Division 9: WA Health, $5 036 993 000 —

Mr N.W. Morton, Chairman.

Dr K.D. Hames, Minister for Health.

Professor B. Stokes, Acting Director General.

Mrs R. Brown, Deputy Director General.

Professor T.S. Weeramanthri, Assistant Director General, Public Health.

Professor G. Geelhoed, Assistant Director General, Clinical Services and Research, and Chief Medical Officer.

Mr A. Joseph, Acting Group Director, Resources.

Ms K. Towie, Assistant Director General, System and Corporate Governance.

Mr G.A. Jones, Group Director Finance, Chief Finance Officer.

Mr R.W. Salvage, Acting Chief Executive, North Metropolitan Health Service.

Professor F. Daly, Acting Chief Executive, Child and Adolescent Health.

Mr J.D. Moffet, Chief Executive Officer, WA Country Health Service.

Ms R.A. Lawrence, Acting Chief Executive, South Metropolitan Health Service.

Mr L. McIvor, Group General Manager, Contract Management, South Metropolitan Health Service.

Ms T. Chinery, Executive Director, Commissioning.

Ms M. Hayes, Chief of Staff, Office of the Minister for Health.

Mr C. Warner, Principal Policy Adviser, Office of the Minister for Health.

[Witnesses introduced.]

The CHAIRMAN: This estimates committee will be reported by Hansard. The daily proof *Hansard* will be available the following day.

It is the intention of the Chair to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point. The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. Questions must be clearly related to a page number, item program or amount in the current division. It will greatly assist Hansard if members can give these details in preface to their question.

The minister may agree to provide supplementary information to the committee rather than asking that the question be put on notice for the next sitting week. I ask the minister to clearly indicate what supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the principal clerk by Friday, 19 June 2015. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office.

I give the call to the member for Kwinana.

Mr R.H. COOK: I refer to "Works in Progress" on page 140, and my question relates to Royal Perth Hospital. I know we have raised this issue in Parliament before, but I thought that perhaps today with the help of advisers the minister might be able to provide us with a more comprehensive response. Before I ask my question, I welcome Professor Stokes to his final estimates hearing and also the minister to his final estimates hearing, too. I wish you both very well.

Dr K.D. HAMES: I would not make presumptions if I were you.

Mr R.H. COOK: We simply take the Premier at his word. I know it is foolish, but that is our nature.

Dr K.D. HAMES: I will see the member for Kwinana next year.

Mr R.H. COOK: In previous years, the minister has allocated as much as $200 million in the forward estimates for the redevelopment of Royal Perth Hospital. This was essentially the minister's demonstration of his commitment to keep the election promise that he made in both 2008 and 2013. This was later reduced to $180 million, with $20 million of planning money. It also followed from the committee that the member for Ocean Reef chaired to provide the minister with information in terms of future use of the site. There is obviously

no forward estimates this year in relation to the actual capital spend, although there is $19 million for yet more planning on Royal Perth Hospital. What happened to the $200 million original allocation? If the minister was serious about not breaking his election commitment, why is that money now not in the forward estimates as it was before? The Treasurer says that it would be better to demolish the hospital—of course we are talking about the south wing. What are the minister's plans?

Dr K.D. HAMES: As the member will know because he raised this in Parliament in the last month, I stated that we have not been able to meet that commitment of funding to do the extension we committed to, as the member says, on multiple occasions, to do a major upgrade of Royal Perth. The $19 million is not for more planning; there was a review on Royal Perth Hospital looking at essential infrastructure that required urgent upgrade. On things the member is aware of like the lifts, chillers, coolers—a whole range of other things within the hospital that need essential maintenance. The $19 million is for that. We are putting in our submission for the detailed requirements of that now to the Economic and Expenditure Reform Committee, listing what that work will be. I am hopeful that within the next couple of months we will be able to start that urgent work.

In terms of the total, as the member knows the debt situation for the state is critical. I have not given up. The proposal that we settled on in the end was a major refurbishment of the southern side—the old A block situated between the north block and the church—with a major refit-out. The structure of that building is still good. Once this $19 million has been spent, the key core requirements for running that hospital will all be in good condition. What will be left then is at some stage in the future, as soon as we are able to generate the funds, is to fix that. We originally estimated that at $180 million roughly—about $20-odd million per floor. Subsequently, Building Management and Works got its hands on it and the price doubled to $360 million as the estimated cost. I have to say that within that $360 million, there was about $180 million worth of contingency fees and escalations of payments to BMW. Nevertheless, it is a commitment that we have not been able to meet. I accept that and we have not given up. In my view, it will occur at some stage when the funding becomes available. We are committed to retaining Royal Perth as a tertiary hospital and continuing the great work that it does.

Mr R.H. COOK: When we considered the Royal Perth Hospital Protection Bill 2013, the minister talked about those parts of the overall Royal Perth Hospital precinct that the minister was prepared to look at preserving under that bill, and other areas he said could be surrendered. In that context, have those surrounding buildings been identified as part of the asset sale program that the government has highlighted in this budget? If so, what is the value of that land or assets, and will that money come back into the redevelopment opportunity for Royal Perth Hospital or will it go simply to retiring debt?

Dr K.D. HAMES: That has not been decided yet. I have put forward the proposal that we still want to do that. The difficulty is that there is some usage already. Remember, it is the stuff on the east side of the existing hospital, not including the outpatient clinic that is on the opposite corner—the rest of the building that currently has some occupancy. The old nurses quarters is still there, and that will be demolished as soon as the YMCA is out, which is in the not too distant future. Marginata house, down on the corner, gets little use. With the rest of it on the Wellington street side, one of the buildings has wax in it, for example. The older part of the hospital that is used much less needs to be refurbished. We need to move out the occupants, so that the buildings can be sold. That has to be determined.

I forgot to answer something in the former question about what happened to the $200 million. I am fairly certain—I do not recollect exactly—that that went on significant requirements to do with information technology at Perth Children's Hospital, as we discussed earlier. It was required for other major projects either at Fiona Stanley Hospital or the kids' hospital. I am pretty sure it was for the kids' hospital. That is where that money went two or three years ago.

[9.10 am]

Mr R.H. COOK: Just to clarify, the minister has submitted some parcels of land to the asset sale process. I think the minister said he has made a submission on that. I am not quite sure what he meant by that.

Dr K.D. HAMES: No, not yet. We have identified land that can be sold, as I said to the member. In fact, that was done very early in the piece, when the original review was done some years ago. We have identified that land.

Mr R.H. COOK: Is that the land the minister just described?

Dr K.D. HAMES: Yes. The process that that follows will be identified over probably the next six months. We can deal with that land only once we have sorted out what will happen to the people who are still using the buildings. They have to go somewhere and space needs to be provided in the existing hospital. Remember, we have gone from 680 beds down to 450 beds, which has freed up space inside the old part of Royal Perth Hospital. Some of the premises will be upgraded for administration. We do not need all that space for patients. My view is that the units close to the north block, on the Wellington Street side of the H-shaped block—the

A block—should be totally refurbished for patients and the outside bit where the emergency department is should be expanded for patients coming in by ambulance to stay, and the rest should be redone for administration. I think that is the best way to do it.

Mr R.H. COOK: Essentially, is the $19 million that has been identified—I think it was an engineer's report that found its way into the media last year—to fulfil the requirements to make good the lift services, air conditioning and other what were at that time termed "crucial repairs" to the buildings?

Dr K.D. HAMES: That is correct.

Ms M.M. QUIRK: I refer to Aboriginal health on page 128. The minister would, of course, be aware that there are disturbing levels of dementia and Alzheimer's disease amongst the Aboriginal community. It has one of the highest rates in the world, with 12.5 per cent of the population over 45 years having some form of dementia. How is that being addressed from a service, treatment, or research perspective?

Dr K.D. HAMES: As the member would know, the state government is largely responsible for hospital services not primary health services, and we certainly look after those. We fund Aboriginal medical services. I made the point during a ministers hook-up yesterday that this is primarily a commonwealth responsibility, but without state government money, those services would be in deep trouble. We provide something in the order of $800 000 a year to individual Aboriginal medical services to help them provide services to communities. Most people with dementia are in one of three places: back in the community where Aboriginal medical services and WA Country Health Service support is provided; in our hospitals, although clearly people with dementia do not stay there long; or in special retirement villages funded by the commonwealth. I will ask the director general whether he has anyone here who can provide further information about the Kimberley.

Professor B. Stokes: The Mental Health Commission is looking at and has talked to us about this very issue. As the member would be aware, a problem with people with dementia is that they require special care. That is something that we need to look at significantly, because at the moment those people are falling between two stools. I hope that discussions with the Mental Health Commission will enable us to come to some arrangement to help those people. Telepsychiatry has been in the Kimberley for many years, and that is being expanded. The Mental Health Commission has consistently visited the area, particularly some of the Aboriginal communities at the periphery. That is all being taken into account at the moment; although there is no progress to speak of at this stage.

Ms M.M. QUIRK: Is dementia categorised for the purposes of government response as a mental illness?

Dr K.D. HAMES: I would not have thought so. As I said, we look after people with dementia in a range of different areas, but dementia is a mental illness whichever way we look at it.

Professor B. Stokes: If I might say, it is like geriatrics, which is a psychiatric specialty. In the metropolitan area that is looked after by us from a clinical perspective, but also overseen by services from the Mental Health Commission.

Dr G.G. JACOBS: Good morning. Predictably, minister, I would like to ask about the regional infrastructure developments on page 128 for country health services. Can the minister outline the major infrastructure developments with particular relevance to Kalgoorlie Health Campus, because quite a few of my constituents in Boulder, Esperance and the surrounding areas access Kalgoorlie Health Campus? What is the cost of that redevelopment? The budget papers mention lower and upper ground floor specialist units, allied health and the construction of a new cancer unit. Can the minister put a figure on that for me? "Completed Works" on page 141 states that stage 1 of Kalgoorlie Regional Resource Centre redevelopment is complete but there is no money for it in the out years. Can the minister clarify where the money is to do more work at Kalgoorlie?

Dr K.D. HAMES: I thank the member. He may recall the history of that project. The major upgrade of Kalgoorlie Hospital was deferred by the previous government because, as I recall, it stated there were not sufficient contractors in the Kalgoorlie region to do the work. I strongly suspect it was a financial issue. We committed to the project and we are working our way through it. I have to say that the hospital now looks amazing. I happened to work at Kalgoorlie Hospital for three months in the old days, and it is nothing like it was then.

Dr G.G. JACOBS: I thought the minister was going to say he had worked there recently!

Dr K.D. HAMES: No, I have hung up my shingle.

There is no work for stage 1 because the work has been completed, but we are continuing to work our way through the project. In fact, we are nearing the completion of phase 2, which has just been cleared. I will hand over to Professor Stokes or another staff member to go through the rest of the question, particularly the details of the total funding.

Professor B. Stokes: Phase 1, palliative care, was completed in December 2010; phase 2, acute services, was completed in October 2012; and phase 3, the cancer outpatients allied health area, was completed in April this year —

Dr K.D. HAMES: I am sorry to interrupt, but that is the official opening I was talking about.

Professor B. Stokes: Phase 4 was services, air conditioning, operating theatre services, and that was completed at the same time in April. The estimated cost was $57.9 million, and the expenditure has been $39.6 million, with $18.3 million this financial year. Jeff Moffet may be able to add to that.

Mr J.D. Moffet: I was in Kalgoorlie on Monday to look at the new chemotherapy unit and the upstairs and downstairs outpatients units that have just been completed, as Professor Stokes and the minister indicated. The project is run over a period of time, obviously, in a range of stages; we have just completed the final stage. As Professor Stokes indicated it was a $57.99 million project and the cancer ward, in terms of chemotherapy and outpatients, was at the end stage of the program. It was looking excellent on Monday when I saw it.

[9.20 am]

Ms J.M. FREEMAN: I refer to page 136 under the heading "Prevention, Promotion and Protection". In the line items I note there has been a decrease from the 2014–15 estimated actual to the 2015–16 budget. I also refer to the heading "Public Health" on page 129.

Dr K.D. HAMES: Can I just —

Ms J.M. FREEMAN: I am just using the line item on page 136, but I want to take the minister to the heading "Public Health" on page 129, which is one of the items under the heading "Significant Issues Impacting the Agency". In this budget the state government has cut funding to financial counsellors. The minister would have heard me in a speech to the Parliament talking about public health being a holistic aspect of taking into account people's wellbeing in the community. One part of their wellbeing is their capacity to have financial stability and not become stressed because of the financial implications of the loss of a job or various other things, especially at the present time of unemployment. Given this, and given the focus we are about to have on public health, would the minister agree that cutting funding to financial counsellors will be detrimental to the health of the community?

Dr K.D. HAMES: I do not think the member can use her speech in which she said that the Public Health Bill should be more holistic than what is actually in the bill to extrapolate and ask me about things that relate to another minister and not what we are dealing with now in the estimates relating to the Public Health Bill as it exists and our concern about general health promotion, which is about people leading strong, healthy lives. Therefore, I am not able to answer that question.

Mr R.H. COOK: I am sorry the minister is reluctant to talk about an important public health issue; perhaps we can talk a bit more about patient transport on page 136. The minister is presiding over record incidences of ambulance ramping and that situation is getting worse. The minister has also previously said he has a solution to ambulance ramping, but the ambulance ramping figures continue to deteriorate. When will the minister implement his so-called solution to ambulance ramping?

Dr K.D. HAMES: The answer is in two weeks' time. For the benefit of the house—the member knows this well—currently what happens with ambulance ramping is that an ambulance brings a patient to a hospital. The patient is taken out of the ambulance and into the hospital. The urgent patients are taken straight through and received immediately and those regarded as not urgent are held in an area at the front of the hospital where the ambulance drivers remain until a space is created. When the hospitals are extremely busy, those patients wait for a longer time than is acceptable. Beyond 20 minutes is counted as ramping, so once those drivers have been there longer than 20 minutes looking after the patients, that is ramping—that does not include them going off and having a bite to eat. As the member said, that ramping has been getting worse. I have stated and expected that once Fiona Stanley Hospital opened, it would significantly ease the pressure on other hospitals and ambulance ramping would go down, particularly because Fiona Stanley Hospital, being a brand-new hospital, would be able to address that. That proved not to be the case. I have to say I was extremely disappointed. Ramping has almost become an institution. I have looked in detail back through the figures of presentations to hospitals, the number of patients in beds, the number of beds available within the hospital and ramping figures, and tried to see a correlation between all of those. However, there is no great correlation. It may well be that it is difficult to determine exactly how many beds are available and how many people are in the emergency department, but there are days of high ramping with less presentations than on a day, say, a year ago, so the ramping is worse with fewer patients and more availability of beds.

I have given up; I have lost my temper on this and I am now telling the hospital that legally once the patient arrives at the hospital, they are the responsibility of the hospital. They are not the responsibility of the ambulance drivers. I have passed on instructions, which will become as strong as they need to be, that hospitals are no

longer allowed to have ramping and from 30 minutes—I am giving them an extra 10 minutes, so there will perhaps be still 10 minutes of ramping—the hospital will be responsible. From 20 minutes they have to start a handover and from 30 minutes the hospital is responsible for looking after those patients. They are already in the hospital, they are already on a couch and they will need to be moved off the ambulance bed onto an alternative bed, which may well be identical, in order to fit them in. There is not much space; looking at Royal Perth Hospital in particular, there is very little space at the front of the hospital and previously there has been no capacity to create extra space. All I am saying is that hospitals will now be responsible for those patients—that is, in our three tertiary hospitals—from 30 minutes of their arrival, which will mean that hospitals will themselves need to employ paramedics to care for patients when they are there. Preferably, nurses, nurse practitioners or even doctors will look after patients while they are waiting to go into the ED, and that will encourage hospitals. I reminded hospitals that when the Labor Party was in government, there were 40 per cent, eight-hour waits to get a bed. The patients would come into the ED, be seen, be earmarked for a bed and then lie on a stretcher in a corridor. The EDs were filled with stretchers with patients waiting for a bed. That no longer happens and I do not think that patients waiting at the front of the hospital where they already wait is unreasonable, and staff will have to look after them. I have also phoned St John Ambulance to let it know that I am making these changes and that its staff have to initiate the handover to the health staff at 20 minutes and to make sure it happens, and at 30 minutes, providing the patient is being cared for, of course, they need to take off. There is flexibility in that. If the nurse gets caught up with a patient who becomes urgent, clearly they cannot leave that patient unattended, so they will have to stay there if that is the case, but that is the only case. Professor Stokes is in the final details of discussions with those three tertiary hospitals to make sure that this starts on 1 July.

Mr R.H. COOK: Can I confirm that the minister is only planning to run this in tertiary hospitals; and can the minister please provide the cost of staffing and equipment to implement the program?

Dr K.D. HAMES: Yes, it is only tertiary hospitals to start off with. We will be having discussions, and have been having discussions in fact, with Ramsay Health Care about Joondalup and it has been involved in the meetings to discuss how this will be implemented. I will not worry about Midland, because the new hospital is opening towards the end of this year and I do not want to put pressure on the existing hospital, the facilities of which are very poor. Although Swan District Hospital has a fair amount of ramping, we will just leave that be. As the member knows, Rockingham General Hospital has very little ramping—I think it has been 23 hours lately.

Mr R.H. COOK: Lately it has gone up.

Dr K.D. HAMES: Yes, it was about seven hours and lately it is about 23 hours, but looking at those stats, I can see that it happens on one, two or three days in the month, and that is often when patients are being held and waiting to be transferred to the tertiary hospitals. We will have to keep in mind how we deal with that. For example, if Ramsay sends a patient to Fiona Stanley Hospital where there are already queues of ambulances, how are patients to be kept and are they to be kept in the ambulance? Are they taken and put back in a bed in the hospital or left in the emergency department? Those minor things still have to be worked out but to start off with we are working on tertiary hospitals. The cost will not be significant. We are working through that now—remembering that ramping does not occur every day; when it does occur, we have at the most eight to 10 patients but in most cases it involves only three or four patients in the emergency department. Therefore, we will probably need only two staff at any one time to look after them when they are there. The costs will not be significant.

[9.30 am]

Mr R.H. COOK: Are we talking about two staff to manage the patients waiting in the ramping area?

Dr K.D. HAMES: The ambulance hours are high because some people stay there with one patient for a long period. Remember when we previously put in place a plan with St John Ambulance Australia by which if eight patients were waiting, we had 16 paramedics to look after them. All the patients had been stabilised and were lower, not higher, acuity, because the higher ones had gone through. The staff were just looking after those people and waiting for them to go through to ED. We made arrangements by which just two paramedics would stay behind to look after those people. It only lasted a day because the union decided it did not want to cooperate with that process; otherwise, we would probably still be doing that. But it will need whatever staff. It will not necessarily be just two staff because it will depend on the number of patients. My guesstimate is that it will require a minimum of two staff with more being sent out or moved to that area if the number of patients is significant. Again, the patients are low acuity and are generally not there for a long period. My assessment is that once the hospital and the emergency department doctors become responsible for them, there might be some changed behaviours as to how long those patients stay out there as opposed to going into ED.

Mr R.H. COOK: In the minister's budget he has identified a reduction in the number of staff working in emergency departments. Where will he find these new staff, and how will he fund them given the overall reduction of emergency department staff?

Dr K.D. HAMES: I am not aware of any reduction. I need the member to point that out to me in the budget papers.

Mr R.H. COOK: I would be very happy to, minister.

Dr K.D. HAMES: I will finish my sentence while the member is looking that up. We are not reducing staff in EDs. Although our overall budget goes up about 1.3 per cent, our hospitals budget goes up by 4.6 per cent. Although we have reductions in full-time equivalents through the redundancy packages, we have no booked reductions within our hospital staff. As I said, the tertiary hospitals budget goes up by 4.6 per cent. If the member could point me to the page —

Mr R.H. COOK: The table on page 135 under "Emergency Department" refers to employees, full-time equivalents. For 2014–15, there are 2 572 staff, and in 2015–16, there are 2 571 staff. Staffing will be held at current levels, but the minister is now shooting from the hip perhaps saying that he will employ extra staff in EDs to look after patients. Is the minister suggesting cuts to other areas or is this a totally unfunded program?

Dr K.D. HAMES: As the member said, the numbers go down by one, but we will have lost a hospital at Swan District Hospital that has ED staff. Part of the figure will include staff from Fremantle Hospital, but they will have transferred to Fiona Stanley Hospital. The total numbers will be the same. The estimate of growth in EDs has been variable in presentations to EDs, and we have seen significant fluctuations. In fact, last year in some hospitals the number of patients presenting to EDs went down. Remember that although this is the estimate from the budget, my instructions regarding ambulance ramping are fairly recent so they will not appear in the budget papers. Altogether, hospitals have significant numbers of staff, and how they distribute those staff will be a matter for the hospitals.

Mr R.H. COOK: The minister will then have to cut services in other areas.

Dr K.D. HAMES: I do not think the member has accepted the first part of my argument. Swan District Hospital is being closed and we are transferring across to the Midland Public Hospital where we will not be employing staff. The total numbers of ED staff relate to our ED staff, not the St John of God's public hospital staff in Midland.

Ms M.M. QUIRK: I refer to the first dot point on page 125, and the third hyphen point that refers to presentations to emergency departments—the minister might need to provide this answer by way of supplementary information.

Dr K.D. HAMES: Which line is it?

Ms M.M. QUIRK: I refer to the third hyphen under the first dot point, which refers to presentations to emergency departments. Lately there have been a number of prescribed burns —

Dr K.D. HAMES: We cannot find it.

The CHAIRMAN: The member is referring to the first dot point under "Health System Overview" and then the third hyphen that refers to 2013–14.

Dr K.D. HAMES: Yes, we have it.

Ms M.M. QUIRK: I want some information about the presentations in recent months to emergency departments by patients suffering from respiratory illness and asthma because of prescribed burns. I want to know whether there has been an increase in presentations, and how many, if any, health warnings has the Department of Health put out this year.

Dr K.D. HAMES: We are not able to provide that answer immediately but we are happy to provide that by way of supplementary information.

[*Supplementary Information No A30.*]

Mr V.A. CATANIA: I refer to "Country Health Services" on page 128. I would like the minister to talk about the Northern Inland Health Initiative and the projects it covers, such as the brand-new hospital in Onslow into which Chevron Australia is putting some money. I also want to know where we are situated within the Northern Inland Health Initiative with the Paraburdoo Nursing Post, Tom Price Hospital, and Newman Hospital—and also the Carnarvon high-end aged-care facility to be based at the newly upgraded

Carnarvon Hospital. Can the minister give a rundown on the time frames with those hospitals and the amount of money associated with each of those projects?

Dr K.D. HAMES: As the member knows, the new Onslow hospital has been approved by government for construction. The Northern Inland Health Initiative package is a comprehensive package within a range of different things, but within it is a significant infrastructure component that includes, as the member noted, Paraburdoo, and Tom Price and Newman Hospitals. Newman Hospital was included for a replacement also as part of our submission through the Economic and Expenditure Reform Committee, but they were separated and a new submission will be made hopefully in the near future. I hope everybody is listening! We wish to get on with that. I will need some help with the rest of the question.

Mr J.D. Moffet: Tom Price and Paraburdoo form part of the current planning and business case process that WA Country Health Service is working on with the Department of Regional Development. We are now in the second round of that and our business case should be forwarded to the minister in the coming month. They are both proposed on the program in different ways and forms given the different status of both Paraburdoo and Tom Price infrastructure. As the minister indicated, Newman is in budget and is well planned and well progressed. We have good planning progressed on the ground and we are looking forward to that new development initiative. Carnarvon aged care also has been part of` the planning for the North West Health Initiative. Currently, we have 16 beds and with the NPS-style arrangement, the commonwealth would be supportive of up to 24 beds. We are looking at additional capacity there. We have master planned the site using existing efficiencies for either ourselves or an alternative service provider if a service provider is interested in that environment. We have, as the member may be aware, tested the market twice in the north west, and Carnarvon in particular, and found it very difficult to attract a private provider, but we do want to test that again. Essentially, we are well advanced with the planning for Carnarvon aged care and the rollout of the program is consistent with the forward estimates for 2016–17 and 2017–18 at this stage.

[9.40 am]

Mr R.H. COOK: I thank the member for raising the question on the North West Health Initiative. That was an important part of the government's election policy announcement in 2012–13. But the words "North West Health Initiative" seem to have disappeared from the budget altogether. There is one reference to "North West Health Initiative–Other" but all the other aspects seem to be stripped out of it. Even if we add the amounts of $17 million for Onslow Hospital, $52 million for the Newman health service redevelopment and $63.7 million for "North West Health Initiative–Other" it falls well short of the original $161 million or the $147 million in last year's budget. I am not sure why the government unpacked the North West Health Initiative, because it was an important election policy announcement. Why has the government now unpacked it, and can it please pack it back together? I am happy to receive this answer by supplementary information to show where the government is spending this money.

Dr K.D. HAMES: I will get some support from my staff on this, but I must say that I do not know why it is not listed. Page 129 of budget paper No 2 lists the Southern Inland Health Initiative. I do not know why the North West Health Initiative is not listed; it is still a package and it is still proceeding as per the government's original announcements. Nothing has changed and the funding is still there. The process of getting funding, to have designs done and to receive approval for structures and to get it through the processes of government is quite difficult. It is a long process, particularly working with Building Management and Works. However, as far as I know, it remains intact. The capital works index program does contain a reference to the northern inland health package on page 103, with all the details of the package. I will ask Mr Moffet to provide further information.

Mr J.D. Moffet: The North West Health Initiative remains a package in terms of the business case approach. Two elements of the North West Health Initiative did come forward at the request of government, primarily because of opportunity and funding contributions. In Onslow there was a partner contribution from Chevron Australia of approximately $22 million, and Onslow is proceeding. A co-contribution of $10 million from BHP for Newman has been committed for some time, and that has been brought forward as well. They are early and substantial parts of the package, but the remainder of the $161 million for the scope that was set early on for the commitment has been retained. Page 141 of the budget paper No 2 is the best way to look at the residual. The line item "North West Health Initiative–Other" has a balance of $63.8 million. The cash flow there is primarily in 2017–18 and 2018–19. In addition, recurrent elements are being built into the business case that are of a much smaller proportion, but other elements are being built into the business case that remain in scope for the original $161 million scoping commitment.

Dr G.G. JACOBS: I refer to the first dot point on page 125 under the heading "Sustainable Delivery of Public Hospital Services". I understand the government's challenge with the ever-increasing cost of delivering health services and ensuring their sustainability. I acknowledge that an additional 450 000 people have come to

live in Western Australia over the past five years. Can the minister take us through the expenditure on public hospital services? As is noted in the budget paper, there is an increase of $417.2 million. No-one would gripe about an increased health budget if it reflects increased activity, so what extra activity will be funded by this higher expenditure?

Dr K.D. HAMES: There are many components to what the government needs to do to increase expenditure in health, but it must be done in the context of having a state price that is higher than the national efficient price and the agreed glide pathway with Treasury in which we have to get back to that national efficient price; hence our total budget increases by only 1.3 per cent. However, as stated, the budget expenditure for hospitals will increase by 4.6 per cent to reflect a combination of increased demand and also increased efficiency. People talk about budget cuts, although they have been non-existent. We have gone from in the order of $4.6 billion when the Liberal Party came to government up to $8.2 billion now. That is a massive increase. I was interested to find out that my health budget in Western Australia for 2.6 million people is greater than the total national budget for Zimbabwe and also Zambia. It was scary to find out their budgets. Those countries spend about only 10 per cent of their budgets on health. The state has gone from spending about 24.5 per cent of the total state expenditure on heath under the previous government to up to 28 per cent. We are getting an increasing share and an increasing budget, but it is against the background of increasing demand. We have growth in demand of about two per cent as a result of the ageing population. As the member for Eyre stated, there is an increase in total numbers with the growing population of two plus per cent each year for a number of years. Many of those tend to be younger and healthier people; nevertheless, it has placed difficulties on government to increase that demand. Much of that increased funding is about maintaining existing services and catering for the growth in population and demand but being more efficient while we do that. The government needed to be more efficient, comparing like with like hospitals, including with loadings we get as a result of regionality or Aboriginality. Our hospitals are more expensive than the equivalent hospitals in other states. Part of the reason for that, of course, is that we pay more money to all of our staff than the other states. Western Australia's nursing and medical staff are higher paid than those in any other state. There is a reason for that, which is that we had to compete with the mining companies that were taking nurses to drive haulpaks at 100 grand a year. The government had to ensure it was competitive in the pay rates offered, and similarly with our teachers. The government is not embarrassed about paying more; in fact, it is not embarrassed about its costs being slightly higher, but it needs to be within reason and we need to get it back under control.

Dr G.G. JACOBS: Is the figure for the community service subsidy decreasing—that is, the gap between the state price and the national average—and how much of that increase in the budget has gone to providing a community service subsidy? Is that gap narrowing?

Dr K.D. HAMES: There is a gap. I have a graph here that shows the gap. It is a bit complicated but I point out the line to members that shows the increase in our costs. The national efficient price was going up and we were going to meet it at a certain point in four years, but the commonwealth has just recalculated its national efficient price and it is lower than it was. That is based on the national efficient price in other states coming down. The actual price has come down from what it was. Treasury has given us a longer glide path. In his speech the other day, the shadow Minister for Health asked how the state price can go up and we can narrow the gap. That is this top line I am pointing to on the graph. The state price is continuing to go up, but it is going up at a lesser rate than the national efficient price. We are closing the gap. The gap between our slightly increased state price and the national efficient price gets lower and lower until, in eight years, we meet in the middle. We are becoming more efficient even though, as the shadow minister says, our state price rises, as it will. It will rise because of those things I mentioned—the ageing population and —

[9.50 am]

Mr R.H. COOK: And the minister's failure to manage Health.

Dr K.D. HAMES: No, not failure to manage at all.

Mr R.H. COOK: The minister's failure to manage costs.

Dr K.D. HAMES: Interestingly enough, there was some commentary from my favourite person, the former Minister for Health, back in about 2005 when he said that the increase in price for health should not go up by more than 5.5 per cent a year. In that same time our funding went up by more than that. If he had still been the minister and Labor was able to achieve the target he set, the state would have $1.2 billion less to spend on health now than this government is spending. There would have been $1.2 billion less if a Labor government was still in office.

Dr G.G. JACOBS: So —

The CHAIRMAN: The member for Kwinana has a further question.

Dr K.D. HAMES: It was about an answer that I did not finish.

The community service subsidy is what we are calling the gap between the national efficient price and the state price. We have a subsidy each year. That subsidy will slowly reduce as we get closer and closer —

Dr G.G. JACOBS: What is it now? What is it today, in dollar terms?

Dr K.D. HAMES: I will ask —

Mr R.H. COOK: In dollar terms, it is $401.2 million for 2015–16.

The CHAIRMAN: Has that been answered now?

Dr K.D. HAMES: My answer is $401.2 million!

Mr R.H. COOK: The 2014–15 budget states —

- The 2014–15 Budget continues this budget strategy with a commitment that the State's public hospitals converge to the PAC by 2017–18.

The PAC is the national efficient price. I know the minister says that that is because other hospitals have become more efficient, but that of itself is not a defence that our hospitals remain inefficient. In some graphs that I also prepared earlier —

The CHAIRMAN: I am feeling sorry for Hansard at this point, with all these graphs!

Mr R.H. COOK: — it can be seen that the community service subsidy continues to grow. In fact, on this particular glide path the gap can be seen between the national efficient price, which is this line at the bottom, and the Western Australian price—the state price—which continues to grow. That gap continues to widen. In 2013–14 the subsidy was $167 per weighted average unit episode; now it is $464 per episode. How will the minister improve the efficiency of Western Australian hospitals, given that every other state is improving efficiency, driving the national efficient price down? What will the minister do to improve efficiency in WA hospitals?

Dr K.D. HAMES: I do not accept the member's graph because —

Mr R.H. COOK: We do not accept the minister's, but I have just asked a question.

Dr K.D. HAMES: I point out that my graph was not prepared by me or my staff, as was the graph, presumably, of the shadow minister. My graph was produced by officials within the health department —

Mr R.H. COOK: Who are trying to justify an inefficient system!

Dr K.D. HAMES: — and confirmed by the Treasurer of Western Australia. I am happy to give the member a copy of the graph. But even this year, compared with last year, we have seen a narrowing of that gap between the national efficient price and the state price.

Mr R.H. COOK: It is just not true, by the minister's own numbers.

Dr K.D. HAMES: That will continue to occur over the forward estimates. Our hospitals are becoming increasingly efficient in the service they provide. We have had this argument with the commonwealth and with Treasury about meeting the national efficient price. We believe that they are not taking into account costs that are outside the realm of the health department—for example, the wages of staff. Members will be aware that the Department of Health has not reached agreement with various unions about wages for their staff. That is done by government as a whole. The health department has to continue to do its best to pay those wages. I do not begrudge those staff their wages. The only way to get enormous efficiencies in a short period is to significantly reduce staff wages, because a large component of Health's costs relate to staff wages. I am sure the Deputy Leader of the Opposition would not be advocating that because the government certainly is not.

Mr R.H. COOK: On the issue of efficiency, the minister would have seen that the national authority's report shows that hospitals such as Rockingham General Hospital and Sir Charles Gairdner Hospital have some of the most expensive per episode costs of any hospital in Australia. It is a fact that Western Australia as a whole not only runs a more inefficient system, but also has some of the most expensively run hospitals in Australia. Sir Charles Gairdner Hospital and, in particular, Rockingham hospital, which is over $6 000 per weighted average unit episode, are perhaps the most expensive hospitals to run in the country. It is one thing to say that in general we are victimised, which is what seems to be the minister's argument, but what is the minister doing about the fact that within the state system there are some incredibly inefficient hospitals and that is why the minister is not driving Western Australian health dollars further?

Dr K.D. HAMES: I think the member has provided an excellent example of the success of this government. He will be aware that the figures in the report related to 2011–12, as was stated clearly on the document, as a certain

other member of government failed to notice as well and made some comments about it. That was 2011–12. Since then, there have been enormous efficiencies. As the member is aware, 200 staff positions in excess of requirements were removed from Sir Charles Gairdner Hospital to bring that price down significantly towards the state price. There have been enormous changes since that time at Sir Charles Gairdner Hospital. Rockingham General Hospital, too, has had significant efficiencies since that date, but part of the issue there related to psychiatric patients. When patients were being cared for at home, after being admitted to hospital, they were still regarded as hospital patients in the way that they were calculated. Rockingham hospital had by far the biggest number of any state in Australia. The times that patients were in hospital significantly reflected on that method of recording. That has now been corrected. The efficiency of that hospital has improved significantly. It is in the member for Kwinana's electorate. I am sure he would be happy to talk to the hospital about its alleged inefficiency and tell them to lift their game.

Mr R.H. COOK: Is the minister telling them that?

Dr K.D. HAMES: They have lifted their game.

Mr R.H. COOK: What are the numbers now? Could the minister please provide the current weighted average unit costs of all hospitals in Western Australia?

Dr K.D. HAMES: We can provide the latest information on the weighted average costs of hospitals. We are happy to do so. We will provide that as supplementary information.

The CHAIRMAN: You have agreed to that, so I will allocate —

Dr K.D. HAMES: Does the member want it for all hospitals?

Mr R.H. COOK: I would like more clarification of what we are actually asking for, Chair.

Dr K.D. HAMES: The member is asking for the current weighted average costs for patients in Sir Charles Gairdner Hospital and Rockingham General Hospital —

Mr R.H. COOK: The current weighted average unit cost for every hospital.

Dr K.D. HAMES: That is a lot of work.

Mr R.H. COOK: Previously I have asked for every metropolitan hospital and the minister has been able to provide it.

Dr K.D. HAMES: Metropolitan hospitals, too?

Mr R.H. COOK: Yes.

The CHAIRMAN: Can you state that again, minister?

[10.00 am]

Dr K.D. HAMES: We will provide the weighted average unit cost of patients within all metropolitan state government hospitals.

[*Supplementary Information No A31*.]

[Ms W.M. Duncan took the chair.]

Ms J.M. FREEMAN: I refer to page 135 and the heading "Public Hospitals Non-Admitted Patients". The minister will know that I have tabled petitions on many occasions about the cancer centre at Sir Charles Gairdner Hospital. I will be happy to receive a brief answer to this question. Part of the issue is about staffing. The minister just talked about the 200 staff who have been cut at Sir Charles Gairdner Hospital. An issue that has been raised with me on an ongoing basis is staffing and waiting times. The minister will know that I recently rang the centre and was put on hold for six minutes, and then at the end of that time I was told to leave a message. This happened three times when I rang back after I was called. I wanted to use that example as a demonstration of the issues at the centre. The second part of the issue is about facilities for people who are very ill. When the opposition health spokesperson and I visited, I raised this issue, and the response was that the centre is considering seating options. Will the department fix the problem with staffing at the cancer centre at Sir Charles Gairdner Hospital, and when will the seating and facilities for patients at the centre be improved? The facilities for the doctors are good, but patient facilities are not.

Dr K.D. HAMES: I am aware of the petitions that the member has been tabling, and her phone calls, and I am aware of the issue about the seating. I attended Sir Charles Gairdner Hospital about six months ago with my daughter, who had sustained a hockey injury, and while I was there I took pictures of some of the chairs and sent them to the department. The chairs have now been replaced. I understand this has been done in the cancer centre,

but I will hand over to Professor Stokes, who might pass on answers to the rest of the question. It is something that we have discussed recently.

Professor B. Stokes: We invested something like $4.8 million last year to increase staffing in the cancer centre at Sir Charles Gairdner Hospital, and at Princess Margaret Hospital for Children, for medical oncologists, radiation oncologists and radiation physicists. At the moment we are carrying out a significant review of oncology in the state. The member may have heard about that. A group will report to me this week about how it feels we should be best dispersing oncology across the metropolitan area and how we should provide services to rural and remote areas for people with cancer. At the moment, the area is at a standstill until that report arrives, and then we can look at exactly how staffing should be arranged. We have improved the clinical staffing of the hospital, but the clerical staffing at the cancer centre has not yet been improved. When we consider the workload, we will be able to look at that at the same time.

Ms J.M. FREEMAN: What about the facilities—chairs, basically?

Professor B. Stokes: I thought that they had been repaired, but we will have a look at those again. I think the member will find that they have been repaired recently, but I will look at them again for the member.

Dr K.D. HAMES: My staff have advised me that the reclining chairs that the member requested have been put in.

Mr R.H. COOK: The minister would have seen recently some media coverage of chemotherapy in the home. While he was not negative about it, the minister did not embrace the concept that was detailed in the press article. Given the costs associated with chemotherapy in the home, and the delivery of hospital substitute services, has there been any consideration of introducing chemotherapy in the home in the current funding in this budget?

Dr K.D. HAMES: I met the two women who are involved in providing chemotherapy services in the home. They already do some of it, but largely in the metropolitan area. They put forward a proposal for chemotherapy in the home for the Peel region, so I asked the department to investigate that and report back to me. The report that came back suggested two problems. One was that some chemotherapy in the home is already being provided by our hospitals through the Hospital in the Home program, so we were already doing some of that ourselves. The cost structure that the proponents put forward was no better than that of what we are doing already, so we are happy to continue that. The difficulty for Peel is that oncology services are already being provided on contract by the Peel Health Campus, and if we were carrying out some chemotherapy in the home, that would take away some of the services currently being provided, although not all of them, which would make the unit no longer viable with a reduced workload. The advice that I received from the Department of Health was that that was not the best way to go for the provision of good health, and that was the decision we made. I am happy to review it again if there is any further advice or change in the future. The concept seems good to me, but I can only go on the advice that I have been given. Professor Stokes just advised me that the review of oncology services will include the value of Hospital in the Home.

Mr R.H. COOK: My next question relates to page 124, and the line item "Fiona Stanley Hospital Facilities Management Contract Negotiations". Can the minister please detail the $16.7 million shown in this line item? Can the minister provide details to the committee of failures by the facilities management contractor in meeting its key performance indicators in fulfilling its contract?

Dr K.D. HAMES: I will hand over to Professor Stokes for that question.

Professor B. Stokes: The problem here is that some of this information is commercial-in-confidence, as the member can appreciate. I will ask Mr Leon McIvor, who has been dealing with these issues with the contract with Fiona Stanley Hospital and the facilities manager, to talk in general terms about that. The member will be aware of a number of issues, including sterilisation, in the contract, and that can be dealt with later at the member's request.

Mr L. McIvor: Would the member like me to address the question of KPIs and failure points? Is that his question?

Mr R.H. COOK: That is right—the KPIs that the facilities contract manager is currently not meeting.

Mr L. McIvor: In relation to general performance over the last three months against Serco's monthly reporting on performance failure, the highest areas of performance failure are currently the services it provides in cleaning, estate services, helpdesk, information and communications technology, and logistics. In relation to abatements, which are applied due to performance failure, the total abatements since October 2014 amount to approximately $1 million, against a total operational payment regime of $45.4 million for the same period.

[10.10 am]

Mr R.H. COOK: In a recent presentation to a conference, representatives from Serco said that they had an internal KPI of less than $250 000 in abatements per year. So we can assume that Serco has missed out on that particular one. One of the other KPIs that Serco has talked about is that it achieves a 70 to 85 per cent "Amber" rating on customer satisfaction surveys with WA Health and patients. Can the minister confirm whether Serco achieved this particular target?

Dr K.D. HAMES: Mr McIvor.

Mr L. McIvor: We have not completed that survey.

Dr K.D. HAMES: No; we cannot provide that answer as we have not completed those surveys yet. Remember that Fiona Stanley has been in operation for only a short period.

Mr R.H. COOK: One of the other KPIs that Serco aspired to is that there would be no liquidated damages in 2014. Can the minister confirm whether Serco achieved that KPI?

Dr K.D. HAMES: As the member would be aware, the significant issue with the Serco management was with sterilisation. We are currently in the process of negotiation about the partial take-back of that service by the Department of Health. We are in discussions about the cost of that service and how it will be provided in the future, but as far as I am aware there are no liquidated damages at this time.

Mr R.H. COOK: In relation to the $1 million of abatements since October 2014, can the minister provide details of which service area that is apportioned to or set against?

Dr K.D. HAMES: My understanding is that Mr McIvor told us in his answer what those were.

Mr R.H. COOK: No. If I may, just for clarification, minister, my understanding is that we have details of the areas that Serco is providing well, which are cleaning, estate management—I cannot read my own handwriting—ICT and logistics, but that the $1 million in abatements is against other areas that Serco is not achieving. Is that correct?

Dr K.D. HAMES: No, that is not correct.

Mr R.H. COOK: So the $1 million of abatements is against those particular items? Are they the areas in which Serco is not performing well?

Mr L. McIvor: Just to clarify my previous answer, the areas listed were the areas performing the worst in the last three-month period and based on Serco's reporting of abatements in its monthly reports. The $1 million is divided across all 27 services lines to differing degrees.

The CHAIRMAN: Member for Moore.

Mr R.H. COOK: Sorry, Madam Chairman; I was trying to attract your attention for a further question, if I may.

The CHAIRMAN: Yes.

Mr R.H. COOK: Can the minister provide us with details of the service failures in the area of cleaning?

Dr K.D. HAMES: I will hand over to Robyn Lawrence.

Ms R.A. Lawrence: The service failures as they occur is a complex process to explain. Therefore, it is not as simple as being able to tell the member that they did not wipe a desk down. It could be a time failure or it could be an outcome failure, and there are complex calculations around those. So to detail exactly what they are is almost impossible.

Mr R.H. COOK: One further question.

The CHAIRMAN: Final one, thank you, member for Kwinana. I have quite a long list.

Mr R.H. COOK: Would it be possible for the minister to provide us with a summary of information in relation to service delivery by Serco under its KPIs, and perhaps for simplification purposes across just those five areas, for the purposes of expediency and moving us forward?

Dr K.D. HAMES: I have been advised that we can do that. That will be provided as a supplementary.

The CHAIRMAN: Can the minister define what he will be providing?

Dr K.D. HAMES: Ms Lawrence, can you define what you will provide?

Ms R.A. Lawrence: We will provide a summary of the service failures against the key services that were identified as the worst performers currently.

[*Supplementary Information No A32*.]

Dr K.D. HAMES: I just point out before we move on that when we contract out a service, the whole point of having KPIs is to make sure that we have good controls over that. Unlike the situation with public hospital services, where it is very difficult to have great oversight and KPIs on the standard of services being provided, this provides us with the opportunity to make sure that the services provided are of a very high standard; and, when they are not, there is a financial penalty for the company if it does not meet those, which is a great incentive to do it better in the future.

The CHAIRMAN: Thank you. Member for Moore.

Mr R.S. LOVE: Thank you, Madam Chair, and thank you, minister, for the opportunity to ask you some questions. I refer to page 140 of the *Budget Statements* and the heading "Works in Progress", and I note an item there for wheatbelt renal dialysis that is funded by royalties for regions. What is being provided for wheatbelt patients, and when will we see further improvements at centres such as Northam?

Dr K.D. HAMES: One of our election commitments was to provide additional funding for renal dialysis, particularly based in Northam, but with outreach home dialysis services as well, funded by royalties for regions. Mr Moffet will provide details of how that program is going.

Mr J.D. Moffet: Wheatbelt renal dialysis in particular has a focus on Moora and, as the member is aware, Northam also. We are currently incorporating the wheatbelt capital in-service development with the broader stream 2 district hospital investment programs so that we have a single approach to the project management. So there will be a single project in Northam, for example, that incorporates both the renal and the broader service elements.

Mr R.S. LOVE: I am sorry, Madam Chair, but I could not quite hear the answer.

Dr K.D. HAMES: Can I just say that Hansard was not able to hear either, so I ask Mr Moffet to start the answer again; and for all our staff on this side, you need to be close to the microphone and speak up.

The CHAIRMAN: Thank you, Mr Moffet. Try again.

Mr J.D. Moffet: There are two specific elements to the wheatbelt renal dialysis in particular. Moora specifically has beds planned to be incorporated into the existing program, as well as Northam. Northam has a planned renal dialysis capacity that will be incorporated into the broader stream 2 overall district package. There is a very significant package of works going into Northam around ambulatory services that will incorporate the small renal investment. So we are running them as one capital program, despite them being two different service lines—two different funded lines—if that is the basis of the question.

Mr R.S. LOVE: I am wondering when we might actually see those services in the town of Northam, for instance, where I am constantly getting inquiries from constituents about having to travel for that service.

Mr J.D. Moffet: I guess that goes to the broader planning and project management at this stage. For Northam we are currently going through the final concept master plan development phase, so we are getting some early level design in relation to the district sites—the stream 2 sites—and Northam in particular. Moora is part of our stream 4 investment, as the member knows—the small hospitals investment—and we are currently finalising the time frames for those. I can give the member some indicative time frames in terms of early and late, which were previously announced by government. In relation to Northam, the intended commencement of construction is in the early part of 2016, so around March 2016—in the first to second quarter of 2016—subject to current planning. The anticipated practical completion is for a roughly two-and-a-bit year build and finishing in the third quarter of 2018. Depending on the staging—I do not have the staging details with me—some parts of that redevelopment will start services during that time frame. I am not sure whether the renal program is at the beginning, middle or end of that program, but I can provide that information once we get through the concept master planning, which will be in about two months.

[10.20 am]

Dr G.G. JACOBS: Mr Moffet referred to a broader planning program for renal dialysis in Western Australia. Goldfields and Esperance are not the wheatbelt, but can he outline the broader planning renal dialysis program for those areas?

Dr K.D. HAMES: Mr Moffet.

Mr J.D. Moffet: We do have a renal program that is separate from the one I spoke about and to which the member referred. It has a pretty extensive program right across the state. Did the member want me to comment specifically on goldfields and Esperance?

Dr G.G. JACOBS: Please.

Mr J.D. Moffet: There are three elements to the project, broadly. One element is hostel accommodation for patients; another is actual dialysis services, so treatment services; and the other element is called project support. That incorporates additional regional services such as physicians, nurse practitioners in renal care and administrative support workers. There are three elements to the program. We have an allocation of approximately $6 million for a 19-bed hostel to be built in Kalgoorlie. We are currently in the planning stages, but my understanding is that we will be going to market later this calendar year for that project and the majority of the hostels around the state. In Esperance—this is about the renal dialysis chair element as opposed to the hostels—as the member would be aware, we are incorporating that with the current capital program similar to the planning that we are doing for Northam. A two-chair renal dialysis unit at a cost of approximately $900 000 is planned inside that capital program. Construction for that particular part of the Esperance program will commence and we anticipate its completion in September next year so that services in Esperance should commence in the fourth quarter of the next calendar year.

Ms M.M. QUIRK: I refer the minister to commonwealth grant expenditure on page 124. I want to ask a couple of questions about the aged-care assessment program and home and community care. There is no provision for the aged-care assessment program in the out years; why is that the case?

Dr K.D. HAMES: Professor Stokes will answer that question.

Professor B. Stokes: It is because there have been discussions between the state and the commonwealth about the future of the home and community care program, and associated with that are the aged-care issues. That is why there is no funding in the out years at this stage.

Dr K.D. HAMES: I might as well answer that question in anticipation. The commonwealth has taken over the upper end of HACC in the other states. I think it is those who are 55 years and above or something of that order, which is well before my age! That leaves those largely with disabilities who are getting that sort of care. The commonwealth said that it should be managed by the Disability Services Commission, but we do not agree. We believe that the HACC service is excellent and that providing an integrated service across that range of ages is not a problem because it is the service being provided that is important. We expressed our reluctance to change and that was accepted by the commonwealth, so we are in a holding pattern for a couple of years. As the member knows, state and commonwealth funding has increased to respond to those services. We are waiting to see how it goes in other states and how it will be affected by the rollout of the national disability plan. We will wait and see how that goes. I would prefer to keep it the way it is.

Ms M.M. QUIRK: Is it correct that the sticking point is purely around the 55 to 65-year gap for people with disabilities?

Dr K.D. HAMES: HACC funding currently provides services across whatever age is required for people who need that support at home. The commonwealth has changed the arrangement in the other states. It looks after the aged-care component while the states look after younger people even though it is the same people in the same towns providing the same service, which is silly. I want to keep it together so we keep providing that service. That is not to say that those with disabilities might get alternative disability funding and may not need HACC in the future, but I do not want to split it up. HACC staff are excellent and do an amazing job. I do not want them to suddenly be responsible for one group. My concern is more about the younger age group missing out and with the commonwealth taking over responsibility, because there have not been too many examples of the commonwealth taking over responsibility for something and getting a better outcome than the one provided by the states.

Ms M.M. QUIRK: There is no funding for HACC in 2017–18. Is that because discussions are ongoing? How is it that we are the only state that is holding out, if you like, in relation to HACC?

Dr K.D. HAMES: It is because discussions are ongoing. I have given the member the reasons that we are holding out; namely, I do not agree with the commonwealth model. One of three things is possible. First, the commonwealth will not give us the money unless we agree to adopt its system, in which case we will not have a choice. Second, the commonwealth might accept that its model is not working in the other states and that our model is fine and leave it as it is. Third, a future Minister for Health who does not agree with me or think as I do will change the system.

Ms M.M. QUIRK: Eighteen months ago, it was the intention of those in the Premier's department and of various commonwealth–state policy people to move HACC to the commonwealth. Did one particular event cause that change of heart?

Dr K.D. HAMES: Yes; my arguments caused that change of heart.

Ms J.M. FREEMAN: The power of the minister's persuasion!

Dr K.D. HAMES: One small step forward for many steps back!

Ms J.M. FREEMAN: I refer to dental health on page 137. I understand that the government intends to have a dental health chair in the development on Milldale Way in Mirrabooka. Can the minister provide me with an update on the negotiations with the provider in that area for the land, particularly given that it has been given a time line before it loses the federal funding to build that facility? Can the minister provide an update on where that is at and advise whether it will be delivered in time?

Dr K.D. HAMES: Yes, and it has already lost some commonwealth funding as a result of the time it has taken. Part of the issue has been that the state government does not normally hand over land, and there have been difficulties with how it will be done and the process to get there. In fact, the organisation involved, Myvista, needs to be able to commit to state government services on that land and the state government must know what services the organisation wishes to provide. We had meetings two weeks ago; we are now seeking to follow an alternate direction. I cannot make that public, but I am sure that if the member talks to the persons involved, they would be happy to tell her what that process is. I am satisfied with that process and am trying to progress that as quickly as possible.

[10.30 am]

Mr V.A. CATANIA: I refer to "Outcomes and Key Effectiveness Indicators" on page 131. With all the doom and gloom that comes from the opposition, I want to see how Western Australia compares with other states from these reports that the minister has in the budget. Does the minister have any data on where we rate amongst other states and how Western Australia performs overall on a national scale?

Dr K.D. HAMES: It has been the case that I have been in the comparisons between us and other states. Since we have been in government there has been an enormous improvement. We used to be last, or close to last, in all the key components of the provision of health services. In particular, we were worst at eight-hour waits in emergency departments, often with 40 per cent of patients in EDs waiting for a bed. We have now moved to being in the top two in most categories. In particular, in our four-hour rule comparison, we have reached a steady state. Individual hospitals continue to improve within that, but we are in front of every other state in that category. In waitlist surgery, we have been running a very close second to Queensland mostly in the total wait times for surgery. We have been doing very well in all areas of health. One area in which we have not done so well is the time in which category 3 patients are seen in EDs. We have consistently lagged behind the other states. That is partly due to the process that we have in seeing patients. Some other states record when that patient is first seen as meeting the requirements of that category, whereas we do not. We have much stricter requirements for that category. I am confident that in that category we will improve. I do not think there is any area in which we are not certainly in the top half, if not in the top two of all categories. On our four-hour rule, WA has remained well ahead of other jurisdictions with this indicator. As noted in the budget paper, WA's percentage in 2013–14 was 79 per cent. This compares with the national average of 73 per cent. In other jurisdictions, it was 74 per cent for New South Wales, 69 per cent for Victoria, 76 per cent for Queensland, 64 per cent for South Australia, 68 per cent for Tasmania, and for the two territories, 62 per cent.

I have to say that in the early days when we brought this program in, we were looking at much higher percentages than that. We were advised to do that by the United Kingdom, and we have had them come out on a number of occasions since then to see how we can improve further. Our system is considerably different from that of the UK, but it is still an excellent performance and we really see the difference in the total attitudes of the hospitals towards management of patients and the way patients flow through, and the fact that our eight-hour waits are now down to figures of around eight per cent, compared with, as I said, under the previous government, around 40 per cent. It is a significant improvement. We have had some setbacks recently, largely due to our transfers to the new hospital. Some of our waitlist surgery figures for the metropolitan area have fallen away and the total number of people on the waitlist has increased as a result of us having to close down Kaleeya Hospital and transfer patients across to Fremantle Hospital. We are going to have a very strong focus now on getting that figure back to where it should be. Over the next 12 to 18 months, funnily enough, we are going to make sure that we get those figures right back.

The professor has given me some figures about perinatal and infant mortality. The infant mortality rates continue to decrease for Western Australia at a consistently lower rate than for the whole of Australia. We are doing better in a whole range of those areas, including life expectancy. Although we are not at the top for either males or females, when we combine the two—the last time I looked at this was about a year ago—Western Australia has the longest life expectancy of any other state or territory.

Mr R.H. COOK: I refer to "Completed Works" on page 141 and the "South Metropolitan Health Service Reconfiguration (FSH link)". I notice that this is under "Completed Works" and also the problems that have

been associated with the transition of patient services to the new Fiona Stanley Hospital. I wonder if this really is a completed work. I want to draw the minister's attention to two case studies that I think are very good examples of some of the problems we are confronting. This particular constituent from Two Rocks has said that after transfer of oncology from Fremantle to Fiona Stanley, he was scheduled to attend Fiona Stanley Hospital for a follow-up. He attended at Fiona Stanley at the appointment time of 11.30 am, but was not seen until around 2.30 pm that day, which he found stressful. What he found disturbing, however, was that when he was attending the appointment, the hospital had no record of him at all. This chap also says that half a dozen people were in the waiting area and they were all in the same situation; that is, their records had failed to be moved from Fremantle to Fiona Stanley. I also want to draw the minister's attention to the plight of Mr Arnold Bird from Beverley, who has written to the Minister for Health. He says in part that since 1997 he had been receiving treatment from specialists in RPH, which included haematology, rheumatology, endocrinology, vascular, dental and cardiology. He was told in 2014 that he was to transfer to Fiona Stanley for all future appointments. However, once he had been attending Fiona Stanley for his rheumatology appointments, he was told that had to then go to Armadale Hospital. He said that in each of the circumstances he was advised for the first four months that there were no files—I repeat, no files—for these visits, which he described as making a mockery of the whole care situation. I was wondering whether the minister could provide us with an explanation of why this reconfiguration has gone so badly and what he is doing to resolve the situation.

Dr K.D. HAMES: I do not know how the member gets it under that particular dot point, but at the end of the day any dot point will do for that sort of question.

Mr R.H. COOK: It was about the reconfiguration of services and these patients being sent from other hospitals to Fiona Stanley.

Dr K.D. HAMES: I get the question, but it is not really the reconfiguration component that is there, and the budget has nothing to do with these particular cases. What has happened, though, is that there have been teething problems and we accept that. It is not just in the areas that the member for Kwinana referred to, trying to change the process of moving services, some from Royal Perth and some from Fremantle, to the new hospital, particularly when we have doctors who have been operating under different systems. Fremantle doctors typically operate on one system and Royal Perth doctors operate differently, and we have them going to the same hospital and providing a service. There definitely were teething problems, particularly with the transfer of notes, but this is not new history. As the member said, those people wrote to me. Those are older things. I think they occurred around February or March, not very long after the opening of the Fiona Stanley Hospital. A lot of those earlier teething issues have now been resolved. The only issue was oncology. As I said, under the system operating at Royal Perth, everything was done in a single day, which I personally think was a good system, but that was not the way things were operating at Fremantle. We are now looking for best practice in management of those patients, and also looking at how the oncology services are distributed. That is the review that Professor Stokes just spoke about. I am not absolutely certain that the removal of all of those oncology services from Royal Perth Hospital is working out the way it was intended and it may well be that we need to put some of those services back to Royal Perth. We will be making announcements about that in the near future when that review assessment is completed, but I think we still have a bit of work to do to ensure we have the best service at the best place for the patients given the locations they come from.

[10.40 am]

Mr R.H. COOK: Obviously one of the key performance indicators in relation to the reconfiguration is how the elective surgery waitlist continues to be managed. The minister would acknowledge that in the last few months it has gone very badly. One of the reasons it has gone so badly is because of the performance of our hospitals in the south metropolitan area. Part of that I assume is the reconfiguration process. Interestingly enough, Joondalup Health Campus, Swan District Hospital, Princess Margaret Hospital and Osborne Park Hospital all have in-boundary elective surgery numbers north of 95 per cent, so those are going fairly well. It is in the South Metropolitan Health Service that the wheels have really fall off. For instance, Royal Perth Hospital is at 85 per cent and Fiona Stanley Hospital at 84 per cent. However, there is one shining light in elective surgery in the South Metropolitan Health Service and that is Bentley Hospital. I want to talk about the delivery of services at Bentley Hospital under the reconfiguration model. I understand that overnight surgery will not be continued at Bentley Hospital and staff there have been informed that the general surgery will be shut down. I think the professor is rightly saying that same day surgery—scopes and things like that—will continue there, but general surgery will be cancelled. Does it remain the case that maternity services at Bentley Hospital are unfunded in 2015–16, contrary to the noises the minister has been made in this place that he is seriously looking at continuing them there? If those services are unfunded, how will they be continued?

Dr K.D. HAMES: There were a lot of statements that led up to that question that I do not agree—that is, things have gone badly and the wheels have fallen off. Neither of those things are the case. Things have gone as

expected, and as expected when new hospitals are being opened and hospitals like Kaleeya Maternity Hospital are closed, wait times will go up and the amount of surgery that can be done will go down. It is not that things have gone badly or that the wheels have fallen off. Waitlist numbers have, as predicted, increased—both in total numbers on the waitlist for the south metropolitan region and the wait time. When all those things settle down—we have been able to significantly increase surgery at Fiona Stanley in particular—we will get on top of those figures and get them back to normal. Next we transfer our attention to Bentley Hospital. As the member would be aware, the Labor plan, which is presumably the same as ours, because I have not heard that it has changed, is still to close the maternity unit at Bentley Hospital. That was the Labor Party's previous plan. We have said we would do a review and that review has just been completed by Professor Con Michael. It has not got to me yet, but it will do very shortly, and we will then make a decision about what we do with those services based on the whole of the maternity service for the south metropolitan region. Again, under the Reid review and the reconfiguration of services, which is still part of Labor Party policy as far as I know, we will provide those same services that involved a change in the amount of waitlist surgery that would be done at Bentley Hospital. I am aware of the conversations the member mentioned in which he was told that everything would close, but I am not sure they were interpreted correctly.

Mr R.H. COOK: I have seen the PowerPoint presentation; it is pretty straightforward.

Dr K.D. HAMES: I have seen it, too, and I do not think it is as clear-cut as the member states. At the end of the day, I am very keen for surgical procedures to continue there. There will be a lot of day surgery and safe overnight surgery, but there is not an intensive care unit there to deal with high-risk patients. As far as I am aware, that configuration is identical to the Labor Party policy, unless it has changed.

Ms M.M. QUIRK: In relation to the relocation of services, I want to ask a question that the minister will need to answer by way of supplementary information. I have a lot of complaints about constituents —

Dr K.D. HAMES: Is that from constituents or by constituents?

Ms M.M. QUIRK: — about the removal of rehabilitation services to Fiona Stanley Hospital. As the minister knows, those patients are in for some considerable time and those in the northern suburbs find it difficult to travel the further distance over an extended period. I wonder whether the minister could provide information about how many patients in Fiona Stanley Hospital are from the northern suburbs. Secondly in that regard, there is not a stroke unit at Joondalup Health Campus. At what stage will numbers be sufficient to warrant reconsideration of that matter?

Dr K.D. HAMES: I am happy to provide the answer to the first part of the question by way of supplementary information. As the member would expect, we do not have those numbers. We will provide the numbers of patients in the rehabilitation unit at Fiona Stanley Hospital who are from north of the river.

[*Supplementary Information No A33*.]

Dr K.D. HAMES: Professor Stokes will answer the second part of the question about the stroke unit.

Professor B. Stokes: We have just had a significant review done. The member may remember that a stroke model of care was put out approximately eight or nine years ago that looked at comprehensive stroke units and stroke units, which, as the member is aware, are slightly different. One of the areas earmarked at the time was to have one at Joondalup. As the member might imagine, there are some issues at Joondalup because of the differences between private and public patients, and that type of issue was raised at the time. We have just had Andrew Wesseldine, a very young neurology general physician, look at the whole of these stroke services, and one recommendation is to put one into Joondalup. We will have to have discussions with the operator of Joondalup Health Campus about that.

Ms M.M. QUIRK: Finally in that regard, I have written to the minister about—I do not know what the clinical term is—the bedwetting clinic at Mirrabooka.

Dr K.D. HAMES: It is enuresis.

Ms M.M. QUIRK: I thank the minister. I understand the clinic at Mirrabooka is closing down and patients have to be sent elsewhere and they go down to the bottom of the list. Is the minister able to give us any more information on that?

Dr K.D. HAMES: I think I provided an answer to the member's letter, but I cannot remember what it was. I have been advised that it is not closing and staffing issues are being looked at. Is that enough?

Dr G.G. JACOBS: I have a question on Fiona Stanley Hospital and the theme that the member for Kwinana mentioned of patient records and some of the deficiencies. The minister well knows that I chaired a committee

on the Fiona Stanley Hospital information and communications technology development and we released a report that we titled "More than Bricks and Mortar", which the minister knows about. In the nicest possible way we found that the ICT development was lagging. I wonder whether some of those deficiencies have been attended to and the ICT improved in order to improve communications and overcome some of these issues of deficiencies in patient records, files and other important information for the care of people.

[10.50 am]

Mrs R. Brown: We have done a significant amount of work over the last 15 months to improve WA Health's capability around the planning and delivery of ICT projects. We have put in place a new governance structure with an executive board that involves representatives from across the WA Health executive team chaired by Professor Stokes. We also have an external member from another government agency, which is primarily about ensuring that the business collectively takes key decisions around ICT priorities for WA Health rather than the ICT technical people involved in the past. Getting the governance right was the first step. The first priority of the ICT executive board was to develop a new ICT strategy for WA Health, which was released in April and is a three-year strategy focused on building strong foundations across ICT such as our planning and delivery capability, our network and infrastructure for ICT, and how we manage future rollouts statewide of new applications that are already in some hospitals. We have pretty much looked at every aspect of improvement for ICT from the way in which decisions are made about what the business needs, right through to the way in which we put in place proper governance, project management and procurement capability around the delivery of those projects. It is fair to say we still have a long way to go in terms of building that capability. The Department of Health has also invested significantly in improving its procurement capability so that we are better positioned to engage with the market around our requirements and ensure that any procurement that is in place is then managed appropriately going forward. Step by step we are getting closer to addressing all of those issues. It will take some time, particularly around building capability. We have made some structural changes around that part of the WA Health business. Previously the Health Information Network area reported directly to the director general. We have now put in place new arrangements by which it reports through to executives who have oversight across that area to ensure that it also has the appropriate governance and management within that part of WA Health.

Ms J.M. FREEMAN: So the nuts and bolts of it is that Fiona Stanley Hospital has one system that was bought off the shelf, the new Perth Children's Hospital has a different ICT system that was also bought off the shelf, and Sir Charles Gairdner Hospital and all those other hospitals have the old Health Information Network system that needs an upgrade because it does not work as well as it should. How will the department get all those systems talking to each other?

Mrs R. Brown: There are probably a couple of aspects to that question. The underlying network and infrastructure for WA Health is largely consistent across all sites. In relation to Fiona Stanley Hospital, it is part of the arrangement with Serco and British Telecom. There are many applications—into the hundreds—at Fiona Stanley Hospital and across WA Health. However, some of the core applications that were rolled out at Fiona Stanley Hospital—approximately 50—already exist as statewide applications. Certainly the key patient administration system, webPAS, has been progressively rolled out across all sites. It has already been rolled out at Princess Margaret Hospital for Children and will be rolled out at the Perth Children's Hospital. That becomes one of the key aspects. Other applications, for example, the picture archiving system, are statewide. A number of applications are either statewide now or have been rolled into Fiona Stanley Hospital, which will give consideration to progressively rolling them out statewide. As part of the commissioning of Perth Children's Hospital, some of those applications that have been rolled into Fiona Stanley Hospital will also be rolled into Perth Children's Hospital initially and Albany and Busselton Hospitals and other country sites. There is a plan to progressively roll out statewide applications. At Perth Children's Hospital, an integrated health system is also under consideration and development. However, that is not directly related to the initial commissioning of that hospital. It will have similar applications that have already been rolled out at Fiona Stanley Hospital, but all of these applications involve an element of interoperability so that we can progressively communicate across sites.

Dr K.D. HAMES: Can I just add that it highlights the problem we have had with information technology in this state with the previous system that was set up in the old days of each hospital having a board. Each board did its own thing and put in its own IT stuff with no thought that they might need to communicate with other hospitals. It has been a difficult thing to turn back because it involves enormous expenditure in IT trying to roll back systems in place in other hospitals. One advantage of the Reid review and its recommendations and the huge number of new hospitals that we have been able to build, is that we have been able to better coordinate between our hospitals using systems that will talk to each other and have the potential to talk to general practitioners and other users of the health system, but it is a long and particularly expensive process.

Ms J.M. FREEMAN: With the new governance oversight and the fact that we are progressively moving towards having one system so that hospitals can talk to each other and transfer records and all of that sort of stuff, what are the time lines and when will that be delivered, given how much money has been spent on ICT in Western Australia in health over the last four or five years?

Professor B. Stokes: It will take at least two years in order to get the system fully functioning. Rebecca has mentioned a number of issues including a very important program called BOSSnet, which is a total electronic medical record of patients. A laboratory system also has to be fed into that and integrated and these are not easy things to do. New South Wales and Victoria have been using BOSSnet very successfully so we are rolling that out. Rebecca alluded to a number of legacy systems, which go back to the days of the disk operating system as members will remember, and they have to be put into the system. To roll out all these issues takes time and money, so I suspect that it will be more than two years before hospitals are fully talking to each other across the state.

Ms M.M. QUIRK: I refer to "Works in Progress" on page 145 of volume 1 of the *Budget Statements* and the Midland Health Campus stage 1. A figure of $36 million has been allocated to the Midland Health Campus, which it is said will open in November. The Premier said that the government would invest $22 million to establish the campus. This is not in the budget yet, so how will that be funded?

Dr K.D. HAMES: It will not be funded by us, but I am happy to talk about the hospitals because the university campus has nothing to do with the Department of Health. The member is right about the total cost of Midland Public Hospital being just over $360 million of which $180 million is state government funding and $180 million is commonwealth funding. The building is almost complete and expected to open in November some time.

Ms M.M. QUIRK: I have a further question —

The CHAIRMAN: Before the member goes on, can she tell us again what page she is referring to?

Ms M.M. QUIRK: Works in progress —

The CHAIRMAN: Did you say page 145?

Ms M.M. QUIRK: Yes.

Dr K.D. HAMES: If the member says page 140, that will solve the problem.

Ms M.M. QUIRK: Yes, page 140. Thank you very much.

The CHAIRMAN: Does the member have a further question?

[11.00 am]

Ms M.M. QUIRK: At this stage, does the minister not know whether the funding for that will be linked to the sale of Swan District Hospital?

Dr K.D. HAMES: I doubt that very much. The sale of Swan District Hospital land will be handed over to LandCorp, which has responsibility for the sale of state government land, so the health department will not be responsible for that, nor, sadly, will we see the money that comes from it. That will go to Treasury and it will be responsible for funding; however, it will be for the funding that the Premier is committed to.

Ms M.M. QUIRK: I have a further question, which probably relates to health workforce planning. Will the planned opening of the proposed Curtin medical school, which looks as though it will take 60 places a year, result in a reduction in the number of medicine places at both the University of Western Australia and Notre Dame, or will there be an overall net increase in the number of medicine places currently allocated to WA?

Dr K.D. HAMES: Yes, there will definitely be an increase. There will be no reduction at either of the other two universities. This will create a net increase in places, which, as the member says, will start at 60 and build beyond that.

Ms M.M. QUIRK: Part of the rationale for opening this medical school was, in the words of the Premier, "In Western Australia, 38 per cent of Western Australian doctors are coming from undeveloped nations." It is true, is it not that we rely very heavily on the skills and expertise of overseas doctors and any aspersion on the competence or otherwise was unintentional on the Premier's part?

Dr K.D. HAMES: Yes; I heard the member's interjection during the Premier's Statement on that when we were in Parliament discussing it.

Ms M.M. QUIRK: Which I withdrew.

Dr K.D. HAMES: That is good to hear because it is absolutely not true. In fact, the quality of doctors we have been getting has been very good, particularly from some of the undeveloped nations. When I go out to the

countryside and meet those doctors—the last one we met was from Egypt in, I think, Port Hedland—I notice that the quality and standard of service has been very good. But it is not appropriate for us as a First World nation to get doctors who are desperately needed, particularly in Third World nations where there are not enough trained people. We have a significantly high per cent of doctors from those countries. As the member says, the rate of overseas-trained people is in the high 30 per cent range. There has been some criticism, as we are all aware, of that decision, largely by the Australian Medical Association and medical students, interestingly enough, but that relates to their concern about our capacity to provide training for medical students. Members might be aware that medical graduates have to spend 28 weeks of their first year of internship doing particular things such as medicine, surgery and emergency department work. They tend to spend the rest of the time in hospitals and there is great opportunity for us to get them out doing other things, in particular, working with organisations such as Silver Chain, which has great capacity for teaching. That is the prime emphasis of the Curtin medical school, remembering that it will provide a university in that area that will do not only medicine, but also a large number of other courses. I think that will be fantastic for the east metropolitan region. Given that it will be right next to the new Midland Public Hospital, I assume it will have significant involvement with that hospital in particular as well as with organisations such as Silver Chain and country hospitals and country doctors in providing the training of those medical students. I am confident that we will be able to train those students when they come through but we need to do a lot of work in planning for that when it comes, and we have started that.

Meeting suspended from11.03 to 11.11 am

The CHAIRMAN: The next person on my list is the member for Mirrabooka.

Ms J.M. FREEMAN: I refer to the reconfiguration with stage 1 at Osborne Park Hospital outlined on page 140 of budget paper No 2.

Dr K.D. HAMES: I cannot hear the member very well; there are a lot of conversations going on.

Ms J.M. FREEMAN: Sorry. What does the minister plan to do with the $26 million allocated to Osborne Park Hospital? Will an emergency department be established at the hospital and will it provide any additional birthing suites?

Dr K.D. HAMES: I will ask Mr Salvage to answer those questions.

Mr R.W. Salvage: The $26 million, or variants of it, has been on the budget for a number of years. It is currently sitting in the last year of the forward estimates. It was originally tagged for the development of the mental health inpatient unit, which has been deferred at this point in time. There are no current plans in place for its deployment as part of stage 1 redevelopment, but that will be given further consideration.

Dr K.D. HAMES: The whole issue was there for mental health beds, but the Mental Health Commission has done a review of what is required through mental health in this state and it determines what is required at that location.

Ms J.M. FREEMAN: Will that $26 million that has been allocated in the forward estimates—there are no current plans for how it will be spent—stay allocated to Osborne Park Hospital and for important things such as an ED, additional birthing suites, and additional beds or parking or has the government just parked the money there with an expectation that it will be shifted somewhere else? Can Osborne Park Hospital and the people in the community who use that hospital be assured that that money has been allocated and is for that hospital and will stay allocated to that hospital?

Dr K.D. HAMES: Is the member going to declare an interest?

Ms J.M. FREEMAN: Absolutely. I just had another great-niece born in that hospital; what a great hospital!

Dr K.D. HAMES: I am referring to a personal interest. The clinical services framework did an assessment of what services were required for the whole of Western Australia into the future. One of those in particular identified Osborne Park as a hospital that needed further expansion and development because of the growing demand in that region. The exact detail of what is required and how it will be provided has not been determined yet, so that money is parked there without an allocation. I expect that it will be part of whatever development proposal is required for Osborne Park into the future. We cannot leave it too much longer; it is not something that we can just sit back and watch. Armadale–Kelmscott Memorial Hospital also needs expansion, as do hospitals further into the northern suburbs and, in fact, into the southern suburbs. The Peel Health Campus needs further expansion as well. A range of hospitals through the clinical service framework need plans into the future. As the member for Mirrabooka knows, the government has spent over $7 billion on hospital upgrades in this state, but that does not mean we can sit back and forget what is needed in the future as the population grows.

Ms J.M. FREEMAN: Can the minister commit that that $26 million will not go to Armadale hospital or Peel, but will be committed to the people of that area serviced by Osborne Park Hospital for the upgrade and increase in services there?

Dr K.D. HAMES: No, I cannot make that commitment. I expect that to be the case, but until the final plans are completed as to how upgrades are done, both to that hospital and others, I am not in a position to make any commitments.

Mr V.A. CATANIA: I refer to "Asset Investment Program" on page 139 of the *Budget Statements*. Can the minister provide an update on a couple of the hospitals being upgraded in my electorate—Carnarvon and Exmouth hospitals—and give a status of where they are at? I know there has been some talk about Mt Magnet Nursing Post being upgraded. Could the minister provide the status of that, as well as some of the issues that have confronted the Meekatharra Hospital and some of the changes the WA Country Health Service have had to make to ensure the services continue to be provided in Meekatharra?

Dr K.D. HAMES: As the member would be aware, there is significant upgrading to health services in his electorate. I hand over to Mr Moffet to provide the details.

Mr J.D. Moffet: Carnarvon is a $26.8 million upgrade. I will briefly talk through the elements of those. There is a significant refurbishment of the emergency department; a reconfigured area for four-chair renal dialysis; new ambulatory outpatient facilities to house community mental health; population health; and a dental health service. There is also a significant upgrade to telehealth facilities for the site and dedicated treatment areas and approved amenity by virtue of access and parking facilities. We are currently dealing with separable portion A2—that is, the ambulatory care building, a new staff car park that is currently underway and the ED that has substantially progressed, as the member may know. We have started separable portion 2B, so the ED and renal areas are progressing quite well. Mechanical services installation has commenced. The electrical and mechanical work has commenced well. I do not have in front of me a date for the completion of the ED. That is probably the most recent update on milestone development I can provide on Carnarvon at this stage. I am happy to provide more on notice if the minister would like that.

Exmouth is an $8.1 million budget program. The scope there includes ambulatory or outpatient health care facility upgrades.

Dr K.D. HAMES: Sorry to interrupt, but can I point out to whoever controls the microphones that it is still on me; it needs to be on Mr Moffet.

[11.20 am]

Mr J.D. Moffet: Perhaps I will just start again. The Exmouth scope upgrade will include the ambulatory outpatient upgrade similar to that at Carnarvon, co-locating community mental health, population health, social work and child health into a single service location. Works also include new hospital entry, reception, triage and waiting areas, and refurbishment and reconfiguration to accommodate new medical imaging equipment, expanded communications, an information and communications technology room, and a fourth dedicated general practitioner consulting room. That is a fairly substantial ambulatory scope. As a milestone update, works are progressing according to our baseline program, so the anticipated practical completion is October this year, with final completion due in October 2016. Completion of the pathology laboratory and X-ray has occurred ahead of schedule, and we are currently partway through separable portion 3, which is a new ambulatory healthcare centre upgrade. That is currently underway, and we are looking at transition planning for service relocation during June this year.

I am happy to provide more information on detail, but I will just move along now, as per the minister's request. The member had a question about Mt Magnet. Mt Magnet is being incorporated into the planning of the North West Health Initiative. That is due for consideration in the next month by the minister, so Mt Magnet is still part of that consideration. Infrastructure at Meekatharra is also being considered as part of the North West Health Initiative. The member had a question about the service changes in Meekatharra. Did I hear that correctly?

Mr V.A. CATANIA: It was mainly about infrastructure.

Mr J.D. Moffet: That will be considered by the minister in the coming month as part of the broader balance of the North West Health Initiative.

Mr R.H. COOK: My question is about Aboriginal health, and refers to page 128 of the *Budget Statements.* We are all now beneficiaries of the Holman report. I commend Emeritus Professor Holman on the report, which is a great piece of research. My question is a follow-up to my question without notice asked on 20 May. In answering the question, the minister agreed with me that the funding for Footprints for Better Health in the budget papers appears to have been halved. During his answer the minister expressed a desire that all those programs identified by Professor Holman as being good or very good would be funded, which amounts to about 88 per cent of the program. My question on that is: has the minister now found savings within the health budget

to fund the rest of the programs that are not currently funded in the budget papers; and, if so, where has that money come from?

Dr K.D. HAMES: Each of the divisions within the Department of Health—north metropolitan, south metropolitan and all the country health services—have been through their budgets and programs. As the member knows, we are not continuing with 12 per cent of the programs. That was all in the Footprints for Better Health services. We provide a lot of other funding for Aboriginal communities, non-government organisations, universities and a range of other areas, and we have trolled through those. Remember, Professor Holman did not consider just the Footprints for Better Health funding; he considered other areas, some of which he was critical of. As the member knows, he stated that the renal dialysis program was very expensive. We are not taking money out of that; we are taking money from areas in which we believe the Footprints for Better Health funding is better for the community. Areas that have lost funding will be informed shortly, as will those that have been successful in retaining funding. Some areas, such as south metropolitan and north metropolitan, have not yet identified where all their funds will come from, but they have had a reduction in their total budget to provide the funds for those services, and they will need to continue to work through their budget programs. Given that they were able to identify significant programs, that amount of money is relatively small in comparison to their total budgets, and they will need to find savings within their system.

Mr R.H. COOK: In the context of his answer about other Aboriginal health services, be they in universities or whatever, having been identified as being not worthy of funding, can the minister provide, possibly by way of supplementary information, a list of those programs that will not be funded to contribute towards funding the other 88 per cent?

Dr K.D. HAMES: I did not mean to suggest that they were all Aboriginal health programs. Quite a few of them are not; they are other programs. Some of them were just contracts coming to a conclusion—for example, some funding within universities for a specific purpose had three-year funding that finishes this year. That has given us the opportunity to recoup that money. I do not intend to provide supplementary information until we have notified all those that have lost funding. In the future, I will be happy to provide those details, so I suggest that the member put that question on notice, which will give us time to make sure that we notify all those organisations. We will then be able to provide a more detailed answer.

Mr R.H. COOK: One issue that has continually vexed or annoyed Aboriginal health funding—essentially, any area of Aboriginal funding—is the way that it is provided by piecemeal 12-month programs. Sometimes funding is for even less than 12 months. Many of these programs are due to come to an end in a matter of weeks, and a lot of the organisations have not yet been informed about funding for the next 12 months, let alone the funding for the next two to three years. Given that one of the particular observations that Holman made was about the sustainability of this funding, and long-term funding to make a difference on issues around Closing the Gap, does the minister have plans to put in place a regime that does not see these organisations funded on a 12-month basis?

Dr K.D. HAMES: There are two parts to the answer. The first is that those who are not successful in having their funding continued into the future will be given a two-month extension of funding to give them a reasonable time in which to notify staff that they will not be continuing. We accept the three-year suggestion by Professor Holman, but remember that this came about because we had an agreement with the commonwealth on Closing the Gap funding. We provided three-year funding for those organisations, as did the commonwealth, but when that period came to a close, and the commonwealth did not continue its funding, we decided to continue as a state. Of course, in doing that, which is a $30 million-a-year ask, convincing Treasury was no easy task. We managed to get that one-year extension to funding, which covers the current financial year, on the condition that we carried out a detailed assessment, particularly looking at the key performance indicators. There was some criticism that a lot of the organisations provided with funding either did not have KPIs or were not meeting them, and hence the review by Professor Holman, which showed that a significant number are actually doing very well. The plan is that quite a few of those who are going to get funding will still have requirements to better develop their oversight, procurement and KPIs. Over the next year, we will tell those people that they have funding, note the fact that we have funding for three years, and say that we are looking to develop a three-year program at the end of that single year. We will seek additional funds from Treasury in that out year to sign up to a three-year agreement. The plan currently is to do one year and then three for those organisations.

[11.30 am]

Mr R.H. COOK: Professor Holman in particular highlighted two areas, and I quote —

> In examining how resources were allocated across different health programs, nutrition education and food security as well as alcohol education and rehabilitation were grossly underfunded, …

He also stated that road trauma and other injury prevention were grossly underfunded, although that is across a range of portfolios, as the minister would be aware. Professor Holman also talked about the lack of funding in the

Pilbara and wheatbelt. In terms of now casting around and getting this extra cash together to top up the halving of this particular budget, is the minister going the extra steps to rectify those problems that Holman identified?

Dr K.D. HAMES: The member will be aware, as he just stated, why any discussions we have today are not going to be on the front page tomorrow. That is because of the credit rating of the state government, brought about largely because of the issues of debt, so any suggestion that we might have extra money to spend on extra services is wishful thinking. It would be lovely to be able to do those things, but we do not have any financial capacity to expand any further programs. So, no, we are concentrating on the programs that we have—on the 88 per cent that Professor Holman identified as being good or excellent—and those programs will have continued funding. We are not in a position to address other suggestions that he has made.

Mr R.S. LOVE: I refer to page 124 and the table headed "Spending Changes", which makes reference to the contribution from royalties for regions funding to various health projects. What projects is royalties for regions funding contributing to, and how important is this to the overall regional health infrastructure program?

Dr K.D. HAMES: I thank the member for the question, but I am sure he is aware that I have nowhere near enough time to detail all the programs in health that are being funded through royalties for regions, because they are numerous. I have to say that that particular program has been enormously beneficial to the Department of Health because it has enabled us to do programs that we would never previously have been able to afford, in particular the Southern Inland Health Initiative, for which nearly $500 million of additional funding has been provided through royalties for regions, and the North West Health Initiative; additions to other services that we have been providing, particularly country Aboriginal health; extra money that we needed for Albany and Busselton; and all the money that has been required for hospitals such as Karratha; and so on and so forth. The latest of those, of course, is the Laverton health complex, at a value of just under $20 million, which has also been funded by royalties for regions. There is no capacity within government to do significant other infrastructure, and the $1 billion per year that is within royalties for regions gives us the capacity to do all this additional work. We will continue to do that work in all the programs that we have, and also to seek funding for additional services in country regions that can be supported through royalties for regions, because it provides us with a great opportunity to improve health services outside the metropolitan area of Western Australia.

Mr R.S. LOVE: Could the minister outline how royalties for regions is contributing to the recruitment of general practitioners to work in country areas? That is generally not a state responsibility, but it is something that royalties for regions is being used for widely.

Dr K.D. HAMES: That particularly comes under the southern inland health package, although the north west health package will contribute. We have been trying to work with the commonwealth for a long period under different governments to improve the standard of health services in country areas. One of the particular concerns was the shortage of GPs in country towns, particularly through the wheatbelt. It was proving very difficult to attract GPs to those locations and local governments were forking out huge amounts of money to not only guarantee income but also provide houses and cars for GPs. The new model that we put forward under the southern inland health package has enabled considerable increased funding by the state government to support the work of doctors within our regional hospitals, and that has enabled the private sector doctors to continue their operations with certainty of funding. Part of that has been to support a recruitment program for country doctors. There has been a significant increase in the number of doctors in country areas, and I will hand over to Mr Moffet who might be able to provide us with some detail, particularly in the southern inland health package, of the total number of doctors that we have been able to recruit through that program—a short answer, please.

Mr J.D. Moffet: Okay; a short answer. The Southern Inland Health Initiative, through the streamlined district medical workforce program, provides a range of incentives, as the minister has said, including relocation and practice incentives, but in particular incentives for participation in rosters that are directly relevant to the communities, such as emergency department rosters and procedural rosters. To date, 24 new GPs and 16 full-time equivalent specialists and hospital doctors have been attracted. That is 40 doctors over the last two and a half to three years, which is an excellent achievement in that zone. We have also established the emergency telehealth service as part of the medical support to existing GPs in the wheatbelt, and that has been incredibly successful over the last several years. We have about 80 per cent recruited the number of doctors that we required for the wheatbelt. It has been very successful.

Mr R.H. COOK: I notice the time, so perhaps this will be the last question, but the minister raised a couple of points that I would like to follow up on. The minister mentioned Karratha hospital. I notice that this was first announced in 2010 as a $150 million program. It is now at $207 million. I am particularly interested in what essentially have been the time slippages around these things. In 2014–15, $14.3 million was to be spent but only $5 million was spent, and in 2015–16 it was identified that $70 million was to be spent, but this budget will

show that in 2015–16 only $15 million of that will be spent, with another $4.3 million pushed out to 2018–19. Given those time lines, what is the new date for the opening of the new Karratha hospital?

Dr K.D. HAMES: Yes, there was some pushing out of time lines, for two reasons. One was due to the overall budgetary position. The member might recall that a lot of the funds within country health through the program were pushed backwards through the royalties for regions program, and Karratha hospital was one of those. However, combined with that, the decision was made to change the location of the hospital. There were issues around the 100-year flood level at that site and how we might work around that, and quite a lot of engineering work was done and it now actually has the hospital higher and the car park lower, to cater for that system. The pad is down, I think, and site works undertaken by LandCorp have commenced, with the site to be handed over to the Office of Strategic Projects in 2015—this year—and with a completion date of, I think, 2018.

Mr R.H. COOK: Is the commitment still to complete —

Dr K.D. HAMES: It has started, which is the good news. I think the pad is down.

Mr R.H. COOK: I understand that the population of Karratha was just over 26 000 in 2014 and it is due to rise to 30 000 in the very near future. However, Karratha hospital will have the same number of beds as Nickol Bay Hospital, which is around 40. Can the minister explain why we are getting this new hospital at a cost of over $200 million without any actual expansion of bed numbers?

[11.40 am]

Dr K.D. HAMES: I will hand over to Mr Moffet to explain that little gem.

Mr J.D. Moffet: Nickol Bay Hospital has undergone several condition audits in the past 10 years or so. Each of those demonstrated that that facility requires either a significant upgrade or replacement. A decision was taken several years ago to look at a new site to pull together all the services, so all our community and hospital services will be relocated in the main town centre where LandCorp is currently doing the groundwork or land preparation works. It is true to say that the 40-bed inpatient capacity of the current hospital is being retained. We do not fully utilise Karratha hospital at the moment, so there has been proper service planning for the future. Therefore, the 40 beds cater for future population growth. We also have an increased range of ambulatory services—I refer to things such as renal, chemo and day surgical services—so the configuration of services inside the facility has changed to be more contemporary and consistent with the service planning that occurred several years ago.

Mr R.H. COOK: What is the time horizon for the new Karratha hospital in terms of the adequacy of its time? It strikes me that the Karratha community is growing very quickly. How long does the minister think it will be able to meet the needs of that community?

Dr K.D. HAMES: I will let Mr Moffet answer that, because that is detailed in the planning assessments done by the Department of Health that predict future demand.

Mr J.D. Moffet: Can I just clarify whether the question relates to the existing facility?

Dr K.D. HAMES: The question relates to when the new facility is there and whether we have done forward planning on the growth in population and the growth in demand, and how long into the future that planning provides for; that is, does that predict such growth and demand that the hospital will be adequate for 10, 20 or 30 years?

Mr J.D. Moffet: Thank you. I do not have the clinical services plan with me, but ordinarily it would be a 10-year horizon, so I would anticipate a 2025 or 2026 demand-modelling environment. Most of the growth in Karratha has been in the ambulatory space—that is, the emergency department, day surgical cases, and a broader range of ambulatory services around mental health et cetera. We have not had substantial growth in the inpatient setting for quite some time despite the population growth. Karratha has a fairly young and mobile population, so it has quite a different demographic and service profile as a result. In terms of the other part of the member's question, the facility at Nickol Bay has been maintained to run for another three years, so for the life of the project, and we have co-located ambulatory services on the existing Nickol Bay site, so community health is being provided from the existing facility during the construction of the new hospital.

Mr R.H. COOK: Another area that the minister mentioned, which was raised by the member for Moore, is the Southern Inland Health Initiative. The Auditor General identified that this area still requires significant work and that another 20.5 GPs are needed to contribute to the capacity of the health system in the area. The Southern Inland Health Initiative was highlighted as an area of significant cuts and re-cash flowing across the forward estimates. Given that the SIHI was having some success, has the government taken its foot off the pedal when so much work is still to be done? Why is that money being pushed into the outer years of the forward estimates?

Dr K.D. HAMES: The SIHI proposal was first developed by the Department of Health to look at how we can better address long-term needs. There was a lot of estimation of the capacity to grow and the time lines that that would take. It has done exceptionally well and there has been huge progress forward, but not everything is able to proceed at the same pace, particularly the infrastructure components, because it has been difficult getting through the building works process and community liaison and planning to get them there. Some of those things slipped back. As the member is aware, as I said earlier, the whole royalties for regions program was pushed back to some degree because of financial circumstances. Far from taking our foot off the pedal, our people are working exceptionally hard to make sure those things continue. Remember that in terms of a GP shortage, we have been recruiting lots of GPs—altogether 40 additional GPs or specialist doctors in the regions. Remember, too, that we have the huge cohort of additional medical students who are in the process of coming through. In my year, 90 students graduated; there are now more than 300. A lot of those have just come through the system after graduating three or four years ago, and they are reaching the stage, having done three or four years in the hospital system, of being ready to go out. We anticipate that rather than having to chase overseas doctors, we will be able to get more of our doctors to go to the regions. A great example of the success of that has been sending some medical students to the new hospital in Albany for their final years of training. They have come to love the town, as many people do when they live in Albany, and now want to go back there to work. We are confident that we will get much better use of our GPs in going to country towns throughout Western Australia.

The appropriation was recommended.