjourn until twenty to four. So if people want to stretch their legs, we will start again in 10 minutes.

Proceedings suspended from 2.29 to 2.42 pm

The CHAIR: I will give the call to Hon Adele Farina followed by Hon Jim Chown and Hon Brian Ellis.

Hon ADELE FARINA: Can I have an indication of how many questions I can ask?

The CHAIR: I have been roughly allocating members 10 to 15 minutes. If you think about that sort of time frame, it is easier than numbers of questions. There might be a further opportunity. We have until four o'clock. See how we go.

Hon ADELE FARINA: I start with the heading "Southern Inland Health Initiative" on page 146 of the *Budget Statements* under "New Works". How much of the South West Region is incorporated in that initiative? I understand the coastal areas are not, but no clear map has been provided to identify which areas of the South West Region are likely to be covered by that initiative.

Hon HELEN MORTON: I might make a few comments at the beginning, in case people are not aware of what the southern inland —

Hon ADELE FARINA: No; we have all read it. It is in the budget papers. Do not worry.

Hon HELEN MORTON: Everybody is happy with that?

Hon ADELE FARINA: Yes.

Hon HELEN MORTON: Then I shall throw straightaway to Ian Smith.

Mr Smith: The southern inland health initiative is built around, in the first instance, establishing some district network centres. In that sense, for the south west health region, that is focused around Manjimup and Collie. It will have flow-on benefits to the other towns surrounding that. It has a benefit therefore to Boyup Brook, Bridgetown and Nannup. I am thinking very hard about what other towns were there. That covers those. Donnybrook and Harvey are close enough to Bunbury to be part of a very effective emergency hospital system down there. It is fundamental for the South West, Manjimup and Collie.

Hon ADELE FARINA: I understand that the decision as to which hospitals will be upgraded to become integrated district campuses has not yet been made, is that right?

Mr Smith: No. For the district network centres, that includes Collie and Manjimup. It is the smaller hospitals, the different stream in the announcement, related to the 16 or so smaller hospitals, that is still subject to a condition and fit-for-purpose audit. It is a little further away. A definitive decision has not made on which hospitals get that upgrade.

Hon ADELE FARINA: The six district hospitals which are going to be upgraded to integrated district campuses, that decision has been made and those hospitals have been identified?

Hon HELEN MORTON: It has. I have that information here. The director general can talk about that.

Mr Snowball: In addition to Manjimup and Collie, there is also Northam, Narrogin, Merredin and Katanning. They represent the six integrated district health campuses.

Hon ADELE FARINA: Can you tell me what the difference is between a district hospital and an integrated district campus? What additional services are provided out of these locations as a result of this great change?

Mr Snowball: Initially, there is a range of things that these campuses will do. This was really homing in on a couple of areas in the country around access to medical coverage, so GPs providing primary care as well as GPs providing hospital services. The intent was these district centres would house and home additional GPs to provide services for emergency coverage, on-call, after-hours and visiting services to the smaller communities in the event they could not recruit their own GPs. Importantly, that was around bolstering the existing GP services operating in those towns rather than replacing them or providing salaried services. Around $26 million is allocated towards primary health care. In addition to the doctors, it is around nursing and allied health professionals. There will be teams established in these centres, again providing outreach to the broader district. That is why they are describing them as integrated district health campuses. It is providing a service beyond

a local service. It is outreach to the smaller communities both in terms of visiting integrated primary health care teams, with allied health, nurses and others, as well as providing the medical backup and support into these communities.

Hon ADELE FARINA: The new primary health centres that will be created under this initiative, have they been determined yet?

Mr Smith: Yes. The four primary health care teams are the six sites excluding Collie and Manjimup, because they have functional primary health care teams delivering that service now. The model of having the enhanced primary health care teams is to ensure we have a much better outreach to the myriad smaller hospitals surrounding that district centre outside of Katanning, Northam, Narrogin or Merredin. They are the sites that have the greatest failure in the commonwealth's primary health, which we are trying to address.

Hon ADELE FARINA: Collie hospital will move from a district hospital to an integrated district campus but will not get any additional funding for primary health?

Mr Smith: Yes.

Hon ADELE FARINA: I will move on to another area.

Hon HELEN MORTON: Can I make a further clarification around that? The director general makes the comment that it already has enough.

Hon ADELE FARINA: Yes; but it is being upgraded to an integrated district campus, the same as the other five in that list, yet it does not appear to be getting the same level of services or the same level of funding that the others will. I find it interesting it has been given the same name.

Hon HELEN MORTON: But the response is because it actually has the required resources to achieve that outcome.

[2.50 pm]

Hon ADELE FARINA: How many additional general practitioners will be provided at Collie?

Hon HELEN MORTON: Some of these specifics are not clear and are still being negotiated, but it will be in the vicinity of four to five.

Hon ADELE FARINA: And for Manjimup?

Hon HELEN MORTON: The same.

Hon ADELE FARINA: Where are you going to find these GPs?

Hon HELEN MORTON: The director general.

Mr Snowball: Through the minister: there is a variety of sources for us to recruit. This represents an attractive package to get doctors into these areas. We will certainly be running quite an aggressive recruitment campaign in other states, but we also have our own doctors coming through now and we are looking to attract many of them. In fact in our medical schools now almost a third of medical students are originally from a rural background. So, there is a kind of level of recognition, if you like, so that some of those graduates are going to be attracted to the country. This is setting up an environment that is going to be good for them, because they will operate much more in a group-type environment, so it will be attractive in that sense, as well as being an attractive remuneration package. Failing those two sources of recruiting, we will also look overseas, as we currently do, but we are quite confident that this package is extremely competitive and will be very attractive to both current grads as well as being attractive to doctors working both in Perth and in other states.

Hon ADELE FARINA: What is the time line for providing the additional doctors to both Collie and Manjimup.

Mr Snowball: Through the minister, we are still working through that with the practices in those locations. In fact, there have been discussions with practices in both Collie and Manjimup. Those discussions will then work through what is the best timing, what is the source and how we are going to establish it in this district that best suits the way that district does its business. So, without kind of pre-empting, we are looking at getting as many of those additional doctors. It is the equivalent of around 44 doctors that we are talking about—that is the equivalent of, not in actual bodies—so we will be attempting to do that during the course of the next financial year. In fact, they are cranking up right now in order to be able to meet that sort of requirement. But this is the fundamental bit of the inland health initiative. Communities have made it very clear in the consultation processes we have run with them that what they value most out of their health system is having a good, effective, available emergency service first and foremost, as well as having an effective GP primary healthcare service. That is what this seeks to home in on. I think in terms of providing services, it is a little different from the metropolitan area, where many people are used to seeing a GP in their rooms, quite distinct from a hospital event or an emergency presentation; whereas in the country it is very much one person who does both GP and surgery, as well as looking after patients in the hospitals and covering the emergency department. So, this is about providing enough resources in those areas to provide those services across a number of communities rather than each trying to compete for their own.

Hon ADELE FARINA: What is being done through the budget to provide additional GPs to Bunbury? I continually get constituents raising with me the issue of very long wait times—in excess of six weeks—to access GPs in Bunbury. It is an issue that has been picked up by the chamber and by the South West Development Commission, but it does not appear to me that I can find in the budget any sort of dedicated allocation of funding to address the shortage of GPs in Bunbury.

Hon HELEN MORTON: I remind the member that GP services are federally funded usually and it is a federal initiative to ensure there are sufficient GP services operating. The impact, of course, on acute-care services when there is a lack of GPs does impact on the state, but Bunbury is not part of the inland special service that we have been hearing about. So, the impact of the budget on increasing, recruiting and retaining GPs in Bunbury is through the more general assistance that comes from having an acute hospital service et cetera operating in that town. There are some other additional initiatives generally applied that are not specific to Bunbury but I will let the director general mention those.

Mr Snowball: Through the minister, there is a range of programs to support recruitment into general practice in country areas. One of the things announced as part of this budget was $75 million towards supporting junior doctors through the junior doctor case, which includes about 40 per cent of those funds being directed to the country. Bunbury will be a recipient of a level of support from that, which is about providing the internships so that the rotations through obstetrics, surgery and so on are in a country setting; so, in fact this current budget provides the means to substantially increase our support for supervision and in particular training and education within country settings. As I said, Bunbury is a key kind of part of that where students will be able to get their internship in Bunbury. The view is and I expect that local general practice will be seeking to lure those interns into general practice, and in particular general practice in Bunbury in time. So, this is focusing very much on where we have critical, chronic shortages in communities that do not have access to the service, versus a community that has a level of service but needs to have other processes in place to support recruitment into the future, including training our own.

Hon ADELE FARINA: How was the catchment area for the southern inland health initiative determined?

Mr Snowball: Through the minister, the initiative has been targeted towards those areas as I have described that have small communities with poor access to GPs or that have had difficulty in recruiting GPs and have had chronic difficulties over a large period of time.

Hon ADELE FARINA: Yes, but we have the same sort of shortage in Bunbury as well. I am curious about the criteria used to determine the catchment for this initiative, because the reality is that the problem does not exist just in those small country towns; it exists in the big country towns as well.

Mr Snowball: Through the minister, the particular problem we have had in the small inland towns is that they are small. By contrast the larger centres, first of all, have less difficulty in recruiting doctors; there is a level of back-up and support. Whilst you might wait longer to see a GP in a larger centre, there are communities in the inland areas that do not have a GP, so that those people have to travel quite substantial distances to access a GP. It also leaves it problematic for us to cover emergency departments to ensure that they have good cover for our inpatients. Bunbury Regional Hospital does not have that issue; it has adequate cover for both the emergency services through having FASEMs, emergency consultants and so on. So, it is a very different level of service and access to and recruitment of practitioners into that centre. But this is about the combination of hospital support as well as a GP service in those towns.

Hon ADELE FARINA: Has a business case been prepared for the southern inland health initiative?

Hon HELEN MORTON: Yes.

Hon ADELE FARINA: Can the minister table it? She can take this question on notice.

Hon HELEN MORTON: I am aware of this through the EERC and through cabinet, so I do not think that that would be available.

Hon ADELE FARINA: Can you take that as a question on notice?

Hon HELEN MORTON: What is your question?

Hon ADELE FARINA: I ask the minister to table the business case for the southern inland health initiative.

Hon HELEN MORTON: I think I have just indicated that as it was part of a cabinet submission, it would not be appropriate to table it.

Hon ADELE FARINA: Do you not think that is a question that should be put to the Minister for Health?

Hon HELEN MORTON: I can put it to him but I actually do know the rules around cabinet papers and cabinet confidentiality and the EERC being a subcommittee of cabinet. So, if you want that to be confirmed by the Minister for Health, I am happy for the Minister for Health to confirm it.

Hon ADELE FARINA: Thank you.

[*Supplementary Information No A8.*]

[3.00 pm]

Hon ADELE FARINA: There was a recent announcement about the coronary unit in Bunbury. Is that unit being funded out of state moneys or is it federal government funding? I cannot see a line item for it anywhere in the Health budget.

Hon HELEN MORTON: We are just doing a final check on this but we are pretty sure it is under royalties for regions. I am fairly confident that what I am saying is correct. However, just to be certain, we will take that on notice.

Hon ADELE FARINA: I find that curious because all the other royalties for regions projects are listed in the budget papers. I suspect that it is federal government funding.

Hon HELEN MORTON: Did you mention coronary care or intensive care?

Hon ADELE FARINA: It was referred to in the media as a coronary facility and it is being provided by St John of God Bunbury.

Hon HELEN MORTON: That is private.

Hon ADELE FARINA: No, it is not. The government announced the initiative and that government funding was going towards it. Is it state government funding or federal government funding of $6 million?

Hon HELEN MORTON: It will be state funding, but we will confirm that.

[*Supplementary Information No A9.*]

Hon ADELE FARINA: My next question is about the ICU in Bunbury, which was completed in February and has not been able to operate as an ICU because of the lack of a medical director. I understand that someone has been appointed to the position on an acting basis. When was that person appointed to that position in an acting capacity?

Hon HELEN MORTON: I will ask Mr Ian Smith to answer.

Mr Smith: Through the minister, that is still being finalised as we speak but there is an expectation that it will happen over the next few weeks.

Hon ADELE FARINA: The ICU has not been operating as an ICU to date but has been operating only as an HDU. Is that correct?

Mr Smith: Yes.

Hon JIM CHOWN: My question also deals with the southern inland health initiative and I would be more than happy if the minister wishes to expand on any part of that initiative or component thereof. My specific question relates to the second dot point on page 130 regarding GPs once again. If possible, I would like the minister to provide a bit more detail about the medical model that will encourage and reward doctors practising within the region. Also, what sort of financial incentives will be offered to private practitioners to preserve and improve medical outcomes? My third question is: how did you get the figure of an increase up to 44 new GPs, and where will they be allocated?

Hon HELEN MORTON: I want to make sure that we put on the record what a fantastic initiative this is.

Hon JIM CHOWN: I could not agree more.

Hon HELEN MORTON: The state government is committing over $565 million of royalties for regions funding over five years to substantially reform and significantly improve access to health care for all the residents of the southern inland area of Western Australia. The region includes localities in the north and east of the metropolitan area and stretches from Kalbarri and Meekatharra in the north to Laverton in the east and down to Esperance in the south east. We have already heard about the towns that will be covered under the super towns concept that the Western Australian government is planning to further enhance and develop to meet the longer term challenges and effectively manage Western Australia's economic boom and the predicted rapid population growth. That package comprises six streams: the district medical workforce investment program, $182.9 million; the district and health services investment program, $147.4 million; the primary health centres demonstration program, $43.4 million; the telehealth investment program, $31 million; and the residential aged care and dementia investment program, $20 million. I can only imagine how fantastic this will be for those communities.

Hon JIM CHOWN: In regard to the number of GPs —

Hon HELEN MORTON: Did the member ask how we got to that number?

Hon JIM CHOWN: I asked for the details of the medical model that will encourage and reward doctors to practise as part of the district network. That was my first question.

Hon HELEN MORTON: Can the member just ask that again, sorry.

Hon JIM CHOWN: Can the minister provide the details of the medical model that will encourage and reward doctors who are practising as part of the district network?

Hon HELEN MORTON: I will ask the honourable —

The CHAIR: Mr Snowball?

Hon LJILJANNA RAVLICH: It did sound complex!

Hon HELEN MORTON: I will ask Kim Snowball to answer.

Mr Snowball: Through the minister, the decision on the number of doctors was an estimate of the current shortage in these districts. That is what is needed to back up and guarantee 24-hour emergency cover as well as providing on-call and overnight cover for inpatients and access to primary care services in those communities. It is about shoring up the service across those inland country towns. It goes one step further by creating an environment in which a group of doctors work out of the one district centre to provide an on-call service and other support services. We are investing in the infrastructure of those towns to make them fit for purpose so that they start to expand their ambulatory care services and become an attractive and good environment for not only GPs, but also visiting specialists. A lot of attention has been given to technology, particularly telehealth, so more and more people in the districts can be supported by outpatient services through a telehealth model or can be covered by EDs with the backup and support that telehealth can offer people in isolated circumstances. The basic model will support a group of doctors in district centres to provide expanded services in that location as well as provide a backup and guaranteed service for the towns in the immediate surrounds of the centre.

Hon JIM CHOWN: What sort of financial incentives will be offered?

Mr Snowball: Through the minister, the packages are being worked up with the practices in those locations. What we are trying to do through this process is support and encourage more private GPs. If a town has three or four GPs, this initiative is about supporting them to recruit a fifth, sixth and seventh GP to provide a broader service. It is being tailored, but there will be a premium for providing an on-call GP for the wider districts. A GP will not just sit in one community and wait for an emergency service to be required, but will offer support in the broader district. There will be a premium for proceduralists. If you come into a practice and you have emergency skills, anaesthetic skills or obstetric skills, there will be a premium package available to you. The total package itself represents a substantial premium on what doctors currently receive in these sorts of centres. That is why we are confident about being able to attract them to this initiative.

Hon JIM CHOWN: When you talk about tailored packages, does that mean that each package will be relevant to the particular area?

[3.10 pm]

Mr Snowball: Through the minister, the packages will be tailored but there will be a level of consistency in terms of what someone is paid for being on call; that amount will not be much different between the six centres. What will be different is how those centres want to operate in terms of the service. For example, we have cases where backup to a particular community might be provided on a rotating visiting basis. In a group practice, you might have male and female; you might have people who have an interest in mental health or in maternal care or whatever their area of interest is. By providing that rotation, you are able to provide a more comprehensive service to the smaller centres in the outlying areas, so it is really about then rewarding the people involved in that model in a different way. If I can just add one more piece: in terms of the package, it also

includes coordination support to those practices to coordinate not only the doctor care, but also the allied health and nursing support that go out into the smaller centres.

Hon JIM CHOWN: This is a first across the nation, I think, for regional Western Australia. As a tailored package for certain areas, what sort of benchmarks is the health department putting in place to achieve what they are trying to achieve? What sort of goals are they trying to achieve in how they are going to benchmark that? Obviously, it is an evolving program, so once it is in place, is it able to be improved?

Hon HELEN MORTON: The director general.

Mr Snowball: Through the minister, the absolute focus is really responding to the community's needs to have —

Hon JIM CHOWN: In consultation with the community?

Mr Snowball: Correct. So very much the message has been, "Please ensure we have access to good, effective emergency department services and that we have good access to GPs in our communities." So this is absolutely focused towards those two key outcomes, and the measures we have will be by way of ensuring, first of all, 24-hour coverage, and in the larger centres, in some of those district centres, you will see a doctor in the hospital, in the ED, when you arrive. They are the sort of benchmarks that we are applying. There are some service level benchmarks, which are those sorts of things. A doctor, between certain hours, will be available at the emergency department, but any of those smaller communities know that they have access to a GP in the district centre who has emergency skills and that they can get reliable access to GPs, regardless of whether their community can attract one in their own right or not. So they are the sort of benchmarks. We are also looking at how many people thereafter use local services instead of travelling to a larger centre or travelling to the metropolitan area.

Hon JIM CHOWN: So things like outreach GP programs will be part of the process.

Mr Snowball: Through the minister, very much so. There is a very big intent here to not only make sure that people receive an effective visiting service, but also make sure that their needs are accommodated in the skill sets that you have got in those communities. So there is a service element that we are going to be measuring against and there is a quality element that we will be measuring against as well, and ultimately it will be that people vote with their feet. We expect them to be using these district centres more and more as the services develop and grow. So you have got an up-front investment that has got resources, infrastructure and staffing in place. People are then going to be using that local service and not travelling elsewhere for it.

Hon JIM CHOWN: I have another question. The Albany hospital has been ongoing for many years. What is the due completion date? How much has it cost until now?

Hon HELEN MORTON: Ian Smith.

Mr Smith: The practical completion date for Albany hospital is 21 January 2013.

Hon JIM CHOWN: And that is on target to happen? That completion date is going to happen, or is it on target to be completed on that date?

Mr Smith: It certainly is on target. There have been some interesting concrete pours over the last few weeks, and it is going tremendously well, and we have got a great response from the builder to work through even some minor precipitation. The greatest risk at the moment is just how wet the winter will be as to whether there are any requests for delay, but we are not anticipating anything at all.

Hon HELEN MORTON: I think the other part of your question was: what is the total cost?

Hon JIM CHOWN: Yes.

Hon HELEN MORTON: It is $170 364 000.

Hon JIM CHOWN: And that is within the budgeted parameters of the original construction cost, is it?

Hon HELEN MORTON: Sorry; what was your question?

Hon JIM CHOWN: Is that within the budgeted parameters of the original construction cost?

Hon HELEN MORTON: Mr Smith.

Mr Smith: Through the minister, there is only one addition to the budget. It was originally $166 million, but there has been a $4 million contribution from the commonwealth for the enhanced cancer service, so that brings it up to the $170 million.

Hon JIM CHOWN: My last question, if possible —

The CHAIR: The last, last question, yes.

Hon JIM CHOWN: Yes. I refer to the works in progress on page 145 for Royal Perth Hospital, $10 million. Is there a government plan to retain Royal Perth as a major hospital, and can the minister update the progress towards this commitment?

Hon HELEN MORTON: The obvious response is yes, it will be retained. I am going to ask the director general to give the specific information that you are looking for.

The CHAIR: It could have been a trick question, minister.

Mr Snowball: Through the minister, the $10 million allocation is towards planning for that redevelopment. So there is work underway, and a lot of that work is focused towards exactly what clinical services are going to be included in the 410-bed hospital that we have been asked to ensure is in place. So that work is happening right now. The $10 million simply provides enough capacity for us to do that work-up before a recommendation in to government as to the various options to ensure that can be achieved effectively for Western Australia.

Hon BRIAN ELLIS: My first couple of questions relate to page 127, under "Appropriations, Expenses and Cash Assets". The total cost of service: I note that the spending on the health service is up by $470 million. What does this increase represent and what will the overall effect be on the health budget?

Hon HELEN MORTON: The director general.

Mr Snowball: Through the minister, this current budget, 2011–12, represents an overall increase of around about 7.17 per cent and a combination of things that have been welcome from a health point of view. One has been to realign the budget against projected activities in health demand in our hospitals and emergency services to make sure that the budget reflects those activity needs going forward, as well as a recognition of the expected cost increases over the course of 2011–12. So that gives you certainty from a health point of view; it gives you certainty about having the funding to deliver the service that you know is going to be coming in through your hospital doors. But, in addition to that, there have been a number of initiatives. You have heard, obviously, of the southern inland health initiative, which is probably a once-in-a-lifetime thing for country health. Having worked in that area for quite a long time, it has been something that really goes over the top to resolve some longstanding chronic issues in our service provision in those areas, but also there are things like preparing for the future around the junior doctors training initiative, a response towards subacute services, and support for our enterprise bargaining agreements with doctors and nurses to make sure we are paying reasonable salaries and so on. So the perspective from Health has been that this has been a budget that has provided sufficient to accommodate that growth in costs, as well as secure funds for the activity that we expect into the future. We have managed, through the activity-based funding approach, to be, I would like to think, much more astute about the management of our costs in the system and driving productivity and efficiency that gives government not only a clear picture of what it is getting for its money, and Parliament sees what it

gets for its money, but also being able to contribute towards the growth in activity and demand in our state through those productivity initiatives in the system itself. So they have been key reforms for us, and they are paying a dividend for us now. Our projected outcome for the end of this financial year pretty much has us right on the nail in terms of budget outcomes, but also right on the nail in terms of activity. Our projections of activity and demand in our system have been extremely accurate, which is very reassuring for looking into the next few years.

[3.20 pm]

Hon BRIAN ELLIS: So there is every chance with that increase that you should be able to stay within budget next year?

Hon HELEN MORTON: I will allow the director general to make a comment about that!

Mr Snowball: Through the minister, we are very confident that, on the basis of our projections, yes, we will be able to deliver on budget, as we will this financial year.

Hon BRIAN ELLIS: On that same page, there is a line item for junior doctors' training—$11.5 million. Could you please provide some detail on what exactly this expenditure is for, and will any of this funding assist the country areas?

Mr Snowball: Through the minister, the junior doctor training was around $75 million, of which 40 per cent will be directed towards country areas—again, about reinforcing the opportunity for junior doctors to get education and training experience in their intern year in country settings. I mentioned earlier that quite a substantial number of medical students are, in fact, country students or, in fact, are under bonded arrangements as well, through the federal government, in which they provide in return a level of service in country locations, so this is good news for getting junior doctors supported into country areas. Inevitably, during the course of that rotation, they may need to come to the metropolitan area for a particular rotation as well. In places like Bunbury, you can do the full rotation, but in other centres it might be two or three rotations rather than the full 12 months. The funding goes towards not only the registrars and the residents, but it actually goes towards consultants as well, to provide the teaching, so you get a good quality of teaching, both in our metropolitan teaching hospitals, but also throughout country areas, where junior doctors are going to be housed.

Hon BRIAN ELLIS: I did have a number of questions on the southern inland health initiative, as it is a major initiative for the country areas, but a lot of the questions have been asked. But I have one from page 147, in relation to telehealth. I think there is some $5.5 million provided in 2011–12, and I just wonder whether the minister can advise what the benefits of this initiative will be for doctors in the country health system?

Mr Smith: Through the minister, the telehealth model is that we have invested quite a lot of money over the last few years in getting the bandwidth and some of the equipment in place, and there is $5.5 million in capital to continue doing that over the next few years. But the big weakness has been actually investing in the clinical staff at both ends of the technology, and that is what most of this money is around—it is about actually employing staff clinicians, both at the point of transmission and also receival. This will have benefits for the whole state because any of the sites will be able to access emergency department physicians at all hours of the day if they have any queries. This will support a lot of the sites where there may or may not be a doctor readily available. We will be able to have the technology linkage straight into the specialty that is needed. The thing that we need to do here is to make sure that the metropolitan hospitals are fully supportive of this model to make sure it works, and part of this is being able to provide services within our own system delivery.

Hon BRIAN ELLIS: Will it take any training for the medical staff in the country? It is a great initiative; I am just wondering what uptake there will be, and how difficult it will be for the staff.

Mr Smith: Absolutely. The changed management component of this is enormous to get people to have confidence in the equipment and knowing how to use it always at the time when they need it

to occur. So we are very confident that this will actually break the back of having technology that is not being fully utilised always, and this will be what will actually drive that forward. We have some good acceptance already by specialists delivering this service with some patients instead of using PATS, and we would expect that this will improve by the bigger range of specialties and being able to access that, but more importantly, under emergency care.

Hon BRIAN ELLIS: I only have one more, or two more questions relating to the same issue, on page 133. I am wondering if the minister can explain what is being done to prevent and reduce the harm caused by alcohol and other drugs. In the same section there, the follow-on question is: where have the alcohol management plans been implemented?

Hon HELEN MORTON: I will throw that question to Mr Guard.

Mr Guard: There are two parts to the question and the first part is prevention activities. A number of things are being done in the prevention space. One of the two major key programs that we have in the alcohol space is "Alcohol Think Again", which involves two streams of campaign activity at the moment, the first around community tolerance for the harms that are currently associated with the misuse of alcohol. Another current stream within that campaign is around the health effects of alcohol, and the initial concentration in there has been around the links between alcohol and cancer—so, a number of campaign activities. We also provide significant funding to the school drug education road aware program, for activities within school environments, and that provides support to a number of schools across the state. We are doing a lot of work with priority regions and communities across the state notably, you will have heard, in the Kimberly and in the Pilbara regions, but not solely associated with those two regions. We are also working with others around Carnarvon, some in the South West, and in the Goldfields, so there are a number of priority regions where the level of alcohol-related harm is more significant. As you said, that does involve working with a number of communities around alcohol management plans. Currently there are a number of alcohol management plans around. In Fitzroy Crossing, Halls Creek and Port Hedland there are existing plans in place, and the Drug and Alcohol Office actually chairs the alcohol management groups in each of those communities. There is also a regional alcohol management plan in the Kimberly and in the West Pilbara, and we are currently supporting the development of plans and management groups in Wyndham, Kununurra, the Dampier Peninsula and in Newman as well. So there is significant work with a number of communities across the state.

Hon LJILJANNA RAVLICH: I refer to page 142, "Contracted Mental Health". Specifically, we know from the WA health performance report for the January to March 2011 quarter that there has been a significant increase in the number of people admitted to mental health services statewide. In particular, if we have a look at the country statistics, we see that there has been an increase of 25.9 per cent. When we then have a look at page 143 and have a look at the cost of providing services through those efficiency indicators on that table on page 143, we see that the average cost per bed day in a specialised mental health unit is $1 106, compared to the average cost per three month period of community care provided by public community mental health services, that being, for a three-month period, $1 842. It seems clear to me that there is an imperative, one, to move people fairly quickly out of the hospital system and transfer them across to community care. The questions I want to ask relate to circumstances at Kalgoorlie Hospital. I understand that there has been a spate of people committing suicide within days of being discharged from Kalgoorlie Hospital. What I want to ask is: has the department conducted, or is the department conducting, an investigation into the spate of suicides that have apparently followed upon days of discharge of patients from that hospital?

[3.30 pm]

That is my first question. My second question is: how many patients have suicided following discharge from that hospital? Thirdly, can the minister advise why the regional director for mental health, who left the hospital in January this year, has not been replaced since then? Also, can the

minister advise why some paediatric patients as young as 14 are being put into the adult mental health ward? Lastly, how many root-cause investigations have been conducted at Kalgoorlie hospital in the past 12 months?

Hon HELEN MORTON: There are obviously five separate questions, so can you start with the first one?

Hon LJILJANNA RAVLICH: Yes; sure, and we will work our way through. I just wanted to put it on the public record. First, has the department conducted, or is the department conducting, an investigation into the spate of suicides that have allegedly followed within days of the discharge of patients at Kalgoorlie hospital?

Hon HELEN MORTON: The Chief Psychiatrist is not here. The Chief Psychiatrist is obviously the person who has to be notified and would be undertaking the reviews. We cannot be specific about the extent and the number of reviews that are being undertaken or the action that is taking place at the moment because the Chief Psychiatrist is not here. We will take that one on notice.

Hon LJILJANNA RAVLICH: There must be somebody responsible for regional and rural health. Would they know whether in fact there has been any investigation conducted at Kalgoorlie hospital?

Hon HELEN MORTON: The answer is that we will take that on notice, because it is a question that is making assumptions that may or may not be as significant as what you are indicating. The person who would know that is the Chief Psychiatrist, and that is the person I am going to be asking this question of.

[*Supplementary Information No A10.*]

Hon LJILJANNA RAVLICH: I assume that the same will apply to the second question, which is about the number of people who have committed suicide since being discharged from that hospital.

The CHAIR: We will include that in supplementary information A10.

Hon LJILJANNA RAVLICH: However, in terms of the staffing of that hospital, unless the staffing is done by the Chief Psychiatrist, I think the minister could advise, through one of her staff, why the regional director for mental health, who left in January, has not in fact been replaced yet.

Hon HELEN MORTON: What were you calling this person—the regional director for mental health?

Hon LJILJANNA RAVLICH: Yes.

Hon HELEN MORTON: Or are you talking about the medical director? Just be very clear with the question that you are asking because they are different positions.

Hon LJILJANNA RAVLICH: I have asked about the regional director for mental health.

Hon HELEN MORTON: We are making an assumption. There is no such position, but we are making an assumption that it is the clinical director for mental health services.

Hon LJILJANNA RAVLICH: Yes; okay. It would be the senior mental health position at Kalgoorlie hospital.

Hon HELEN MORTON: I will just make a comment at the beginning and then I will ask Ian Smith to comment as well. The recruitment process has been underway. There is a fly in, fly out service that is operating while that is happening. However, it would appear that there is no additional information to provide you with.

Hon LJILJANNA RAVLICH: In terms of additional information, can I also get that on notice? Through the minister, will the department provide additional information in relation to when that position is likely to be filled?

Hon HELEN MORTON: So, you want an update on where that recruitment process is up to and when the position will be filled?

Hon LJILJANNA RAVLICH: Absolutely.

[*Supplementary Information No A11.*]

Hon LJILJANNA RAVLICH: Can no-one help me with my fourth question about the patients as young as 14 being put into the mental health ward? I wonder whether you will take that on notice to verify whether this is a regular occurrence at that hospital and why that is the case.

Hon HELEN MORTON: Obviously, that is something that would be looked into. It is not known here at the moment how often or whether it occurs. If you have any specific issue or date that you want us to refer to, or if you are just asking whether it happens —

Hon LJILJANNA RAVLICH: Does it happen and how often has it happened in the last 12 months?

Hon HELEN MORTON: Unfortunately, I do not have that information at my fingertips.

Hon LJILJANNA RAVLICH: Yes, I know; you are going to take it on notice.

[*Supplementary Information No A12.*]

Hon LJILJANNA RAVLICH: Also, can you provide that information on the number of root-cause investigations that have been conducted at Kalgoorlie hospital?

Hon HELEN MORTON: Can I just confirm that you are referring specifically to mental health, or are you talking about any form of root-cause analysis that has been undertaken at the hospital?

Hon LJILJANNA RAVLICH: Correct—any form. Then, can you give me those that specifically relate to mental health? We will take the lot and a subset can be mental health.

The CHAIR: Is this Kalgoorlie hospital that we are talking about?

Hon LJILJANNA RAVLICH: Yes.

[*Supplementary Information No A13.*]

Hon HELEN MORTON: Obviously, as was just mentioned, these are specific questions that are not necessarily related to the budget, so that is not information that is here at the moment, but we are happy to provide you with the information.

Hon HELEN BULLOCK: I have a question relating to two not-for-profit organisations in the Goldfields. They are the Goldfields Women's Health Care Centre and the Eastern Goldfields Sexual Assault Resource Centre.

Hon HELEN MORTON: Can I just interrupt again? Can you please indicate the line item in the budget that you are looking for?

Hon HELEN BULLOCK: I am not sure. That is why I am asking this question; I need to find out.

Hon ADELE FARINA: It is the total appropriation on page 127.

Hon HELEN BULLOCK: That is right, because it is all lumped together.

The CHAIR: Members, we have done very well until now, barring one minor incident.

Hon HELEN BULLOCK: The budget is on page 127. I am not sure which line. Let me finish my question first. I understand that these two not-for-profit organisations are funded by the health department. My question is: is it the health department's intention to continue to fund those two not-for-profit organisations?

Hon HELEN MORTON: One was the women's health care service?

Hon HELEN BULLOCK: One was the Goldfields Women's Health Care Centre and the other is the Eastern Goldfields Sexual Assault Resource Centre.

Hon HELEN MORTON: Dr David Russell-Weisz will make some comments in the beginning.

Dr Russell-Weisz: I did find it difficult hearing the question, but the funding for these two non-government organisations is done through the Women and Newborn Health Service. The funding has been in place for some time, as I understand it, and will continue. Does that answer the question or were you asking something in addition?

[3.40 pm]

Hon HELEN BULLOCK: Okay, I will just give you a little bit of detail. The contract will be renewed in September, and my question is: how long will the contract be for? I understand that in the past couple of years you changed the contract from three years' funding to a year-by-year basis. You used to start to renew it in June, and now you push it back to September.

Dr Russell-Weisz: I would probably have to take that on notice. I understand that the contract will be continuing, but I do not know whether it will be on a yearly or three-yearly basis. There is no threat to the contract, as I understand it, as we speak.

Hon HELEN BULLOCK: I have a supplementary question. Will the new contract increase the funding level or remain at the existing funding level?

The CHAIR: Will you take that on notice?

Hon HELEN MORTON: Yes. The area of information that the member is looking for is quite detailed, and a bit specific for a non-budget item here.

Hon HELEN BULLOCK: Surely it is somewhere!

Several members interjected.

Hon SUE ELLERY: In every estimates hearing I have been in, someone has asked about women's health!

The CHAIR: Okey dokey.

[*Supplementary Information No A14.*]

The CHAIR: There were a number of details regarding funding for those two organisations.

Hon HELEN MORTON: I think the question we are taking on notice is: firstly, whether there will be continued funding; and, secondly, whether it will be for a two-year or a three-year —

Hon HELEN BULLOCK: No, the second part is whether it will be at the current funding level or at an increased funding level.

Hon HELEN MORTON: So there are two parts to it; I was going to give you three.

Hon HELEN BULLOCK: Can I add another one? The third part is how long the contract will be for.

Hon HELEN MORTON: That is the third part.

The CHAIR: That is a three-part supplementary question.

Hon ADELE FARINA: My question relates to page 144 of the *Budget Statements,* and the line item for Busselton Health Campus under "Works in Progress". I understand that the department has been advised by the Department of Water that in terms of flood protection for the new Busselton hospital, the minimum height needs to be at 4.3 metres Australian height datum, and the highest point on the site is four metres AHD. I would like to know what sort of implications that is having on the planning of the new Busselton hospital, and what implications it will have in terms of the cost of the new Busselton hospital. Clearly, there will need to be substantial site works undertaken

to lift the height of the site to meet that minimum standard. The other issue is that most of the remaining area of the site is between two metres and three metres AHD.

Hon HELEN MORTON: What does that stand for?

Hon ADELE FARINA: Do not ask me what it stands for, but I assume it means above sea level.

The CHAIR: Australian height datum.

Hon ADELE FARINA: I understand that there is real concern that the roads leading into the hospital, in the case of a one-in-500-year flood, will be inundated, and therefore you will not be able to get access to or from the hospital and the hospital will become isolated. It will not actually be of much help to the community at a time of a natural disaster when it will be needed the most. I would like to know what the department is doing to address the identified issues.

The CHAIR: That is a long question from the member; I seem to remember asking a similar question. AHD is Australian height datum.

Hon HELEN MORTON: I will ask Jodie South to comment.

Ms South: Through the minister, it is correct that the current development at the Busselton site is being briefed and designed to accommodate 400-year flood levels, so that is something we are working with our building agency on and it is briefed into the current design. I do not have the precise cost of that at the moment—what that has cost us. The issue of access roads is all part of the structure and the master planning for that site, and that is being considered in the current planning process.

Hon ADELE FARINA: Can I just clarify? There will be a cost implication as a result of that, but you do not know what that amount is?

Ms South: I could not say that there would be a cost implication. We are briefing that in; that is how the hospital will be built. We will have to take that on notice, if the minister is happy, to find out whether it has actually cost us something.

Hon ADELE FARINA: I would like to have that question put on notice in terms of the cost implications in relation to flood prevention measures that need to be provided at the Busselton hospital site; the time line for knowing what those implications will be in terms of design and construction; and the impact that is going to have in terms of the access roads leading into the hospital. If you are going to actually mitigate the flood issues that have been raised, you actually need to raise the height of all the roads into the hospital as well. It is not just a matter of raising the height of the land on which the hospital will be built; you actually have to raise the height of all the roads leading into the hospital.

The CHAIR: I will give that a supplementary number.

Hon HELEN MORTON: Let me just make a comment about that, first. All of the things you have identified are known and are incorporated into the tender brief.

Hon ADELE FARINA: No, they are not; they were not known at the time of the tender brief. An error was made in that the analysis was made for a one-in-200-year flood, not a one-in-500-year flood. When that was brought to the department's attention, they set about correcting that, so this information is recent.

Hon HELEN MORTON: Okay. The information I have is that the tenders are not in yet and, as a result, the costs associated with incorporating those requirements into the tenders are not known. In the absence of having the tendering organisations' information and their costs in yet, to try to provide you with information about what the cost is is not possible at this stage.

[*Supplementary Information No A15.*]

The CHAIR: Supplementary question A15 has a number of elements.

Hon ADELE FARINA: Sorry?

The CHAIR: I was allocating a number to those questions that you stated before.

Hon ADELE FARINA: I just want a guarantee from the government that any additional costs for the construction of the hospital on that site will not result in a reduction in facilities and services provided at that hospital; and that if there are additional costs, the government will fund the additional costs incurred as a result of its decision to build on the Mill Street site.

Hon HELEN MORTON: Look, the only thing I can say is that recurrent funding and capital funding are not interchangeable, so you will not see a reduction in services as a result of increased capital.

Hon ADELE FARINA: You might get a reduction in facilities.

Hon HELEN MORTON: As I say, until the brief comes in, it is absolutely not possible to provide you with the information you are looking for.

Hon ADELE FARINA: Can I have that question put on notice as well?

Hon HELEN MORTON: Can you be a bit more explicit then about what it is you actually want us to provide?

Hon ADELE FARINA: I am asking for the government to provide a guarantee that if there are additional costs to build the Busselton hospital on the Mill Street site, the government will provide additional funding to meet those costs, not cut into the current budget allocation for the hospital, which would then result in a cut in facilities provided at the hospital, obviously, if it were to come out of the same cost structure.

Hon HELEN MORTON: That is obviously the minister's call, so I will take that on notice.

[*Supplementary Information No A16.*]

The CHAIR: That will be on notice as A16, and I assume the minister will ask the appropriate minister for a response to that.

We have just less than 15 minutes, and three other people—namely, Hon Ken Travers, Hon Philip Gardiner, and Hon Sue Ellery—have indicated that they have further questions, and I propose that they have roughly five minutes each, if that is okay. I will give Hon Ken Travers the first five minutes.

Hon KEN TRAVERS: I wanted to go to the asset investment program and the Albany Regional Resource Centre. I just want to know what plans you have with respect to that. As I understand it, the construction of the new Albany resource centre will mean that the current easy access between the Albany hospice and the hospital in Albany will be changed, and that to actually take a patient from the hospice around to get any tests or examinations done in the new hospital will require an ambulance or a taxi to transport them. Can you tell me what your proposal is for how that will be managed when the new hospital opens, and how the government intends to address those concerns of the Albany community?

[3.50 pm]

Hon HELEN MORTON: I will ask Ian to answer that.

Mr Smith: That is accurate. There will be a separation between the community-run hospice some 300 metres away basically from the hospital. But it is not an unusual circumstance, I am led to believe, to have hospices not directly attached to a hospital, so the Albany hospice will be treated like many other hospices that then have patients who come into the hospital. There is a lot of work to do with the local committee of the hospice because there are services provided by the hospital in supporting the hospice. We are still working through those items with the committee, such as the delivery of meals and the best way of providing support to the hospice.

Hon KEN TRAVERS: So who is going to actually pick up the cost for the transporting of the patients from the hospice to the hospital under the new arrangement thing? Because it is causing grave concern; I was down there earlier this year and a number of community members raised it. Maybe it was because I was at their Relay for Life, so it is very close to the people there's hearts.

Hon HELEN MORTON: Director General.

Mr Snowball: The first option is we have obviously talked through the WA Country Health Service to the board about seeking ways in which they might source alternative funds to allow a relocation to occur. We have not at this point determined what the implications are for them remaining where they are and the possible additional costs of transporting, if there were any, to provide that service—because staff can go to provide service in the hospice as much as patients out of a hospice for a service—until those are worked through and we have not worked through them. But we will certainly be undertaking to do so with that board, and a reassurance around the patients to make sure that they get access to the services in the new campus.

Hon KEN TRAVERS: So, can you assure us that the patients will get the services they require and it will not be at any additional cost to them? Is that a fair thing of what you are saying?

Mr Snowball: What I am saying to you is that I do not know the answer to those things. We would certainly be guaranteeing that they will have access to a service. What the costs are and how they are incurred, so if they are provided for as part of a hospital whether there is a contribution from patients, we will actually look to lots of other circumstances around the state where hospices are in fact quite separate to hospitals and how those costs are covered in that. That is why I cannot tell you that off the top of my head, but that is the sort of guidance we would look to when we talk to the hospice board about those arrangements within the campus.

Hon KEN TRAVERS: If you can make sure you do talk to them because there is a lot of nervousness down there. I urge you to try to not impose a cost on them.

Hon PHILIP GARDINER: My question is related to the number of doctors. I know it was raised earlier and I think the doctor who was interviewed talked a little bit about how there were more rural students becoming graduates of medicine. My question is: what number of medical students are graduating from Western Australian universities? I recognise that they are not the only source of our potential doctors, but what number is graduating? Also, what number has graduated, if you have the numbers, in 2010 and what is expected in 2011, 2012 and 2013; and, for the same years, what is the number of those who are graduating from their internships?

Hon HELEN MORTON: I am happy to allow the Director General to speak on this.

Mr Snowball: We have seen a pretty extraordinary increase in the number of medical graduates year-on-year, mainly as a result of increases of places to the University of Western Australia as well as Notre Dame. So we are expecting that to rise to a peak of 310 by 2015–16. It was only 115 in 2005–06, so it is almost triple the number of Western Australian medical graduates. When we offer the internships, we offer obviously internships to our graduates first, but we also take graduates from other states and fee-paying students as well who are going through the University of WA or Notre Dame. We provide those interns with access to our hospitals by way of teaching and education in their intern year.

Hon PHILIP GARDINER: Is the constraint upon the number of doctors the university places or is it the education places after they graduate from university?

Mr Snowball: We have been fortunate that we have been able to provide all the intern places to all of our local graduates, so that has not been a barrier to date, but obviously with this sort of increase, that has been an increasing struggle for us. We provide some of that through not only our public hospitals, but, as you are seeing, an increase in the country areas, but also in private hospitals and in community settings.

On the issue about how many doctors actually remain in Western Australia, obviously once you have finished your internship then it is a case of, "Well, where's my vocation taking me? Am I going into general practice or am I going to specialise?" That takes you on different courses or career pathways, if you like. An issue of concern in health is that too few have in fact chosen general practice as a vocation, so we have seen quite a low number of GPs now in Western Australia; we are the last of all states in terms of GP to population ratios. We are very keen through the colleges and others to encourage these new doctors to be looking at general practice as their career option because that is where our need is greatest, as well as a number of specialty areas. So for us it is not just about how many doctors; it is about how many doctors with the right skill set that is going to meet the needs that we know we are going to have not only now but in five and 10 years' time. Medical oncologists are a pretty topical example of that. We know we are predicting almost a doubling of cancer cases in the next 10 years, so we need to gear up to be able to respond to that growth and that means getting our own grown doctors to know this is a niche in the medical profession that we would like you to look at. Outside that, we are looking at recruiting overseas or interstate to fill those kinds of skill needs.

Hon PHILIP GARDINER: If it was that there was a strategy to increase our doctors—did you say from 310 graduates by 2015? I do not know what is expected this year. Do you have the number for the end of 2011?

Hon HELEN MORTON: No.

Hon PHILIP GARDINER: I wonder whether we can get that schedule going from 2010 to 2015 for graduates out of the University of Western Australia as well as those graduating from their internship for those same years. But if it was that we were to increase that by 50 per cent, let us say, is the constraint the TEE level, so that there is a constraint on the quality of young students coming through from schools? Is the constraint on the places that the universities offer or will the constraint then be on the internships? What I am trying to get to is: why can we not increase the number of doctors we are producing Western Australia?

Hon HELEN MORTON: The short answer is that the commonwealth sets the number of medical student places in our schools, not the state. I just wanted to put that on the record, and I will allow the Director General to make some further comments.

Mr Snowball: We certainly inform the higher education sector about what our needs are, what our projected demands are for medical practitioners in our workforce in the future, and they will often seek federal approval to increase their places. They can be approved only by the commonwealth, not by the state. As you may be familiar, Curtin University has also signalled their interest in establishing a medical school in some years' time. They will need to go through that process; they need to get the Australian Medical Council's approval for their curriculum and that it meets national standards so that those practitioners, when they graduate, will meet standards they can practise anywhere in Australia following their internship. So when you say is there a constraint, the constraint is that one. In fact, back in 2005–06 that number of 115 medical students was about that number for almost 10 years before that, so there was an absolute clamp on the number of students going through. This has changed that radically; by a tripling of the medical graduates, we should be in an increasingly better position in terms of supporting our medical workforce needs now and into the future.

[4.00 pm]

But we do have a shortage. We have a shortage right now. So we are looking at that trying to at least get us up to a reasonable level. Constraints are capacity. Can our universities take more graduates? That is a judgement for them about whether they need to increase their own infrastructure. For us, there is a constraint about how many supervisors and teachers we can have in the system. There is a point of capacity in that as well, and that is where this investment in this

budget is around increasing that capacity in our system to accommodate this growth in the number of students.

Hon PHILIP GARDINER: I applaud the strategy in the budget.

The CHAIR: I am sorry, Hon Philip Gardiner; I might just give Hon Sue Ellery a chance for a couple of questions. We might just run over by a couple of minutes.

Hon SUE ELLERY: I refer to page 129 on elective surgery and waitlist activity. What is the average waiting time for patients to see their specialists?

Hon HELEN MORTON: I am sorry, what was your question?

Hon SUE ELLERY: What is the average waiting time for patients on the elective surgery waitlist to see their specialists?

Hon HELEN MORTON: Once they are on the list?

Hon SUE ELLERY: That is right; they are on the list and they need to have a pre-surgery appointment with their specialist. What is the average wait time for them to get that appointment?

Hon HELEN MORTON: There might be a difficulty around the way you are asking that question. To give you a good explanation about that, I will ask the director general to speak about it, but they do not actually get to see their surgeon until they are on the waitlist. So, there may be a possibility that that can be clarified easier.

Mr Snowball: Through the minister, the referral is from a GP to a specialist, believing the patient will need surgery, but ultimately the decision is by the surgeon that indeed they need to have surgery, and that is the point at which they go on the waiting list. If your question was how long it takes once that decision has been made by a surgeon for them to get their surgery, the answer is that it depends on their urgency. We work effectively to three categories of urgency for surgery. Category 1 is essentially within 30 days, so we attempt to deliver surgery to those patients within that time.

Hon SUE ELLERY: I am sorry. Because we are short of time, I will go back a step earlier because I think you are talking about the step after the step I was talking about. From the point a person has gone to see their GP and their GP writing the referral, do you know what the average time is for them to see the specialist?

Hon HELEN MORTON: The short answer is no.

Hon SUE ELLERY: I think I will ride it out so that everybody knows exactly what I am asking for. I refer to page 127, under the total cost of services, and I want to ask about the health corporate network. Has the operational plan for the network been updated; and, if so, when will it be published? Can you provide details of the number of FTEs in the health corporate network and the cost for the offices, if it is rent, of the health corporate network, and do you have a list of how many complaints from medical staff in the AMA were received in the past year?

Hon HELEN MORTON: I will ask Phil Aylward to respond.

The CHAIR: Mr Aylward.

Mr Aylward: First of all, the operational plan is nearing completion, and that will be subject to and signed off once the budget deliberations are finalised between HCN and the Department of Health. So that is imminent, and it is an operational plan in relation to its program and services that it offers. The specifics of the other questions I do not have with me, but that information is readily available and I would be more than happy, through the minister, to provide that by supplementary information.

Hon SUE ELLERY: Thank you.

[*Supplementary Information No A17.*]

Hon SUE ELLERY: I am done.

The CHAIR: Excellent. That is fantastic. That is good news. We will just wind up this session.

The committee will forward additional questions that it has via the minister in writing in the next couple of days, together with the transcript of evidence, which includes the questions that have been taken on notice. If members have unasked questions, please submit them to the committee clerk at the close of this hearing. Responses to these questions will be requested within 10 working days of receipt of the questions. Should the agency be unable to meet the due date, please advise the committee in writing as soon as possible before the due date. The advice is to include specific reasons as to why the due date cannot be met.

Finally, on behalf of the committee, I thank you all very much for your attendance this afternoon and I will close this session. If anybody is interested in the next session, which is the Department of Environment and Conservation, it will commence in just over 10 minutes.

Hearing concluded at 4.05 pm