Division 8: WA Health, $5 353 520 000 —

Ms L.L. Baker, Chairman.

Dr K.D. Hames, Minister for Health.

Mr K. Snowball, Director General.

Mr W. Salvage, Acting Executive Director, Resource Strategy and Infrastructure.

Ms N. Feely, Chief Executive, South Metropolitan Area Health Service.

Dr D. Russell-Weisz, Chief Executive, North Metropolitan Area Health Service.

Mr P. Aylward, Chief Executive, Child and Adolescent Health Service.

Mr I. Smith, Chief Executive Officer, WA Country Health Service.

Dr T.S. Weeramanthri, Executive Director, Public Health Division.

Ms J.E. South, Acting Director, Health Infrastructure Unit.

Mr J.R. Harrison, Executive Director, Corporate and Strategic Services.

Mr S.J.C. Hunter, Acting Director, Client Services, Drug and Alcohol Office.

Mr G. Kirby, Director, Prevention and Workforce Development, Drug and Alcohol Office.

Mr B.C. Sebbes, Executive Director, Fiona Stanley Hospital Project.

Mr I. Wight-Pickin, Chief of Staff, Office of the Minister for Health.

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

Ms M. Hayes, Principal Policy Officer, Office of the Minister for Health.

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

The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. This is the prime focus of the committee. Although there is scope for members to examine many matters, questions need to be clearly related to a page number, item, program, or amount within the volumes. For example, members are free to pursue performance indicators that are included in the *Budget Statements* while there remains a clear link between the questions and the estimates.

It is the intention of the 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 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 committee clerk by Friday, 10 June 2011, so that members may read it before the report and third reading stages. If the supplementary information cannot be provided within that time, written advice is required of the day by which the information will be made available. Details in relation to supplementary information have been provided to both members and advisers, and accordingly I ask the minister to cooperate with those requirements. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office. Only supplementary information that the minister agrees to provide will be sought by Friday, 10 June 2011.

It will greatly assist Hansard if, when referring to the program statements volumes or the consolidated account estimates, members give the page number, items, program and amount in preface to their question.

[Witnesses introduced.]

Dr K.D. HAMES: I point out that the number of advisers is about half of that which the previous minister used to bring into this chamber. The crossbench used to be totally full.

The CHAIRMAN: The first question will be from the Deputy Leader of the Opposition.

Mr R.H. COOK: I refer to the Royal Perth Hospital asset investment program on page 145. In 2010–11 only $800 000 was spent of the estimated $4.3 million that was allocated in 2010–11. Can the minister explain this? Specifically, why is there no capital funding in the forward estimates for the redevelopment of that hospital?

[10.40 am]

Dr K.D. HAMES: I will make some initial comments on Royal Perth Hospital. As a result of an election commitment, upon coming into government we originally allocated $20 million to prepare for the work that would need to be done for Royal Perth Hospital. I made it clear, and copped criticism from a certain member of the Liberal Party—not a member of Parliament—for clearly stating that the work would begin in our second term of government. Before doing that work, we need to prepare for the work that will be undertaken. I clearly remember the Leader of the Opposition's statement about Royal Perth Hospital when he said that the Liberal Party had promised to retain Royal Perth Hospital as a tertiary hospital but that no funds had been allocated to upgrade the hospital. Obviously, they are different statements. We did commit to retaining Royal Perth Hospital as a tertiary hospital, which clearly we are doing. That is contained in our clinical services framework plan and it is part of all the negotiations with doctors and other staff involved in what services will be provided in a tertiary Royal Perth Hospital in the future. Under that clinical services framework, Royal Perth will be an approximately 400-bed hospital. That is clear.

In my view, there are three options for what we could do in the future for Royal Perth. One option is that we do nothing and Royal Perth operates as a tertiary hospital; and there is nothing that would stop it from operating as a tertiary hospital in the future. If that were our decision, we would keep going with Royal Perth Hospital as it is, remembering that it will go down from about 680 beds now to 400 beds and it will have lots of empty rooms. The second option is to keep the old part of the hospital, and in that framework we would do a major redevelopment of the Wellington Street side of that H-shape, the A block, and use that for patients; and we would redevelop the side that was closest to the church as an administration component. We are looking at the outbuildings at each end of that site and at bringing in those people who are doing various tasks and opening that up for public use, such as offices, hotels and the like. That option has not been finally costed, but would be in the order of $200 million to $300 million for a major refurbishment. The other option, which is the option that I talked about leading up to the election and which is my preferred option, is not the one to which we have committed because the costs would be in excess of $600 million. However, it is still my preferred option. That option is to build a new west wing that would make up for what is in the north block, so that we still have a total of 400 beds, and then perhaps demolish part of what is left on the side. The former health minister was going to demolish all of it, but we might demolish half and use the Wellington Street side for administration. Those options are available now. I did look at the option of having a figure in the year 2013–14 budget that would clearly indicate we were going to do something, but the decision was made that, instead, we would work very hard over this next year to develop a plan to decide on those options, and then to look at the timing and the funding source. My view is that we cannot start any work there until everyone has moved out to Fiona Stanley Hospital; it would be silly to do that. We have to wait until all those people have moved, which is in 2014. I want to get the timing right. If we are going to follow the plan that I envisage, we will need funds in the 2014–15 financial year to start that redevelopment process in late 2014. That is because we will be establishing Fiona Stanley Hospital in the first part of that year. Nothing appears in this budget, which goes up to 2014–15, because it has not been determined. Hopefully, I will be able to use the Faganesque characteristics to which the Deputy Leader of the Opposition referred to get money out of the commonwealth—with his assistance!

Mr R.H. COOK: The gentle art of begging is a time-honoured tradition. Has the committee that the minister set up to advise him on the options associated with that site submitted its report; and, if so, can the minister make a copy of that report available to the Parliament?

Dr K.D. HAMES: The committee report was an internal document, so I do not plan to make that public. The committee looked through those various options and came back to me with those options. The committee's report, in effect, talked about moving forward the first two options to which I have just referred as the preferred options—obviously subject to finances—but it also looked at whether there was an option to sell off the rest of the land. The purpose of the committee was to provide me with advice. I now intend to get that to the proper formal committee that looks after all our major infrastructure, which is also dealing with the Princess Margaret Hospital for Children and the children's hospital in Midland, to get them to undertake the proper forming task. We need a fully professional committee doing all those detailed costings and works. The committee that I established was an informal committee to talk to people, to look at those issues and to provide me with advice to see if what I wanted to do was the best direction to take. That committee has done that and has now closed.

Mr R.H. COOK: The minister would be aware that he came under some criticism from the Under Treasurer for this plan. Indeed, last year the government's strategies surrounding Royal Perth Hospital were listed as a risk associated with the budget. It is no longer listed as one of the risks, and in estimates hearings in the other place last week the Under Treasurer essentially indicated that it is no longer a risk because it has gone off into the never–never of planning. I may be verballing the Under Treasurer, but I will paraphrase him by saying that he does not feel particularly threatened by that development happening in any hurry at all. The Under Treasurer

clearly does not believe that the minister is going to develop the hospital. Where are we up to with this program? Members opposite gave a commitment to the people of Western Australia that a Liberal government would redevelop this hospital. Why has the government not done that?

Dr K.D. HAMES: The commitment was that we would save Royal Perth as a tertiary hospital, which we have done, and that we would look towards redeveloping it. That is certainly my intention. It will not come as a surprise to the Under Treasurer that I disagreed with his initial listing of the Royal Perth Hospital proposal as high risk. The Under Treasurer's assessment of high risk was not related to capital infrastructure costs; it was all about the recurrent costs of managing hospitals. That assessment did not change until we released the last clinical service framework, which clearly set out the growth in demand in this state, how that demand would be met and where those beds would be. I think Treasury officials somehow had it in their heads that there would be a significant increase in costs once Fiona Stanley Hospital opened if we kept Royal Perth Hospital. However, the member will recall that under the former government, the then health minister Jim McGinty had planned instead to have 1 000 beds at Sir Charles Gairdner Hospital; it subsequently moved on from that to putting those additional beds at Fremantle Hospital. The total number of beds under our government is the same as that which was proposed under the Labor government; the only difference is that we will have slightly fewer tertiary beds and slightly more secondary beds, but overall that cost is the same. We had not been able to make it clear to Treasury what that progress on cost was. Once Treasury had seen this, its concern regarding risk was gone. On the issue of capital works, Treasury will always wait and see what proposals come forward. It is not going to be easy. Our commitment was to retain Royal Perth as a tertiary hospital. I have confidence that my scabbing abilities will allow me to proceed with the redevelopment that I want to see done. But as a worst-case scenario, I am confident that we will still have a major refurbishment to the remainder of Royal Perth Hospital. If we cannot afford the new west wing, we will still have a major tertiary hospital. If we did nothing, we would have the tertiary hospitals that were operating under the former government continuing to operate under our government. They would not have been there after 2014 other than Mr McGinty's latest version of the plan, which I think was a surgi-centre of some sort. Under this government, a major tertiary hospital will be retained.

Mr R.H. COOK: Can the minister confirm that at the moment Fiona Stanley Hospital is fully commissioned, even though the government has not redeveloped Royal Perth Hospital, it will still be operating as a 680-bed tertiary facility?

[10.50 am]

Dr K.D. HAMES: No; that is not the case.

Mr R.H. COOK: But the minister is not doing anything about it before Fiona Stanley Hospital comes on-stream. That is what the minister said.

Dr K.D. HAMES: That is what I said.

Mr R.H. COOK: Therefore, will it remain as it is—a 680-bed tertiary hospital?

Dr K.D. HAMES: There are "beds" and "staff beds". The Deputy Leader of the Opposition knows the difference; he has been around health long enough to know what beds are. There will be a room where a bed used to be positioned with staff who used to look after patients in those beds. After Fiona Stanley Hospital opens, there will be either an empty room because all those new beds—those potential beds—and the staff will have moved to Fiona Stanley Hospital. In fact, a significant number of wards will be closed to reduce it from the current 680-bed to a 400-bed hospital. That is quite clearly how we will do that. We will not keep it operating at 680 beds because the staff required to manage those beds will be relocated to Fiona Stanley Hospital.

Mr R.H. COOK: I want to confirm that some of the advice the minister is getting from the internal committee secret report to the minister includes possible options for selling the land at the Royal Perth Hospital site.

Dr K.D. HAMES: Absolutely; that is no secret. I have been talking about that for a long time.

Mr R.H. COOK: Which particular areas of the land are involved?

Dr K.D. HAMES: Royal Perth Hospital land occupies the equivalent of five inner city blocks. It is a fantastic opportunity for redevelopment. At the WACA ground end, for example, on the corner opposite Mercedes College, are the Marginata Flats, where I once stayed. It is an old run-down building. Some government services are currently operating out of a lot of those other buildings that are along that side and face Wellington Street. When that space becomes available in the main block, they will be redeveloped and those people will move into them. The same will happen at the city end. Land will then be made available for redevelopment. In our meeting, Lisa Scaffidi and other representatives from the Perth city council, the member for Ocean Reef, who has previous architectural training —

Mr R.H. COOK: Unless the minister is prepared to make that report public, perhaps we can leave it there.

Dr K.D. HAMES: I am happy to tell members what is proposed. We have looked at that land —

Mr R.H. COOK: But he is not prepared to share it with the public

Dr K.D. HAMES: I am sharing it now. There is a capacity to redevelop that land. It is our intention to hand management of that land over to the East Perth Redevelopment Authority once it becomes available.

Mr P. ABETZ: I refer to appropriations, expenses and cash assets on page 127 of budget paper No 2. It appears that the total cost of spending on health services is up $470 million or 8.2 per cent in 2011–12. Can the minister outline for us what this increase represents and its overall effect on the health budget?

Dr K.D. HAMES: I thank the member for the question. The line on the front page shows some excellent trends. Firstly, if we look across the appropriations, the 2010–11 budget was $4.550 billion. The estimated actual was within $23 million of that. That is an extraordinary change from what has occurred in the past in health. I think it represents about a 0.15 per cent variation from our landing spot. If we were to land in a circle, we would have landed on the line. That is an amazing result. It shows that we now have good control of the health budget. It is reasonable to say that in previous years, including our first year, the budget was not as bad as being out of control, but certainly the management of that budget was not good. Demand was growing; there had been insufficient allocation in past years because funds had not been properly allocated to years and the deficit was growing. The first thing we did was rebase the budget so that a significant increase last year got rid of those traditional deficits and brought it up to a level of actual costs. We had to rein in our spending because we were growing at more than 12 per cent spending when, at that stage, growth in demand was officially at only 3.5 per cent. However, the forward estimates last year predicted the growth in activity and pitched it at a certain level. In this year's budget, Treasury has recognised that it had pitched it too low; that the actual growth in and ageing of the population is greater, so more than $350 million has been allocated in the forward estimates to bring us back up to a proper growth pattern. Also in that budget are some of the things we have announced recently, such as the southern inland health package, and a further commitment to replacement equipment spending and the training for doctors package of $75 million over four years. Some excellent new packages will allow us to get to that growth in budget, which is just over eight per cent. That figure is sustainable in a modern, growing economy such as that in Western Australia.

The member will have heard the commonwealth argument about the national health package and the claim that the states will not be able to afford their growth in health expenditure in the future. Western Australia can afford it, so we are joining the national health agreement because we want to, not because we have to. For the past 10 years, Western Australia's income has grown by more than nine to 10 per cent a year. I am sure we will cover in further detail the individual packages involved in that.

Ms J.M. FREEMAN: I refer to the first dot point under the heading "Child Development" on page 130 of the *Budget Statements*. Can the minister provide a breakdown of the 54 positions filled in child development services and where those people are employed?

Dr K.D. HAMES: I will hand over to the director general, who I am sure will pass the answer to one of his staff.

Mr K. Snowball: I will ask Mr Phil Aylward, the chief executive officer of the child and adolescent health service, to respond.

Mr P. Aylward: In that split, 45 positions have been created in the metropolitan area spread across all clinical disciplines—allied health, speech pathology, physiotherapy, occupational therapy, social work and psychology. They are based mostly in outer metropolitan areas such as Armadale, Rockingham and Peel, as well as in Koondoola in the north and across to Midland in the east. I have been out at those centres and they are having quite a significant effect in reducing the wait time and waitlists and, importantly, getting children ready for school. There have also been 15.6 full-time equivalent positions established in the country that relate to this initiative. Again, they are broadly spread across those same clinical disciplines.

Ms J.M. FREEMAN: Can the minister table a breakdown of those 45 positions and where the 15.6 positions in the country have been placed?

Dr K.D. HAMES: I think that answer was provided to a question on notice in the past. It is not hard to provide the figures.

Ms J.M. FREEMAN: Is the minister happy to do that?

Dr K.D. HAMES: Yes; we will provide the breakdown of those positions as supplementary information. The supplementary information will be details of positions provided under the child development state funding of $49.7 million of the 60.6 full-time equivalent positions statewide.

[*Supplementary Information No A23.*]

[11.00 am]

Ms J.M. FREEMAN: In the answer to the question, reference was made to Koondoola. Are the additional FTEs at Koondoola for the integrated service centre? As I understand, the integrated service centre has a community nurse and counsellor from the Department of Health and has received funding through the Department of the Premier and Cabinet for that. The integrated service centre also has a community worker and an administrative assistant from a non-government organisation. Can the minister confirm whether that FTE position is for the integrated service centre?

Dr K.D. HAMES: I refer the question to Mr Philip Aylward.

Mr P. Aylward: The positions in the child development areas that we spoke of before were not going to be in integrated service centres; that is a separate program, as the member would know, relating to children of migrant or refugee status. We intend to continue that program. The funding formally concludes at the end of the year but, in conjunction with a range of government departments, we intend to extend the status quo into the new financial year.

[Mr J.M. Francis took the chair.]

Ms J.M. FREEMAN: Will that funding for integrated service centres be extended for a one-year, two-year or three-year period?

Dr K.D. HAMES: Mr Aylward will answer that question.

Mr P. Aylward: At this stage, several government departments are looking at a proposal to expand and develop the service and give it a long-term future. However, right at the moment in our budget allocation for 2011–12, we are just considering extending it for a further 12 months.

Ms J.M. FREEMAN: I heard the word "consider", so I want to get an idea of whether that funding is confirmed for the 12 months.

Dr K.D. HAMES: It is confirmed to extend funding for 12 months.

Ms J.M. FREEMAN: I thank the minister; I am very pleased to hear that. I have a further question. In terms of the 54 positions, can the minister please —

Dr K.D. HAMES: How is the shadow minister ever going to get a question in?

Mr R.H. COOK: I ask the questions!

Ms J.M. FREEMAN: I refer to child development on page 130. Can the minister provide a breakdown for the child development services waiting list, detailing services required and by region?

Dr K.D. HAMES: We have provided that information also; it was provided to the standing committee. The member will not have access to that, so I am happy to provide that as further supplementary information. Can the member detail exactly what she wants?

Ms J.M. FREEMAN: A breakdown for the child development services waiting list, detailing services required and by region.

[*Supplementary Information No A24.*]

Dr G.G. JACOBS: I would love the minister to talk about the southern inland health initiative. The minister can take as much time as he likes because discussion on Royal Perth Hospital, in fact, took 25 minutes. This health initiative really needs to be discussed. As a person from the regions, I am excited about this initiative.

Mr D.A. TEMPLEMAN: It is good to have the member here!

Mr R.H. COOK: Mr Chairman, I draw the member's attention to the fact that he has not pointed out where in the budget papers —

The CHAIRMAN: I thank the Deputy Leader of the Opposition; I do not need his help. I am about to ask the member for Eyre to tell us.

Dr G.G. JACOBS: The Deputy Leader of the Opposition had 25 minutes on Royal Perth Hospital, so —

Mr R.H. COOK: That is because —

The CHAIRMAN: Okay, members! Do not interrupt, Deputy Leader of the Opposition.

Dr G.G. JACOBS: I refer to the major spending changes on page 127. Can the minister put some flesh on this health initiative for us and what it means for the Southern Crosses, Merredins, Lavertons and Leonoras of this

world—even my home town of Esperance? One of the challenges in telehealth has been the issue of doctors in the regions accessing appropriate consultant services. As the minister knows, there is a fair bit of concern about who will pay the consultant fee for the patient in Southern Cross or wherever. How will this initiative make a difference to that? I look forward to the minister actually putting a bit of flesh on this health initiative, which will receive $42 million this year. I am obviously excited about this and wonder whether the minister can itemise that for us a bit.

The CHAIRMAN: Just before the minister answers, members, I will not re-read the Chairman's statement, but it is a request that questions be kept short and that answers be kept short so that we can get through as many as possible.

Dr K.D. HAMES: Mr Chairman, I will do my best. I have to say that part of the reason discussion on Royal Perth Hospital took so long was my answers, as it is a subject that I am particularly interested in, but no less so than the southern inland health initiative.

The southern inland health initiative will cost $565 million over five years—an unprecedented payment to try to improve something that has proven to be significantly broken. That funding is broken down into $240 million for the health workforce and $325 million in capital. One of the key problems with country health outside the rim of hospitals around the edge, which in most circumstances are going well, has been the enormous difficulty in getting doctors in those inland health areas. The WA Country Health Service has been working for some time with local government, health providers and advisers to try to find an alternative solution. We think that the solution we have brought forward will make a significant difference to the way health services are delivered. It is not about doing what we did in Albany. In Albany, the doctors did not want to continue in the role of providing management of the emergency department, although they still wanted to be involved. Therefore, we have put doctors into the Albany hospital to work for us and to support the general practitioners in the area to ensure that we have an integrated service. That is not what we will do with the rest of these country services. We are looking to support the private practices in the rest of those country areas to enable them to provide for a resource centre—for example, at Katanning, Narrogin or Northam—that will provide outreach services to the country towns around them.

To do that, we need a significant increase in the number of doctors; therefore, we will fund doctors in two ways. We will recruit doctors and assist them to go privately into those practices, while significantly increasing on-call funding for the doctors who cover our hospitals to ensure that the major resource centre has 24-hour coverage of its emergency department by a doctor. Doctors may also continue to work for us and go seamlessly through that service and back to working for us, if they so choose in the future. In that case, they will still work as private doctors with the private practice, but we will pay them and the practice will pay us in the same way that it currently pays a locum service—that is, a 60 per cent equivalent to the state government for providing that service. Those doctors will be backed up by a lot of other things going with it.

I will quickly go through the six streams. There is $182.9 million for medical workforce investment; that is, to improve doctors and the payments for doctors. It will include seamless around-the-clock, on-call medical care and regular medical presence at seven hub hospitals: Northam, Narrogin, Merredin, Katanning, Manjimup—which is Warren hospital—Collie, and the member's town, Esperance. Those will be included. There is also a $147.4 million investment to upgrade the six district hospitals. There was some funding of those by the former government. There is about $9 million for Narrogin and Merredin. Those funds will be significantly increased. We will upgrade Northam, Narrogin, Merredin, Katanning, Manjimup and Collie hospitals as part of that package. An amount of $43.4 million is allocated for what we call a primary health care demonstration program. That is the Jurien Bay model. Instead of a hospital, a clinic can provide lots of other ancillary services but has only 24-hour bed-stay accommodation, after which patients have to be moved on. We put the funds there to allow local communities to choose whether they want to follow that model, in which case the hospital previously operating might be converted to something like an aged-care centre as an alternative. There is $31 million for the telehealth investment program to significantly improve telehealth linkages. We want a nurse practitioner available in a town that cannot get a doctor, or has only a part-time doctor, to link into the resource centre, like at Katanning, or directly to the tertiary hospitals. We will have dedicated rooms at our tertiary hospitals to deal with telehealth so people can receive immediate, direct advice. We will upgrade the standard of our telehealth equipment and training so people working in the hospital are fully familiar with how they can better access those things through telehealth.

[11.10 am]

Dr G.G. JACOBS: How much money is allocated towards that?

Dr K.D. HAMES: That is $31 million over five years. The last area —

Mr P.B. WATSON: I have a point of order.

Dr K.D. HAMES: I am nearly finished.

Mr P.B. WATSON: This is a budget estimates process for us to ask questions related to government accountability, not to issue stuff that has already gone out in press releases.

Dr K.D. HAMES: That has always been my attitude, but actually is not the requirement of estimates. I am happy to give members every opportunity to ask questions. I am nearly finished.

Mr R.H. COOK: He just needs to say "working with the aged-care sector".

Dr K.D. HAMES: We have allocated $20 million to the aged-care sector. The reason for doing that is —

Mr P.B. WATSON: I remember the minister used to go crook at us when he was in opposition.

Dr K.D. HAMES: There is a big demand for aged care in those areas. We are particularly trying to encourage private sector involvement. This affects country areas. I am sure the member for Albany, being a country person, would be very enthusiastic about health improvements in the country.

Mr P.B. WATSON: I have already read the press release; I know what it is about!

Dr K.D. HAMES: Perhaps I should refer the member to previous *Hansards* when the member was in government.

Dr G.G. JACOBS: There is an issue in the Yilgarn area where the shire is paying on-call rates for the doctor. Will that practice be addressed by these initiatives?

Dr K.D. HAMES: Yes, it will. That is the purpose of this. Councils will not have to pay on-call rates anymore. A little country town that has a doctor may still choose to invest in the clinic, or the car or those things, to keep the doctor in the town. If the town does not want to do that, the alternative is to use the resource centre and we provide the doctor whom that town needs to keep it operational.

Mr D.A. TEMPLEMAN: I refer to "New Works" on page 146 of the *Budget Statements.* I specifically refer to "Peel Health Campus — Development Stage 1". What is the current status of those new works? At the completion date of the project, what additional facilities and services are intended for these specific new works? I have a couple of follow-up questions, depending upon the answer.

Dr K.D. HAMES: I will hand over to Jodie South, who will provide details of that funding.

Ms J.E. South: The Peel Health Campus redevelopment stage 1 had a total of $2.464 million. The project included a range of initiatives to ensure that the hospital was maintained fit for purpose. This included the theatre cooling system project, which is still to be completed but is in progress at the moment.

Mr D.A. TEMPLEMAN: But those works are shown —

Dr K.D. HAMES: They are shown as "Works in Progress"; we are talking about "New Works".

Mr D.A. TEMPLEMAN: In the out years there is a figure of $1.4 million in 2012–13 and $1.064 million in 2013–14, but the minister is saying that these works have been either partially completed or nearly completed. Why are they included in "New Works" and why are they shown in the out years?

Ms J.E. South: There remains money in our forward estimates period as holding funds for the Peel redevelopment project. This money can be called on for a range of other fit-for-purpose projects. We have done some work within the Peel Health Campus but some additional moneys remain to be utilised.

Mr D.A. TEMPLEMAN: I need clarification, through the minister —

Dr K.D. HAMES: I have received an explanation. The budget used to be a composite budget, and higher than that. It was just an amount across the forward estimates for stage 1. Some of it was completed, so that has been pulled out. That has been taken out of what was a higher budget for stuff that has already been done. A $480 000 cooling system was put in. The remainder of the funds remain there but have not been allocated for a specific purpose, but we anticipate that things will come up. It has not been pulled out. It is there if required over those forward estimates period for whatever work comes about.

Mr D.A. TEMPLEMAN: I do not want to labour the point, but is it not a bit misleading to show it as "New Works" in that the item "air cooling et cetera" really is a maintenance-related issue? Something new is not being built. There is no new addition proposed to the hospital or an expansion of the emergency department, or anything of that nature. Is it not a little misleading putting it in "New Works"?

Dr K.D. HAMES: Those things currently being done, or that have been completed, are not in that figure. They are in figures elsewhere to show that they have been done. When an allocation of funding across four years is not all spent, there are two options: one is to pull it out and it goes back into some other project; the alternative is to

leave it in the forward estimates so that when things come up that need doing, there is money to do it. In this case that is my preferred option. That money is not funding —

Mr R.H. COOK: It is just money under the mattress.

Dr K.D. HAMES: That is money under the mattress. It is not funding any existing projects, but it is there for new works. It is not existing works. It is available for new work when new work is required. My experience is that something will come up that the hospital needs. We have some funds there to enable us to do that. That is often the case.

[11.20 am]

Mr R.H. COOK: Has the private sector operator of Peel Health Campus been contacted by the department or by the minister in relation to making a contribution to the capital works at Peel Health Campus?

Dr K.D. HAMES: Is that for the current capital works that are being done or for the new capital works?

Mr R.H. COOK: It is for the current capital works, of which some are completed, some are not completed, and some are just money under the mattress. Is the minister engaged in conversations with the private sector operator to get it to make some contribution to the redevelopment of the hospital?

Dr K.D. HAMES: That funding has not been allocated to any particular project. Therefore, it would be hard to ask the operator for a contribution when there is no project to which that funding has been allocated. For the existing projects, I will ask Nicole Feely to answer that question.

Ms N. Feely: We meet on a monthly basis with Peel Health Campus to discuss everything from activity through to budget management. The ongoing maintenance of the building is a matter for discussion. In relation to new capital developments, we would expect that any request would come from Peel to us through a business case, which would then be considered; and, if funds are available, they would be allocated. That is how we do it on an ongoing basis.

Mr R.H. COOK: Has the operator of Peel Health Campus made such a request?

Ms N. Feely: We are in discussions with Peel in relation to some concepts that it has put on the table, but we have not yet received any business cases from it, which, as I understand it, is required pursuant to section 28 of the contract. When we receive those fully worked up business cases from Peel, we will consider them through the normal infrastructure process within the Department of Health.

Mr R.H. COOK: Given that the operator of Peel Health Campus has approached the department with regard to some redevelopment concept plans, will that also include a potential extension of its contract, given that the operator will be making a capital contribution towards the redevelopment?

Dr K.D. HAMES: My understanding is that the operator would like to do some further extensions to that campus. From the conversations that I had with the operator when I was in opposition, the operator was seeking from the former minister an extension to its contract to enable it to do the work.

Mr R.H. COOK: Has the operator discussed that with the minister?

Dr K.D. HAMES: The operator has raised that with me, but my response has been that it should prepare a business case and put it to the health department showing what it wants to do and what that lease extension would need to be. If that is done—the operator has not done that yet—I will ask the Department of Health to do a fair assessment. Two options are available to us. One option is to give an extension on the lease, which the operator would need if it is to get the borrowings to do that redevelopment. Alternatively, we could say no, and make our judgement when the lease expires, which I think is in eight years. I am not even going to bother about considering those options until the operator makes an application and the Department of Health has done a thorough assessment of the options and made recommendations to me.

Mr R.H. COOK: Has the operator indicated when it will be bringing this proposal to the minister?

Dr K.D. HAMES: No, it has not.

Mr D.A. TEMPLEMAN: I have a further question about Peel Health Campus. I refer to page 146, and the heading "Completed Works". The Peel paediatric ward is listed as a completed project in both the 2010–11 budget and the 2011–12 budget. I want some clarity as to why it appears as a completed work in both last year's budget and this year's budget.

Dr K.D. HAMES: It is because it is completed.

Mr D.A. TEMPLEMAN: It was listed in last year's budget as a completed project, but it is also listed in this year's budget as a completed project. If it was completed last year, it should not have been listed again. I need some clarity about how the operation of the paediatric ward is funded. As the minister is aware, there has been some concern about the delivery of services and the ward not being open at certain times to meet the expectations of the community. Some clarity needs to be given to the community about how that ward is operating now and how it will be operating in the future. Key to that is the configuration of the staffing of that ward. Can the minister give us some comments, from his perspective, on how that paediatric ward should be operating with regard to staffing?

Dr K.D. HAMES: Previously, only the hospitals in which services were contracted out, such as Joondalup and Peel, were funded on an activity-based level. Therefore, whatever activity they had come through the door, that is what they were funded to provide. Children who went to Peel Health Campus were previously placed in an adult ward. As the member would know, the community raised an enormous amount of money, with supplementary funding from the commonwealth and state governments, for a paediatric ward at that hospital so that children could be placed separately from adults. However, that did not change the funding; it was funded according to the demand. As part of the national health agreement, all our public hospitals are switching over to that same system. With regard to whether a direction has been given that the paediatric ward must remain open, if only one child comes into the hospital—because that has tended to be the problem—Peel Health Campus has made the decision that that patient will be placed in an adult ward, as opposed to providing additional staff for the children's ward. I hand over to Nicole Feely to answer the question about any specific directions regarding the operation of the children's ward.

Ms N. Feely: To my knowledge, no specific directions have been given. The funding would be accommodated through the overall funding arrangement from a public perspective through the national partnership agreement with Peel hospital. There is also a private funding element if patients with private health cover come into the hospital. How that ward is run is a matter for Peel campus. I am not in a position to give advice now on how it is staffed and those sorts of issues.

Dr K.D. HAMES: What is clear from that is that, in my view, the hospital has a moral responsibility to keep that ward open whenever possible. However, if there are no children in that ward, we would not expect the hospital to have staff work in that empty ward. That just does not make sense. Is the trigger point that requires that ward to be open one child in the hospital or three children in the hospital? We have not given the hospital specific directions about that matter. I think the community is telling the hospital very clearly that it expects it to open that ward and to look after children in the children's ward, and I think it would be far better if it could do that. Some of the information that I have seen has been somewhat misleading. It has been said that children have not been able to be admitted to that hospital and have had to go to Fremantle Hospital. Children can be admitted to that hospital. It is just that if only one child needs to be admitted to that hospital, that child might not be admitted to the children's ward but might be admitted elsewhere in the hospital system. My preference would be for that ward to stay open. As the member for Mandurah would know, he and I, and many other people in the community, have put a lot of time and effort into the funding of that children's ward. I have decreed my $300 a year for about five years, and there is also all the fundraising events that we attended so that that ward could be built. I think we will find that as the population of Mandurah grows and more children are admitted to the hospital, that will stop being an issue. The only reason it is an issue now is that very few children in Mandurah are getting sick; they must be a healthy bunch down there!

The CHAIRMAN: I want to exercise my right as Chairman to ask a brief question. Hopefully, there will be a brief answer. I would not normally do this, but it is in my electorate. I refer to the new works listed on page 147.

Mr P.B. WATSON: Point of order!

The CHAIRMAN: Thank you, member for Albany! My question is about Fiona Stanley Hospital. Can the minister please give me a snapshot update on how we are going with Fiona Stanley Hospital? Is it on budget? Is it on track? When does the minister expect it to be completed?

[11.30 am]

Dr K.D. HAMES: I will hand over to Brad Sebbes, who is in charge of that, in a minute. It is going amazingly well; it is on time and on budget. The original proposal was for Fiona Stanley Hospital and also the replacement of the state rehabilitation centre. They are going exceptionally well. I will hand over to Brad to give any further details he may wish.

Mr B.C. Sebbes: The project has been tracking on time and on budget since the approved business case in 2007. Since then, we have received $255 million from the commonwealth to relocate the state rehabilitation service,

which is currently in Shenton Park. We have managed to contractually get that arrangement into an existing managing contract. That is also now on track to be completed along with the hospital in December 2013.

Dr K.D. HAMES: Before we conclude, I want to point out that on page 145 of the *Budget Statements* the planned expenditure for Fiona Stanley Hospital was $330 million in 2010–11. That is the year just gone. The actual spending is $429 million. We have spent about $100 million more this year than we planned to ensure that work progresses quickly. It is excellent news.

Mr P.B. WATSON: I refer the minister to the line item "Albany Regional Resource Centre—Redevelopment" under "Works in Progress" on page 144 of the *Budget Statements*. Being on the board of the hospice in Albany, I believe the self-funded Albany Community Hospice is at risk of closure due to the Albany Regional Hospital redevelopment. Can the minister confirm that the hospice will have to be relocated due to that redevelopment because it will be 350 metres away from the development and people will have to be transported between the hospice and the hospital in ambulances? Can the minister confirm that he has provided no funding for the hospice's relocation? Is the minister aware that the hospice needs to double in size and has no funds to do so? Will the minister provide any assistance for the hospice to relocate and increase its bed capacity so it is able to keep its doors open and continue caring for the people of Albany?

Dr K.D. HAMES: I will hand over responsibility for those questions shortly. I have always been a bit surprised that the hospice wanted to move. The hospices I have dealt with in the past always wanted to be separate and away from the hospital to have a different atmosphere. Patients are normally transferred by ambulance from one to the other.

Mr P.B. WATSON: They are going to walk through the car park.

Dr K.D. HAMES: Normally they are a lot further away than that; they are sometimes streets or even suburbs away from the hospital because that is where they want to be.

Mr P.B. WATSON: The minister would understand that the one in Albany is connected to the hospital. It saves a lot of time and money.

Dr K.D. HAMES: I do know that but that is not what other hospice managers want. Other hospice managers want it totally separate and as far away as possible.

Mr P.B. WATSON: I am speaking on behalf of the board here.

Dr K.D. HAMES: I know that the member is driving that. Ian Smith, the WA Country Health Service director, is going to answer that question for me.

Mr I. Smith: There were four questions. I did not pick up all four. Can we go through them one at a time?

Mr P.B. WATSON: Can the minister confirm that the hospice will have to be relocated? Can the minister confirm that no funding has been provided for it? Is the minister aware that the hospice needs to double in size but has no funds? Will the minister provide any assistance for the hospice to relocate?

Mr I. Smith: Through the minister, no, the hospice does not have to relocate. That is a preferred option of the board of management of the hospice. As the minister has just described, there are lots of alternatives. Many years ago the hospice was not based on the Albany hospital campus. The hospice has been aware for some considerable time that it was not going to be part of the redevelopment because it has a beautiful building, purpose-built for its pre-existing level of service. The second question was about funding. The hospice is funded on an activity-based requirement. The number of bed days that it is providing is what it is funded for.

Mr P.B. WATSON: I am not talking about that funding; I am talking about funding to relocate.

Dr K.D. HAMES: It is better if the member does not interrupt because he can then ask a further question if the adviser gives the wrong answer.

Mr P.B. WATSON: Thank you, Mr Speaker!

Dr K.D. HAMES: Keep going.

Mr I. Smith: There is no funding for the relocation. In conjunction with the hospice, we did apply for royalties for regions funding in the last round. That was not successful. I understand that the hospice is chasing additional funding to continue to see whether there is another source to co-locate with the hospital if it is able to fund it.

Mr P.B. WATSON: There is space on the new site for the hospice. I was told that during talks it was stated that the government would take over the hospice section, so we could relocate and the area could be used for training rooms or doctors in the old hospice section. Has that idea been looked at by the government?

Dr K.D. HAMES: As the member knows, we significantly increased the funds to build it. I think the final figure is up to $165 million.

Mr P.B. WATSON: That is what we were promised in the first place and the minister said that it was too much.

Dr K.D. HAMES: It was not in the budget. I am sure the member is very pleased that this government has focused very strongly on the Albany hospital, and we are determined to finish it during this term in office.

Mr P.B. WATSON: I am very pleased. I congratulate the minister. The minister forgets one thing: we announced that we were going to build it, and he came out two days later and said that the new government was going to build it.

The CHAIRMAN: Member for Albany and Minister for Health, I do not ask much but I ask that you do not talk over the top of each other.

Dr K.D. HAMES: Relocating the hospice unit is not the highest item on my priority list. My priority is to rebuild the hospital and to get it up and functioning. Having said that, I am not opposed to the relocation of the hospice if there is an alternative source of funds. I do not have the funds, given that we are going to build Karratha hospital, Midland, the children's hospital, Busselton and all those others. I do not have additional funds to fund something that I do not regard as being essential, but I am not opposed to it if it is wanted and if there is a way to do it. If the board is able to resource funds, say through royalties for regions, I am more than happy for the health department to cooperate in how we might achieve that and how it might be done. I am not going out of my way at this stage. If it was a high priority for the Albany community to do that, perhaps in the next term of government we could look at how that might be achieved.

Mr P.B. WATSON: As a senior member of cabinet, I am sure the minister could use his influence with royalties for regions or is that the Minister for Regional Development's ransom he holds over the city people?

Dr K.D. HAMES: I have used my significant influence on royalties for regions; hence, $565 million over five years, plus $150 million —

Mr P.B. WATSON: That would generally come out of the budget.

Dr K.D. HAMES: It is a significant investment by royalties for regions in regional health.

Mr A.P. JACOB: I draw the minister's attention to page 130, in particular to the second heading "'The Four Hour Rule'—Managing Unplanned Care". I noted last week's *The West Australian* article entitled "Hospitals finally on the mend", which highlighted the success of this program. Could the minister please detail the progress of the four-hour rule program and how it is impacting on patient journeys through our hospital system?

Dr K.D. HAMES: I thank the member. What an excellent article that was. I hope all members read it.

Mr R.H. COOK: We were looking at the article on the front page.

[11.40 am]

Dr K.D. HAMES: We are working through that.

This is a significant development in the state. It shows that it is making an enormous difference. Frankly, if we had not brought in the four-hour rule with the growth in demand that we have had, which was about six per cent last year and about nine per cent this year, we would not have coped with the demand. We were the worst state in Australia. Fremantle Hospital was the worst hospital in Australia, with an eight-hour wait for a bed. Sometimes up to 50 per cent of patients were lying in the corridor desperately waiting for a bed. Now those figures are down to seven to 10 per cent. When I was at Fremantle Hospital yesterday, I congratulated the staff on achieving the 85 per cent target. A nurse—I do not know what level nurse she was—had recently given a lecture to nurses from the other states about the four-hour rule. She showed them graphs and figures of the changes that have resulted in a reduced access block. The other nurses could not believe the changes. Western Australia has gone from having the worst figures in Australia to having the best. They are major changes that have not been made without hard work. There is some variation on the 85 per cent target on a day-to-day basis. The figure for Fremantle Hospital on the day I was there was 79 per cent and on the weekend it had been 90 per cent. The hospitals are getting variations, depending on the demand coming through the door. Many of the solutions that Fremantle Hospital has put in place are developing and gaining strength. However, everyone to whom I spoke said that they would never go back to the old system.

The four-hour rule has had a profound impact and has involved a huge effort. Some of the people who helped get those changes through spent an enormous amount of time and effort doing that. A ward nurse at Royal Perth Hospital who arranges patient discharges told me that she had telephoned a doctor and said, "We've got a patient ready for discharge. Where are you?" He told her that he was busy and she told him to get his butt down there

because the patient would be discharged in 10 minutes even if the doctor did not turn up. Often it is that level of staff who are driving the reforms and making sure they work, and sometimes they must drag recalcitrant doctors to do what they need to do to ensure that the system is efficient. This is about efficiency and the patients' journey. Although we are getting an increased numbers of patients, we are not getting huge increases in patients coming into our hospitals because they cannot get a GP, as happened in England. The balance of admissions and the complexity of the patients' cases remains the same. The patients are not all turning to GP services. The morbidity rate throughout our hospitals is going down. When I was in opposition, I used to wave a report by Dr Sprivulis at the then Minister for Health. That report gave the numbers of patients who were either dying or suffering from long-term consequences as a result of hospital delays, and those figures have started to come down. It is a success story all around. As part of the national health agreement, the other states have to do it, too, but the system they proposed would not work. Our middle-level staff are convincing the other states that the way we are doing it is the best way for the other states to do it.

As members know, we set a target of 98 per cent. The advice I had from everyone, particularly those from England, was that we should not set the bar so high that it was almost unachievable. To turn around a ship like this, we needed to make it an extremely difficult figure to reach, which I did. We have now asked for the interim target to be set at 85 per cent, which, on average, has been achieved. The long-term figure will probably be set on a national level that will encompass what all the states believe the national level should be. I believe it will be either 90 or 95 per cent. That is a sensible figure that will ensure patients are not being driven out the door or poor decisions are being made that are not in the best interest of the patient. Unfortunately, we still see statistics reported in the paper that are two years old. Those figures do not look good and we get caned for having those statistics. We need people to see the current figures so that they can see how much it has improved.

Mr R.H. COOK: On that basis, could the minister provide us the daily reports on the performance on the four-hour rule for each of the major metropolitan hospitals over the past four months?

Dr K.D. HAMES: I think we have done that publicly.

Mr R.H. COOK: The minister has provided consolidated quarterly reports. I would like a breakdown per day for each of the major hospitals over the past four months.

Dr K.D. HAMES: A lot of those figures are available on the hospital wards. We make sure that all our staff are aware of how they are tracking, particularly compared with the other hospitals.

Mr R.H. COOK: What we would see, for instance, is that Royal Perth Hospital's performance has deteriorated over the last month. It would be interesting to see the daily rates.

Dr K.D. HAMES: It has deteriorated only in the last week. As we head into the winter demand, it is going to be difficult. We will see how the hospitals cope and how good they are at meeting the 85 per cent target. Yesterday I talked to Royal Perth and Fremantle Hospitals about that. They understand that it will be difficult, but they are feeling very confident. They are telling me that the processes they have put in place are changing and improving on an almost weekly basis. Although there will be days when they cannot cope —

Mr R.H. COOK: That is fine, minister. It would be terrific if the minister could provide those reports.

Dr K.D. HAMES: Sure. There was no need to interrupt my answer. I have agreed to do it. It is my answer, not the member's.

Mr R.H. COOK: I noticed. It was a very long one.

Dr K.D. HAMES: I thought that it was quite short.

The CHAIRMAN: There was a lot of cross-chamber talking going on. I must clarify that the minister is agreeing to provide supplementary information.

Dr K.D. HAMES: We will provide the tracking over the four tertiary hospitals—Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital and Princess Margaret Hospital for Children—on the percentage they achieved on a daily basis in relation to the four-hour rule.

Mr R.H. COOK: The percentage and the numbers.

[*Supplementary Information No A25.*]

Dr G.G. JACOBS: I refer to major spending changes outlined on page 127 of the *Budget Statements*. The government has allocated $11.5 million for junior doctor training in 2011–12. Can the minister provide some details on exactly what that expenditure is for? Will the funding assist country areas like my electorate? Will that be a new funding program on top of the rural registrar program or on top of PYPPP? How will it work? Are we talking about junior doctors going to general practices to be trained in rural medicine?

Dr K.D. HAMES: That funding represents a component of the $75 million in additional funding that has been allocated to the Department of Health to train rural doctors. The member will be aware of the increased number of doctors who have graduated over recent years. I do not know about the number of doctors who graduated in the year the member graduated, but 90 doctors graduated in the same year I did. Today, almost 300 doctors graduate each year, and that figure is expected to increase to 310. In all those years there has never been a specific allocation for the training of doctors. It has been absorbed into the activity growth and the doctors doing that work have had to provide training as part of their employment package. Whereas in the past there were two or three residents on a ward round, there are now many more and therefore they are not getting the same degree of training that they used to.

This funding will allow two components. I must point out that 40 per cent of the funding will go to the country and 60 per cent will go to the city. The first component will allow the employment of 94 additional doctors to do training. Most of those doctors do sessional work. A 0.2 or 0.4 full-time equivalent surgeon will be able to increase to a 0.5 or 0.6 FTE, or whatever capacity we have to recruit them to undertake more training. Perhaps we can even employ more full-time doctors in our hospitals to provide that additional training. The second component of the program is to provide 44 additional doctors who will be educators and will train other doctors at our universities using a range of simulators. That is a significant boost that will enable us to properly look after the training of doctors. As we get increased numbers of doctors, we will have to farm them out. More of them will be sent to regional hospitals where they will be given additional training. That is why this significant increase in funding was needed. I was in Northam last week and met a doctor who is approaching retirement. He told me that new doctors do not have the same skills as the old doctors. He also said that when he is retired, he would be more than happy, if he were paid, to teach doctors how to put in a PICC line, for example, or some other procedures that doctors are not as familiar with now as they were in the past. This is a fantastic step in the training of doctors.

[11.50 am]

Mr R.H. COOK: My question refers to "Emergency Department" on page 138 of budget paper No 2 and sets out the growth in emergency services demand as five per cent in the last financial year, and nine per cent to the end of the March calendar quarter in 2011. Could the minister please provide the projected increase in demand for emergency departments in 2011–12? Given this projected increase, why is the percentage increase in total costed services less than one per cent and why is the number of FTEs falling by over 100?

Dr K.D. HAMES: I will hand over to Mr Snowball to answer that question, but I will point out the previous figures and what a massive increase this government has put into funding. If the Deputy Leader of the Opposition looks at the cost of service in 2009–10, it was $256 million —

Mr R.H. COOK: I did not ask the minister about 2009–10.

Dr K.D. HAMES: The member seems to object to the way that I answer questions. I can answer however I like. The member does not have to like the answer, but it is still my answer, even if I want to add to it.

Mr R.H. COOK: Does the minister remember the guidance from the Chair that his answers are to be short and addressed to points in the budget?

Dr K.D. HAMES: I would be able to do that if the member had not interrupted me.

It is very important to look at those previous figures. The figure of $258 million increased to an actual spend of $434 million. The government has put a lot of money into our emergency departments, which I think is fantastic. I will hand over to Mr Snowball to answer the rest.

Mr K. Snowball: Through the minister, the growth projection for next year, and accommodated in the dollars we have, is eight per cent growth in the major hospitals in ED presentations. This year it has been roughly nine per cent with a variation there, so we are expecting a continuation of that level of growth. As the member will see, it looks like there is a reduction in FTE and cost of service as well. That came about as a consequence of the commonwealth contribution towards EDs over a period of four years being brought to account in the base year. Part of our accounting requirements is that whenever we receive a grant from the commonwealth that might be for a program over three or four years, we are required to bring the entirety of that grant to account in the year in which it is received. It looks like we have a major lift there, but that is then spent over the subsequent two or three years, depending on the length of time of the program. It looks as though there has been a reduction; in fact, the increase follows the increase in activity over that time. So expenditure will in fact follow the activity that we are generating in those major hospitals.

Mr R.H. COOK: Thank you for that answer. Contrary to the minister's earlier comments that there was a massive increase in 2011–12, that is not the case and that is simply an accounting measure to recognise the

increase in commonwealth government funding. It is not, in fact, the substantial increase that the minister began his answer describing.

Dr K.D. HAMES: To save being seen to pad my own nest, I will hand over the question again.

Mr R.H. COOK: The minister contradicted himself in the last answer.

Dr K.D. HAMES: In fact, my answer does not do that and the member will hear the explanation now.

Mr K. Snowball: The year in which the major lift occurred included a state contribution to increased expenditure in emergency departments, but a large part was also associated with the commonwealth contribution and grant. There was a lift in the state's contribution towards ED based on growth—this is the rebase that occurred last year—in which we saw the dollars from the state budget now matching activity through the clinical services framework. That is the projection going forward.

Mr R.H. COOK: Could the minister provide a breakdown of the funding sources that underpin that funding increase in 2010–11; and also for 2011–12? If that is provided as supplementary information, that is fine.

Dr K.D. HAMES: We do not have the figures now, so we are happy to provide that as supplementary information.

The CHAIRMAN: The minister agrees to provide supplementary information, so I ask him to repeat what that information will be.

Dr K.D. HAMES: The member needs to repeat what he has just asked for.

Mr R.H. COOK: It is a breakdown of commonwealth and state funding for emergency department services in 2010–11 and 2011–12, including FTEs that were last year spread across the forward estimates.

[*Supplementary Information No A26.*]

Ms L.L. BAKER: I refer to the line item for "Hospital Nurses Support Fund" in budget paper No 2, volume 1, page 145. I know this government made a commitment to spend $28 million on that fund. Could the minister confirm that $15.47 million is all that has ever been allocated to date to that program?

Dr K.D. HAMES: The member is looking at the capital component and not the total. We allocated $6 million a year over four years. That has been distributed. I have a figure for the year 2010–11 of an allocation of $6.124 million—I will give the member the rough figures—of which $1.5 million went to North Metropolitan Area Health Service, $2.3 million to the South Metropolitan Area Health Service, $443 000 to the Child and Adolescent Health Service, $1.2 million to the WA Country Health Service, $153 000 to other organisations like the Drug and Alcohol Office and NurseWest, and $400 000 to the Joondalup Child Health Centre capital works.

Ms L.L. BAKER: Has anything been allocated for the 2011–12 estimates?

Dr K.D. HAMES: We have made a commitment for the four years of this government, so that money is in the budget and it is there for allocation, but we have not done the allocation. We go out to the nurses and we ask them what they want to spend this money on. The nurses have regular meetings and choose things. The reality was that there was some criticism somewhere along the way of the things they were choosing as being things that helped them personally. I am happy for them to do that. This was about recognition of the value of nurses to our system and providing additional funding that would help make it easier for them in their workplaces. I expected them to spend that on funding childcare centres, painting and all sorts of things like that, but quite a few of them spent it on equipment for patients, which, frankly, I thought we should have to pay for. However, they were things above and beyond what would be the normal allocation to a ward and that would make their lives easier, so I was happy for them to do that. We leave that choice up to those staff.

Ms L.L. BAKER: Would I be able to get a copy of the breakdown, minister?

Dr K.D. HAMES: I have that information for the year that has just been allocated on a piece of paper. I do not need to provide that supplementary information; I will give the member this piece of paper that has last year's allocation.

[12.00 noon]

[Mr M.W. Sutherland took the chair.]

Ms J.M. FREEMAN: I have a further question.

Dr K.D. HAMES: Has the member been given the call?

Ms J.M. FREEMAN: No; this is a further question.

Dr K.D. HAMES: Yes, but the member still has to get the tick from the Chair.

The CHAIRMAN: I have agreed.

Ms J.M. FREEMAN: Was that part of the work–life balance project to support nurses and to retain them in the workforce, and does that mean that the work–life balance project has been cut?

Dr K.D. HAMES: It has absolutely nothing to do with this. That is something I personally cooked up from when I was in opposition as a way to get members opposite out of government!

Ms J.M. FREEMAN: Did the minister cook up the hospital nurses support fund to get us out of government, but now he has cut it?

Dr K.D. HAMES: We had policies that I thought would be of great benefit, such as the patient assisted travel scheme funding and the Silver Chain program, and the work–life balance project was one of them. I recognised a need to give a more reasonable reward to nurses for the work they do. During the lead-up to government is the best time to commit to things because we then get the money out of our own people to do it. I thought it was good concept. We got a commitment from our leaders at the time, and when we won the election, they had to give me the money and I was able to allocate what I think nurses were very happy to get.

Ms J.M. FREEMAN: But now it has been axed.

Dr K.D. HAMES: It is nothing to do with any other program. The pre-election commitment of $28 million for the nurses' support program is in the budget and that is what they get.

The CHAIRMAN: Member for Maylands.

Ms J.M. FREEMAN: I just do not get to ask a question.

Ms L.L. BAKER: I am happy to hand my question to the member for Nollamara.

The CHAIRMAN: The question can go to the member for Nollamara.

Ms J.M. FREEMAN: I refer to the line item "South West Health Campus—Critical Care Unit" under the asset investment program on page 145. How much recurrent funding has been allocated in the 2011–12 budget to run the critical care, or intensive care, unit and how does this compare with the funding allocation in the 2010–11 budget.

Dr K.D. HAMES: That is an excellent question. I will hand over to Mr Ian Smith, WA Country Health Service director.

Mr I. Smith: The funding for the ICU, as we develop it, will come on stream. We have capacity in the base of the south west hospital's budget to do the following year's activity. It is not additional funding, because it is already in our base.

Dr K.D. HAMES: That means that the funding was put in for the capital works. The South West Area Health Service gets a funding allocation and there is some flexibility within that allocation. It is based a lot on demand. As demand grows, the budget grows. The service looks at where it spends that, and there is capacity within that to fund the staffing of that centre without needing me as minister to require an extra specific allocation to allow those staff to be employed. They have recently sought to employ a director for that. They did not have an applicant for that but since then someone has been allocated to that position on a temporary basis. Is that correct?

Mr I. Smith: Yes.

Ms J.M. FREEMAN: Does that mean there have been no employees since late February 2011 for the critical care unit? Has it been operating since late February 2001, or has it been idle?

Dr K.D. HAMES: It has not been opened yet. We have only just got the funds and just finished building it.

Ms J.M. FREEMAN: When was it completed?

Dr K.D. HAMES: The equipment went in during February 2011.

Ms J.M. FREEMAN: Equipment went in during 2011, so when was it completed?

Dr K.D. HAMES: I think it would be better if we gave a proper answer!

Mr I. Smith: The upgrade to the level 1 ICU was dependent on minor changes to the equipment upgrade and some minor changes to the building renovations. They have been finished and the equipment is there as well. However, to operate as a full level 1 ICU requires the appointment of the director of the ICU, which is what the minister was referring to, and that is still in process. In the interim, the hospital operates sometimes with the

capacity of an ICU with the pre-existing staff and specialists in the service. When the additional staffing comes through is when we can guarantee that a level 1 ICU will operate 24 hours a day.

Ms J.M. FREEMAN: The equipment went in during February 2011. When was the building upgrade finished?

Mr I. Smith: I am sorry; I do not know the exact date. I visited it about a month ago and it was completed then.

Ms J.M. FREEMAN: It was completed a month ago but it has not been operating because there has been no staff.

Dr K.D. HAMES: That is not what Mr Smith said a minute ago. He said it has been operating as best it can, but not as a full level 1 ICU; that is, for 24 hours. We have to have the staff there and they are hard to recruit. We are expanding significantly ICU spaces throughout the state, and it is not before time. A study was done in 2004 on requirements for intensive care units, which showed a significant shortfall in ICUs. When I became minister, Fremantle Hospital, for example, was extremely critical. The former minister had promised for four years to upgrade ICUs. We have now done upgrades to PMH and Rockingham and Bunbury hospitals—I think there are more than that. Anyway, there have been significant upgrades to the availability of ICU beds, which is a critical need in the state. I have to say that it has been hard getting the capital funding to do it, but it has been harder to get the significant increase in staff funding because it requires about two nurses per patient. I think in the high dependency unit it is one and a half per patient. It is a significant extra cost. We have been waiting for the process to go through so that we can afford the staff and get the equipment ready for it to proceed.

The CHAIRMAN: I will call the member for Albany and then the member for Maylands.

Dr K.D. HAMES: What about our side?

The CHAIRMAN: Do not worry about your side; I am worried about the other side.

Mr P.B. WATSON: We are not asking dorothy dixers; we are asking really tough questions here. I refer to "Supplies and Services" under "Expenses" on page 149. Can the minister explain why, when a business in Albany was providing water coolers to the health department offices, the process for another contract is now going through Perth? The Albany supplier was not given an option to quote on it. The price would have been cheaper in Albany because the supplier could provide the coolers for the same price as that provided through Perth and, obviously, the Perth suppliers have to pay freight. Can the minister please explain the Buy Local policy in this situation with the health department?

Dr K.D. HAMES: We can answer part of that question but not all of it. Firstly, I as a minister cannot get involved in those things.

Mr P.B. WATSON: No, no; I was wondering what the policy is.

Dr K.D. HAMES: That is a requirement of the health department. I do not think we should air publicly in here that a specific tenderer might have been successful and another one has missed out.

Mr P.B. WATSON: Minister, there was no tender; it was done through Perth.

Dr K.D. HAMES: I have had similar situations in my electorate and have written to the health department.

Mr P.B. WATSON: We have the health department here now.

Dr K.D. HAMES: Yes, but I do not know that people here have knowledge about an individual contract. Things like that are generally raised as questions on notice or as a grievance. The Buy Local policy, generally, is different; it is a policy and that is what the estimates hearings are about. Is there someone here who can answer that question on the Buy Local policy?

Mr P.B. WATSON: Is there a Buy Local policy?

[12.10 pm]

Dr K.D. HAMES: The answer I am given is that there is a Buy Local policy, particularly based around regional areas. Without knowing the particular details, we cannot answer that question. I suggest that the member provide those details to me and I will have the director general investigate that case outside the budget process.

Mr P.B. WATSON: I have a further question. Will the new Albany Regional Hospital have any additional beds?

Dr K.D. HAMES: I answered a question on this recently and I think the answer was that the number of beds would be relatively the same. The question was: how can that be the case given there is major investment and major resource development? There was an excellent answer, which I hope someone can reproduce.

Mr P.B. WATSON: Surely the minister would have given the answer from his heart!

Dr K.D. HAMES: The answer related to the change in the methodology of treating patients; that is, the change in efficiency of the system, patients' length of stays and so on. A careful analysis of how many beds were needed was conducted in developing the business case for Albany. The member might be aware that the business case, developed when the member was in government, for the new children's hospital had a reduction in the number of beds because those beds would be needed elsewhere. We are not doing that —

Mr P.B. WATSON: Beds will not be needed anywhere else in Albany because there is only one hospital.

Dr K.D. HAMES: That is right; there are different circumstances. However, the reality is that modern treatment, particularly the short length of patients' stays, and the big increase in focus on day surgery, so that patients do not need to be admitted, has changed the demand for beds enormously. When I had my appendix out, I had a week in hospital; nowadays, it would be only a day in hospital, if the patient is lucky. The director general will provide a better answer.

Mr K. Snowball: There are probably two key important points to make about bed numbers and activity. Albany has one of the highest lengths of stay of the regional hospitals for two reasons: the design of the old hospital, which is not functional any more for contemporary medicine, so we end up with higher cost overheads to provide the service; and the age of the population. With the hospital's new design, major growth will come from the day surgery–type areas and so on. Therefore, the hospital will expand its ability to provide a service to the wider region, not just the people of Albany, with the intent of lifting the level of local service so that fewer people have to travel to Perth for a range of services, particularly for the higher, more complex services and the day surgery–type services. There will be an increase in the provision of those services. Given the age of the population, there will also be an increase in areas such as oncology. Again, chemotherapy is a day surgery–type treatment. That is where most of the growth in activity is coming from. The bed numbers have been worked out purely from the clinical services framework. It is the same projection that we use in every other service to project how many beds we will need over time to meet the activity. I think that 134 beds are needed in Albany to cope with the projected level of activity.

Ms L.L. BAKER: I am interested in what the Drug and Alcohol Office or the Department of Health will do in response to butane —

The CHAIRMAN: Member, what line is this?

Ms L.L. BAKER: I refer to the first dot point under the heading "Drug and Alcohol" on page 133 about the drug and alcohol interagency strategic framework. It states that the Drug and Alcohol Office will focus on prevention and reducing the harmful impacts of alcohol and other drugs in the community. Given that a recent report by the Education and Health Standing Committee provided evidence that three per cent of Australians over 14 years of age and more than 10 per cent of 12 to 17-year-olds have admitted using butane inhalants, can the minister tell me what resources his department has allocated to produce a plan to deal with the use of inhalants by Western Australian schoolchildren?

Dr K.D. HAMES: I thank the member, but, as she will understand, it is not my department.

Ms L.L. BAKER: Drug and alcohol —

Dr K.D. HAMES: Yes, I am not the minister for drugs and alcohol, but those staff are here to answer those questions.

Mr R.H. COOK: We confronted this issue last year, minister. It is still front and centre in the budget, so I do not understand why it has not been taken out.

Dr K.D. HAMES: I have staff in the chamber who are perfectly willing and capable of answering that question. I refer the question to Gary Kirby.

Mr G. Kirby: I understand that there are two parts to the question: the first is about the interagency framework and the second and most significant part is about what might be in place for the volatile substance use plan. Is that correct?

Ms L.L. BAKER: Specifically, butane inhalants.

Mr G. Kirby: The interagency framework sets out a plan for the development of a volatile substance use plan and the funding for that is within the operating budget of the Drug and Alcohol Office.

Ms L.L. BAKER: I have a further question, although it is the same question at the beginning: how much funding has been allocated?

Mr G. Kirby: The VSU plan will largely be a strategic plan and the actual operating expenses within the Drug and Alcohol Office is approximately $175 000 for this forthcoming year. That needs to also be considered in light of the existing funds that go to various regional services for alcohol and other drug services.

Ms L.L. BAKER: Is that $175 000 for a butane inhalant program across Western Australia?

Mr G. Kirby: That is within the Drug and Alcohol Office, but we need to be mindful of the fact that other funds will be expended by the various drug and alcohol services throughout the state. That will obviously be contributed to as part of their ongoing work.

Dr K.D. HAMES: On that point, I fund most of those non-government organisations through my budget. We fund a lot of drug and alcohol services to the community, which will also benefit from that 25 per cent increase in funding.

Ms L.L. BAKER: I thank the minister. My point, hopefully constructive, is about the need to get a strategic view on tackling this issue. If the government does not want to support legislation, what is the plan for tackling butane abuse?

Mr R.H. COOK: Good question.

Dr K.D. HAMES: Mr Kirby.

Mr G. Kirby: The plan at the moment, specific to butane and volatile substances, is working with the Retail Traders' Association of WA on a voluntary code of compliance and the other education work that is being done within the regions. Some local regional strategies are being developed to respond to VSU plans within those local communities. Alcohol and other drug services will support those communities to work up those plans.

Ms L.L. BAKER: I have a final question. Can the minister point us to anywhere those various pieces are brought together? Is it written up anywhere as a strategy to address this problem? I am mindful of the fact that the parliamentary committee report released last week called for the department to plan overall how to do that work. Is that already in existence or is that something the department plans to do out of this budget?

Dr K.D. HAMES: Mr Kirby.

Mr G. Kirby: That is planned for development in this financial year, 2011–12.

Mr P. ABETZ: I refer to the third dot point under "Patient Transport" on page 132. Can the minister provide us with an update on the extra funding for ambulances? It is very welcome, but has it had any impact on ambulance ramping at our main tertiary hospitals, and is there any space in the budget for an ambulance station down Southern River way?

Mr R.H. COOK: That is called friendly fire!

[12.20 pm]

Dr K.D. HAMES: There has been a significant increase in funding, as the member knows, to St John Ambulance services—$149.6 million in total. Through that, we have 79 new paramedics, 24 new communications officers, 12 new ambulances, and 10 extra transfer vehicles to make sure we increase ambulance services throughout the state. In terms of the more specific component of the member's question, the director general will answer that.

Mr K. Snowball: Putting the additional ambulances on the road also means they have improved their response times. We are working closely with St John Ambulance, particularly on ambulance ramping in our hospitals. We put out an operational directive regarding no ramping and no diversion, which we reactivated last year after we experienced some difficulties. Previously, we increased ramping at a number of our hospitals to deal with increased pressure at Joondalup hospital. We are seeing more ambulances on the road and, similarly, we are working with St John Ambulance in how better to task ambulances to our hospitals—where the capacity is—so that we can reduce ambulance ramping through that process. In conjunction with putting funds into the ambulance service, it is also about how well we work together with them in terms of our emergency departments.

Mr P. ABETZ: The second part of my question has not been responded to yet.

The CHAIRMAN: The member wants to know whether Southern River will get an ambulance station!

Mr R.H. COOK: That was nicely avoided! Don't let him bully you!

Dr K.D. HAMES: The location of extra stations was determined as part of the inquiry undertaken by Greg Joyce. He spent a lot of time talking to ambulance officers, both in the metropolitan areas and country regions. He developed a plan as to where those additional services were required. I do not have the details of where those services are. I am sure if the member writes me a letter, if that is part of it, I will be able to provide that answer.

Mr R.H. COOK: At an earlier Education and Health Standing Committee hearing there was discussion about at which point ambulances start to be ramped.

Dr G.G. JACOBS: When does the clock start ticking?

Mr R.H. COOK: Yes, that is right. At that particular point it was something like 20 minutes, but the director general said it was under review. The minister was to examine exactly when the clock would start clicking. That issue was to be given a fair bit of consideration. Has that consideration been given, and could the minister advise us at what point an ambulance starts ramping?

Dr K.D. HAMES: The time remains at 20 minutes. It is not my intention to change that time, although I have to say some people sitting behind me have a different view—that it should start at a later time, and that that was a fairly arbitrary time to choose. I think it is adequate. I do not propose changing it.

One of the difficulties I have found is when exactly the four-hour rule starts and when exactly does ambulance ramping start and finish. In fact I had a conversation recently with Joondalup Health Campus. An elderly lady had been transported to the hospital by ambulance, which was subsequently ramped. I thought patients actually spent more time in the ambulance, but they do not. Patients are taken out of the ambulance and taken inside. They then have some basic assessment of their problem and a determination is made as to their category. This elderly lady was designated category 4, which is not urgent. At the same time a patient designated a higher category came in. The emergency department was fairly full, so that person was whisked through and treated. The elderly lady stayed on the ambulance couch in the corridor. She had been triaged to determine what was wrong with her. She asked the hospital when its responsibility for her started. The answer was, "It starts at the time the triage is done. You're in our building, you've been assessed, and we're now responsible for you." In theory, the four-hour rule starts from that time. The ambulance driver was left there, so that was counted as ramping because the driver had been there longer than 20 minutes. I was in effect getting caned in both directions!

I want ambulance drivers to do what ambulance drivers are supposed to do; that is, collect people and not stay around emergency departments looking after patients. There are two options for me to resolve this. We are in the process of it now. One option is for the hospital to employ extra staff at the coalface and take over management; that is, put the patient on a bed. The patient then becomes the hospital's responsibility and the ambulance driver can go. Hospitals say to that proposition, "We don't want our corridors to become quasi-wards filled with patients waiting to get into ED." The alternative is to employ St John Ambulance people who are not the drivers to stay in those corridors and look after the patient until the hospital takes responsibility for them. Then I do not have the ramping, because the ambulance takes off, but I have to employ additional people who are not perhaps as well qualified in managing patients. It is a matter of intense discussion at the moment. Different hospitals do it differently. Sir Charles Gairdner Hospital, for example, has very low ramping. The hospital has a very active front-end service. Doctors and nurses come out into a nice area at the front and are much more active in looking after patients. It is a difficulty that I am sure will be resolved over the next few months. From the latest ramping numbers, since I have had those conversations, the numbers have gone down.

The CHAIRMAN: I had firsthand experience of that very nasty area last Thursday evening. I was very well treated.

Dr K.D. HAMES: You should be more careful what you eat!

Dr G.G. JACOBS: You certainly look a lot better than last time I saw you!

I refer to "6: Patient Transport" on page 140 of the *Budget Statements*. I notice the total cost of service has gone from $137 million to $157.56 million. Patient transport involves transport other than ambulances. Can the minister provide a breakdown of that figure? As a country member, I am particularly interested in the patient assisted travel scheme. What does the increase in PATS mean for people from regional areas seeking treatment?

Dr K.D. HAMES: I thank the member for that question. We undertook a major review into the St John Ambulance scheme, which resulted in significantly increased funding. We also made an election commitment to significantly increase PATS funding. We increased it by about 50 per cent. We took the recommendations of a Senate inquiry into account and put them holus–bolus into our policy. Now we are far above what is provided for PATS in any other state. The "self-interest group", as the former Minister for Health called it, the Royal Flying Doctor Service, was also allocated additional funding. That $157 million is made up of $32.42 million for PATS, $81.97 million for St John Ambulance, $37.13 million for the RFDS and $6 million of corporate overheads. I do not know the exact percentage increase for PATS, but I am hoping someone can assist me.

Mr I. Smith: The estimated increase in demand in the calendar year January to December this year is 13 per cent in trips and nine per cent in subsidies.

[12.30 pm]

Dr G.G. JACOBS: In my electorate office, I probably get more inquiries about PATS than I do about any other issue. I understand that the intention of this scheme is to provide assistance, not full compensation. But how will this increase in funding help broaden the eligibility criteria? Will this take off some of the pressure? As an aside to that, the mammogram clinic comes to my town every second year. Therefore, in the off year, people who have been recommended to have a mammogram often fall between the cracks because they are not eligible for PATS. Will this increase in funding for PATS help alleviate some of the difficulties that are faced by country people?

Dr K.D. HAMES: What this goes to show is that people are never happy. In saying that, I am not referring to the member particularly; I am talking about those people who complain about PATS. There used to be a large number of complaints about PATS, particularly about petrol charges and how many cents a kilometre was funded through PATS. It is correct that PATS was never intended to fully pay for the cost of a trip to Perth for medical treatment; it was always intended to be a government subsidy. However, we have done a number of things. We have significantly increased the petrol subsidy so that it now covers the real cost of petrol, based on a country average that is regularly reviewed to cater for fluctuations in the cost of petrol. However, it does not cover the cost of wear and tear on a car, and nor should it; it is just a subsidy to assist people.

The accommodation subsidy for people who have to come to Perth for medical treatment was also inadequate, and we have increased that. We now also subsidise the carers of patients. Previously, if the carer of a cancer patient came to Perth with a patient and stayed in accommodation with that patient, and the patient was admitted to hospital, the carer was no longer eligible for the subsidy. Cancer patients are now given increased assistance in the form of greater access to flights, and the ability to have a person accompany them to treatment to make sure they are properly looked after. We have also changed the eligibility criteria for the flight subsidy. Previously, people had to live 17 hours' driving time away from the place of treatment to be eligible for flights. That has now been changed to four hours' driving time. That means that people from places such as Esperance and Kalgoorlie are now eligible for flights.

However, even though there has been a huge increase in funding—a 50 per cent increase—I still get complaints. For example, a person may live in Boddington, and their specialist is in Perth, and they want to come to Perth for treatment, and they are eligible for funding to come to Perth, but the department says no, because there is now a specialist in Narrogin, within a driving distance of less than 100 kilometres. I have, therefore, asked our staff to be flexible and to consider the history of the patient. I do not want a patient who has been seeing a doctor in Perth for 20 years to have to see a new doctor in Narrogin. But, on the other hand, how will we be able to get specialists to work in Narrogin if patients do not go to see them? Therefore, we need to find a balance.

People who need dental care are not eligible for PATS unless they have a severe problem. People say we should add dental care to PATS. However, that would lead to a significant increase in costs, particularly if people lived in the north of the state and had to be flown to Perth for treatment. Also, we would find that people would tend to get major problems with their teeth at around the time of the footy finals. I am not being cynical. That is true. In the past, there was a huge surge at around those times in the number of people who wanted to access medical treatment in Perth. We have been significantly more generous with PATS funding, but we cannot cover everyone. I have, however, asked the department to show practical commonsense. If the member has an issue on which commonsense is not being shown, and it is not going to blow our budget, the member should put that issue forward as the local member. The director general would like to add to that answer.

Mr K. Snowball: The other side to PATS is the investment that we have made in telehealth. PATS is one way of getting people to specialists for outpatient treatment. Telehealth is another way of getting specialists to patients without the need for travel. The investment of $31 million in telehealth as part of the southern inland funding will create the opportunity for more specialist consults to be done through telehealth. That is a good outcome and one from which everyone will benefit.

Dr G.G. JACOBS: In the area of telehealth, often the argy–bargy used to be about who would pay for the consultant to sit in front of a camera at the other end, because the Medicare rebate would cover only a face-to-face consultation. Will this state have to pick up that cost? Also, will there be a consultant who is on a ward somewhere and who does the telehealth conference? One of the difficulties in rural Western Australia is accessing an appropriate consultant at a time when we can put the patient in front of a camera.

Dr K.D. HAMES: There are two components to that answer. As part of the telehealth package, we will be putting telehealth units into our tertiary hospitals. They will have dedicated staff. Those staff will need to chase up a specialist, and that would normally be a registrar. That will mean that doctors will be able to get through directly to a specialist in a tertiary hospital to get answers. However, if a doctor wants to get access to an ophthalmologist to do telehealth, that is, as the member knows, an issue for the commonwealth government in terms of the Medicare rebate. I understand that the commonwealth government has just made the decision that a

teleconference will be a rebateable item. That will make a significant difference to our ability to get doctors who are prepared to do that work.

Ms J.M. FREEMAN: I refer to page 128, dental health. As someone who has used the excellent dental service for schools, I am interested to know why the dental health budget has increased by only 3.5 per cent when the average increase for the Department of Health is 8.2 per cent, and that includes a consumer price index of three per cent, a wage price index of 4.5 per cent and a health cost index of 6.7 per cent. Does this, therefore, represent a real decrease in the government's commitment to dental and oral health services?

Dr K.D. HAMES: As members would know, there is significant demand for dental health services. In my view, dental health services are primary health care and should be provided by the commonwealth. This state has always provided dental care for schoolchildren. I do not know how many other states do that; not many of them do. That is a fantastic service. However, the difficulty has always been recruiting dentists and dental assistants. Part of the reason for that has been the wages issue, and we discussed that briefly during question time last week. It is also because dentists can earn much more working in the private sector than they can working for government. The budget for dental services in the previous year was $74 million. Our actual spend is about $4 million higher than that. The budget estimate for 2011–12 of $81 million is an increase of just under $7 million from the previous budget. The budget for dental services is growing. I do not know what $7 million represents as an increase —

Ms J.M. FREEMAN: It is about 3.5 per cent.

Dr K.D. HAMES: It would have to be about a nine per cent increase. But it is not a nine per cent increase on what our actual spend was last year. That was higher, because we were able to recruit more dentists. But it is tough going to get more dentists. The member may be aware that during Labor's seven and a half years in government, Hon Jim McGinty had to deal with exactly the same issues, and I used to tell him exactly the same things as the member is telling me. Just because we get into government does not mean that things suddenly become easier. We are going to continue with that extra pay. I heard the member for Joondalup criticising us in his speech on the budget, saying that we were taking some of that away. The previous increase had been tacked on in the wage negotiations; it became part of the budget so the level was increased, which is what the dentists were asking for. The reason we guaranteed it for only a year is that we are trying to do exactly what the member for Joondalup was saying his constituent wanted. We need to increase the level. We need to get them paid at a better level to get people to stay. That will be further than 12 months out because we are going through those negotiations with people working in the industry and the union in question.

[12.40 pm]

Ms J.M. FREEMAN: I have a further question relating to the attraction and retention bonus. During Parliament the minister said that it was recommended that he "guarantee that the bonus for 12 months continue while those negotiations are underway". Can the minister confirm that the attraction and retention bonus will continue for the next 12 months?

Dr K.D. HAMES: The Department of Commerce wants to be part of that decision-making process but I have guaranteed that that will occur in 12 months. Whatever its involvement will be, it will not be getting me to change my mind.

Ms J.M. FREEMAN: Will the dentists be getting the general agreement 5 increases in addition to the attraction and retention bonus that the minister has guaranteed?

Dr K.D. HAMES: I understand that they will get the GA5, which is the agreed position, and the bonus for the first 12 months. After that, either the dentists or the dental assistants—I forget which; I think it is the dentists—will still get that bonus throughout GA5. For dental assistants, the plan is to negotiate that to be part of the salary increases so they do not need the bonus because they will get the same additional money, which will become part of their wage package. The way we do that is to move to the market classification, which is what they are asking for.

Ms J.M. FREEMAN: That is the current offer.

Dr K.D. HAMES: They are guaranteed that for a year while they negotiate with the unions.

Ms J.M. FREEMAN: Is the minister aware of the pay equity case for dental nurses and dental assistants in Queensland and the increases they got, looking at it as a pay equity issue?

Dr K.D. HAMES: I am not aware of that because I am not involved in negotiations over pay issues. The department is aware of those.

Ms J.M. FREEMAN: I understand that dental services is the last area of government to not use computerised records and information systems. When is it planned to introduce computers to bring the records of dental health services into the modern age so that if patients shift from caravan to caravan, as can happen, their records can be accessed?

Dr K.D. HAMES: That is an excellent question. I was surprised to hear the member for Joondalup talking about the dental health services' lack of computer capacity. Like the member, I will be very interested in the answer.

Mr R.H. COOK: It is the last department to still use carbon paper!

Dr K.D. HAMES: I gather it still has carbon paper as part of its requisitions. What is the answer?

Mr K. Snowball: Through the minister, it is part of our ICT strategy to introduce computerised records for our dental records. That has been scheduled but it needs to be aligned with other priorities for the health system in terms of timing. A decision about timing has not been set but it is on our agenda.

Dr K.D. HAMES: I would suggest that we need to do it in the near future.

Mr A.P. JACOB: I refer the minister to page 128, which I think we are already on. Going below that table, under "Significant Issues Impacting the Agency, the first dot point is "National Health Reform". Can the minister please update us on what progress has been made on this reform in talks with the federal government?

Dr K.D. HAMES: It is a very timely question. With the director general and senior staff from the Premier's office, I had a televisual link-up with Nicola Roxon and senior staff from the Prime Minister's office. We discussed some of the sticking points of that national agreement. There are not many but they are significant. Subsequent to that, there has been further negotiation between the first ministers' offices and the Prime Minister's office. Those negotiations have not been conclusive. It really hangs in the balance at present. I was comforted by the commitments that were given in that link-up with the federal health minister. I have reasonable confidence that we will be able to come to an agreement. It was quite clear that the federal Minister for Health and Ageing and I are in clear agreement on what we want and what we should get but the difficulty comes when it progresses beyond that. This has to be signed off by first ministers and the Prime Minister during the Council of Australian Governments meeting. I am sure there will be significant further discussion between now and then to try to reach that point.

We always made it clear that the stumbling block for us was the taking of the percentage of the GST. We always said that we would not be part of that. The change by the commonwealth government from that position was a major success of this government when all the other states had agreed. Now the other states are very happy that that was not the case. We had always agreed to the health components of that national agreement; that is, things such as activity-based funding, which we were always moving towards. That is now in place for this year. We are committed to creating local health networks, otherwise known as boards, and we will move through that process in the relatively near future. Other more minor components around that health package, particularly the publishing of data, making clear comparisons between us and other states, is again something that we supported. We are currently getting funding from that package as though we had signed up, which is what the agreement was at the last COAG meeting.

As I said, we have not yet signed up. Those issues really need to be ironed out. The reality is that if I could do it with the Minister for Health and Ageing, it would be done. We are having trouble with the Prime Minister's staff, who seemed very agreeable and cooperative at that meeting but I gather further issues have arisen since then. We will need to wait and watch that space. The next COAG is in July, when all first ministers are supposed to sign off on that agreement. There will be some negotiations between now and then. We will not sign if we do not get agreement to the two sticking points to which we think we have agreement through the minister. One of those is direct funding of the local health networks—the boards—bypassing the state governments. We will not accept that. The state government runs the health department in this state, and we will not let that occur. The other was a more minor issue about the formation of those boards, what their powers are and how they operate. I do not think that is a major sticking point. We will not sign if we do not get agreement.

The additional funds—$70 million—represent about seven days of expenditure on health by the state. In fact, I think we spend it in fewer than seven days; I think we spend the additional annual funding we are proposed to get in about five days. The reason for the reforms that are put to other states is that the other states cannot afford it unless the commonwealth lifts its funding. The reality is that Western Australia can. We would like the money and we are putting the money that is proposed towards some really important areas for the better management of our health system. However, it is not as though the health system will not function without it. We appreciate the money and we think it is for a good purpose but we will not roll over and sign over the

management of the health system in this state for what amounts to five or six days worth of funding for our health system.

[12.50 pm]

Mr R.H. COOK: When the minister was playing politics with our health system earlier, he said he was quite happy for the federal government to fund hospitals directly through the area health networks. Is the minister now saying that that is no longer his position and that he will not accept that?

Dr K.D. HAMES: I have to say that I resent the term "playing politics". These negotiations have been ongoing for some time. We have made our position very clear from the start. I never said that we would agree to the direct funding of our area health networks. We have agreed to put funds into the commonwealth pool and those funds will come back to the state. That is what each state has demanded should occur. The funds will then be redistributed by a state government fund to those area health networks based on activity-based demands. I do not blame the commonwealth for wanting to do that because in the past some states have got money from the commonwealth for a particular purpose and have then either withdrawn their own money or spent the commonwealth money on something else. I do not blame the commonwealth in the least for wanting the funds that it provides to be clearly accountable so that the states cannot rip off that money from the commonwealth. We will distribute the funds through a state body. We do not need the commonwealth to directly fund our boards, because that removes the management system that the state has. We have a clear line of responsibility from the minister to the director general, down through to each local area health network. We do not want the commonwealth saying, for example, that it will provide funds for a CT scanner in Esperance but not in Kalbarri. The state will decide what its priorities are and the funding direction.

Ms L.L. BAKER: The minister will need to bear with me. I need to start by relating my question to a line item. I do not think it is the correct line item, but it is the closest one that I could find. I refer to outcomes, services and key performance indicators on page 128. The tenth service summary line item is "Contracted Mental Health", which is defined as the contract of mental health services provided by area health services under agreement with the Mental Health Commission for community mental health. That is where I found a reference point for my question, although I might need to be redirected. My question relates to the expert advisory committees and the government's recent commitment to provide a substantial increase to contracted services. The Department of Health is the biggest contractor of services in the state, as a single entity. If it is not the tenth point on the service summary, which I think it probably is not —

Dr K.D. HAMES: Where what is or is not?

Ms L.L. BAKER: I am referring to the increase shown in the Premier's and the government's commitment to hand over more services to the NGOs. Where is the funding for the additional services? What will be outsourced and where is the money for that shown in the out years?

Dr K.D. HAMES: It will be easier if I quickly answer that first. That funding is not in the Health budget; it is in the Treasurer's budget. He has that funding in his budget.

Ms L.L. BAKER: The government has committed to increase the level of outsourcing to non-government organisations. Has the Department of Health looked at that?

Mr W. Salvage: The contracted mental health line item largely relates to the Department of Health's service provision through its area health services.

Ms L.L. BAKER: I figured that.

Mr W. Salvage: The initial funding for NGOs announced by the Premier is not reflected in the Department of Health's budget at this point; it has been allocated to the Treasurer's budget. A process is underway whereby we will provide information to Treasury about the statewide contracts or NGO contracts within Health that we believe are eligible to receive funding. The $600 million will then be distributed, based on a decision-making process in government. At that point the funds will flow to Health and be reflected in the budget. They will then be distributed to the NGOs.

Ms L.L. BAKER: Where are the NGOs shown in the current budget?

Dr K.D. HAMES: The NGOs do not appear as a line item, although I do not know about the total NGO funding. That will appear under the grants funding. I have a large budget for NGOs that does not cover just those that I look after; it covers sobering-up shelters and a range of things. The good news is that that fund was quarantined from the three per cent efficiency cuts, and most of them have a built-in escalated factor. Those that have the

normal escalated factor of two per cent—the consumer price index increase—will get an additional 25 per cent increase over two years through the Treasurer's budget.

Ms L.L. BAKER: Is the Department of Health paying all the NGOs that receive funds for indexation?

Dr K.D. HAMES: Not all of them. Some we do and some we do not. Ngala and other substantive NGO providers get the 3.1 per cent standard CPI increase.

Ms L.L. BAKER: When I was trying to find the NGO budget, I found the budget for royalties for region funding for the Kimberley and Pilbara in the table headed "Major Spending Changes" on page 127. That is a significant increase; it is almost double. Can the minister take some time to run through that good news story and to also tell us about the royalties for regions funding for Carnarvon? My question is a related question, not a further question.

Dr K.D. HAMES: We have only four minutes left.

Ms L.L. BAKER: I am sure the minister can get the answer out in a hurry.

Dr K.D. HAMES: Hopefully the person giving the answer can run up the clock to one o'clock.

Mr S.J.C. Hunter: Through the minister, yes, this has been a significant allocation through royalties for regions for additional alcohol and drug services in the Kimberley, the Pilbara, Carnarvon and also Prospect Lodge in the Goldfields. The additional funding allocated for the Kimberley totals over $11 million over the four-year period. We expect that will provide for an additional 18.5 alcohol and drug worker positions in various locations across the Kimberley. The Pilbara will receive just over $5 million over four years and will receive an additional 10 workers. A new dual-purpose facility will be built at Carnarvon. That will encompass a fairly modest sobering-up facility, similar to the other sobering-up centres that operate principally in regional Western Australia. That facility will also provide day programs from which the existing community drug service teams servicing Carnarvon can operate. The Prospect Lodge facility in the Goldfields is a 10-bed residential treatment service that reopened fairly recently. The additional funding will allow that service to operate at a full 10-bed capacity.

Ms L.L. BAKER: If I added up the figures into the out years, that would be the whole cost of the facility over four years. When will there be a door-opening or a ribbon-cutting ceremony?

Mr S.J.C. Hunter: Through the minister, we are in discussions with the WA Country Health Service about a location for that building. We expect those discussions to reach an agreement shortly and hope that construction can begin in the latter half of this calendar year. The service should be up and operating shortly afterwards. It should be fairly soon.

Meeting suspended from 1.00 to 2.00 pm

[Ms L.L. Baker took the chair.]

Ms J.M. FREEMAN: I have a further question to the member for Maylands' question about the $600 million for community funding. Through the minister, an answer referred to looking at the NGOs and looking at the criteria that will establish them as candidates for additional funding. Is the minister able to outline what the criteria are? Why will there be differences for different NGOs if they are government funded?

Dr K.D. HAMES: I will hand over to Mr Salvage to provide the response.

Mr W. Salvage: Through the minister, it is to be clear about what the scope of the application of the policy is. For example, within the health budget there are things that receive additional funding allocation for large contracts—for example, St John Ambulance or the Royal Flying Doctor Service. It is about being clear which contracts are within the scope for applying the $600 million additional funding.

Ms J.M. FREEMAN: Further to that, is that scope and that criteria available or can it be made available?

Dr K.D. HAMES: No, we cannot do it. I am told it is within the Department of Treasury and Finance, so the member would have to ask that department.

Mr R.H. COOK: I refer the minister to page 129 of budget paper No 2 and "Elective Surgery". Can the minister provide the current waitlist numbers for patients waiting to see specialists from referral? What is the average waiting time for patients to see these specialists?

Dr K.D. HAMES: It so happens, I can. It was the next question on our list. The member has not got our questions over there, has he?

Mr R.H. COOK: The member for Southern River has ours!

Dr K.D. HAMES: In April 2011 there were 6 000 admissions from the waitlist. I have the actual waitlist numbers somewhere. Someone while I am talking will try to find the actual current number. A key point to make is that, as the member knows, the number has been going up since we have been in government. While I am mildly troubled by that, I am not extremely troubled by that. It is not so much how many people are on the waitlist; it is the time that is taken to treat them. If the number on the waitlist tripled, and they were all treated within the approved time that they were supposed to have surgery, that is just a reflection of demand. That is what we are striving to do. We have done significantly more operations and significantly more have been in boundaries in a lesser time. The average time in 2010, for example, used to be 33 days; now it is 28 days. We are above the commonwealth requirements, by the way, as part of our agreed reforms. Therefore, we are doing better than as required. In April 2011 there were 6 000 admissions from the list, and 91.1 per cent those were within boundary.

As I said, in April 2010 it used to be 33 days; it is currently 28. The proportion of those waiting for over a year has decreased significantly—nationally, not just here. When I look at the median wait times in days and compare WA with other states, WA is second; Queensland is first. The second graph shows the proportion of patients who have waited longer than a year. Again, we are second best—South Australia is best; we are second best. We are progressing well. Has someone found an actual number of people on the waiting list yet?

Mr R.H. COOK: There are 16 661 people on the waiting list.

Dr K.D. HAMES: I thank the Deputy Leader of the Opposition; it had to be in my figures somewhere. As we have said before, that is an increased number, but those people are being seen in time. I do not know how long I have not been bothered by that number going up. I guess it should not bother me for as long as patients keep getting seen in time. I would be worried if times start going out rather than coming in, as they are at the moment. The reality is, to meet the increased demand that is coming on the list all the time and keep patients getting treated within the time, we have to increase our capacity to do elective surgery all the time. We have been doing that. Each year there has been more surgery compared with the last. The critical question is how to keep the capacity growing.

Mr R.H. COOK: The minister is quite right. The number of people on the waiting list is as high as it has ever been under this government. What I am asking about—I think it is a bit different—is people waiting for pre-surgical assessment; that is, people who have been referred to a specialist for surgery but who have not yet seen that person. They are the people the minister described previously as those who are "hidden" on the waiting list.

Dr K.D. HAMES: It is a large number. The system, in my view, is anything but perfect. What has tended to happen with these people—it was the same under the opposition's government as ours, and we have not been successful in finding ways to significantly reduce these numbers—is that the categories used for people to have their surgery are the same categories used for people to see the surgeon in the first place. What tends to happen is, if a person is a category 5 and needs a hip or a knee replacement, they can wait up to a year to have their surgery, but they can wait up to a year to be seen. That is regarded as accepted practice. To me, it is not acceptable. But finding a way to fix it is tough, particularly for category 1 patients. A person who is a category 1 waits 30 days to get surgery, but it can take 30 days to get seen as well. Someone could have a major problem and not be seen. That tends not to be the case, particularly with the urgent cases. However, in category 2 cases, which are not quite so urgent, such as angina in which the patient is not actually physically having a heart attack, it can be 90 days before they are seen because they are not dying. As soon as that person starts having a heart attack, they move straight in and are seen straightaway. It is not satisfactory.

The way to fix that is to have a better outpatient clinic system. We have been talking to Nicola Roxon about that, because there is talk, as part of the national health care agreement, of the federal government funding outpatient clinics. Currently, outpatient clinics in New South Wales are funded. NSW was clever—it got on and just outsourced all its outpatient clinics to the private sector, and the private sector runs them. The commonwealth pays for them. Having realised its mistake, the commonwealth stopped anyone else from doing it. We have to run those clinics ourselves. There are long wait times to get in, particularly for some of the key practices like plastic surgery.

I have recently put in some changes to try to address that. A good example was someone from my way—I forget whether he was from Mandurah or my electorate. He was category 2 for a hip replacement. He had been offered by the doctor in Mandurah an opportunity to see either an orthopaedic surgeon who worked at Peel Health Campus or one who worked at Fremantle. The specialist at Peel happened to be on holiday, so this person saw the one at Fremantle Hospital. He is in great demand, and his wait times for category 2 patients were way outside the boundary already, yet he still got that patient. Once he sees that patient, he is not going to send him on. Some patients have to be treated in a tertiary hospital, which is fair enough as they have other conditions, but this patient did not. Trying to get this patient off that specialist to go to a local doctor was very difficult. The change

that I am putting in place is that, on getting that initial referral, the tertiary hospital has to do an assessment of the paperwork of the patient to see if they should be seen in a tertiary hospital or not. If they are not assessed as a tertiary hospital patient, the hospital has to directly refer that patient either to Rockingham hospital or to a specialist who operates in Rockingham or Peel, so that they see them first and follow through their treatment and do their ops. In that way we will get them seen to much quicker. That is fine for south of the river, but not so easy for north of the river because Joondalup hospital is chock-a-block. We are actively looking for a different system, and if the member comes up with any good ideas, I am all ears.

[2.10 pm]

Mr R.H. COOK: While we are on good ideas, before the last election the minister said that by March 2009 he would publish by hospital the number of patients waiting for pre-surgical assessment and that by the end of 2009 he would ensure that the time from the original identification of a problem to an outpatient pre-surgery proponent would be no more than six months. Has the minister met that election promise?

Dr K.D. HAMES: No, I have not. In fact, I was not aware that I had made that commitment. It seems like a good idea.

Mr R.H. COOK: It is from the 2008 Liberal Party plan for a better health service.

Dr K.D. HAMES: If it is from my document, obviously it is a good idea.

Mr R.H. COOK: The minister was just asking for good ideas.

Dr K.D. HAMES: I am always full of good ideas. We go through those documents quite carefully to identify the things that we have committed to, and I do not recall that being one of them but as the member has read it, it has to be there.

Mr R.H. COOK: It is a direct quote.

Dr K.D. HAMES: Regardless of the commitment made, I have been doing my absolute best to try to get those times down. We have significantly reduced the number of people on that wait-for-surgery list by improving procedures through outpatient clinics. Obviously, if I made an election comment, we had better work harder over the next year and a half to make sure I keep it.

Mr R.H. COOK: Could the minister please provide by way of supplementary information the average cost for elective surgery procedures in priority 1, 2 and 3 patients?

Dr K.D. HAMES: I do not know why the member wants that as supplementary information, rather than putting a question on notice because we have a fixed time and it takes time to put all that information together.

Mr R.H. COOK: It looked like interesting information and was asked by a previous shadow Minister for Health.

Dr K.D. HAMES: Did I not put it on notice?

Mr R.H. COOK: No, the minister just asked Jim McGinty to provide the information.

Dr K.D. HAMES: Did Jim McGinty agree to provide it as supplementary information?

Mr R.H. COOK: Of course, he did!

Dr K.D. HAMES: Then I agree to provide it.

The CHAIRMAN: Minister, would you like to state again what you will provide?

Dr K.D. HAMES: What he said!

Mr R.H. COOK: It is the average cost for an elective surgery procedure in each of the priority categories.

[*Supplementary Information No A27.*]

Dr G.G. JACOBS: I refer the minister to page 140, around the "Prevention, Promotion and Protection" area, which is a very important area, particularly in child and community health but also in breast cancer screening. Can the minister advise of the progress of the newborn hearing program that was implemented some time ago? I have noticed this program is ongoing in all regional hospitals, particularly those in my region. The second question is in and around the prevention area of breast cancer screening services, particularly in regional areas. I am sorry to harp on the regional component in my questions. As the breast screen service is offered only two yearly, is there any plan or possibility of making that a yearly service and what impost would that be to us? There are a lot of women who are in very distant areas and who are recommended medically to have a breast

screen every year, whereas the van comes only every second year and so there is the impost of travelling et cetera.

Dr K.D. HAMES: In the lead-up to the last election the Labor government made a commitment to introduce newborn hearing screening in all government hospitals. We matched that commitment, and we have done that. One of the earliest things we did was to bring in newborn screening tests in all public hospitals. I have had some criticism of that program recently, not of public hospitals but of what happens in the private system where there is a fee. In St John of God Hospital, for example, the test can be done but the fee is in the order of $100 and only about 40 per cent of patients are paying that fee and getting that hearing screening done, which means some children miss out. I am told that most other states and territories provide a screening program that covers people in public and private hospitals. I have asked the health department in the past few months to go away and come back to me with a program that covers all children, not just those in public hospitals. It is not finished yet, but I expect it relatively soon so that we can work out the additional cost. There are different options as well. We could pay the hospital or a non-government organisation to do this screening, or a state government employee could go to the private hospitals on a regular basis and do the screening. It should be the responsibility of parents to do that, but at the end of the day the children suffer if they do not have their hearing defect detected early, and also the state suffers because these children will have significant problems later on in life that will impact on all of us and on budgets—not that that is the key issue.

I have not been asked before to try to get breast screening vans out on a yearly basis. Our challenge has been to get them out two yearly to all parts of the state, so that everybody can have access to them. There are some places that do not get good access yet, particularly in the northern regions of the state. It really depends on how many women there are as to whether it is cost effective when compared with the alternative—the patient assisted travel scheme. How many women would there be in the member's electorate who would need annual breast screening? If I think back to my surgery, not a lot of my patients would have needed annual screening; it may have been a dozen in a year.

Mrs C.A. MARTIN: PATS is good.

Dr K.D. HAMES: It depends on the numbers, and we would use PATS to get to the nearest centre for screening.

Dr G.G. JACOBS: So it is based on the numbers?

Dr K.D. HAMES: Yes, and on cost effectiveness. We provide the money for them to be flown to a location, depending on the distance of course, or it may be that driving is the easiest option. As the member knows, someone who would need a breast screen annually is someone who has either had breast cancer or a strong family history of breast cancer, so it is obviously very much in their best interests to make that effort to go and get the screening done on an annual basis.

Dr G.G. JACOBS: The minister would know the prevalence of breast cancer in the community, but from my point of view the number of women who need a yearly breast screen is more than just a few. My recent experience of PATS concerned a lady who came to see me the other day who could not get PATS because she had a mammogram the previous year. PATS said she had to wait for the van, which only comes every two years. Fortunately, we have solved that problem and I thank the minister very much for that, but that was an issue for that woman.

[2.20 pm]

Dr K.D. HAMES: That issue is not to do with the provision of service; it is to do with the way PATS operates. Quite clearly, there was an error in that case. I do not know whether that error is common or occasional. However, if someone requires PATS on clinical grounds, that is enough reason for PATS to have to pay. All it has to do is have some evidence of that clinical necessity.

Mrs C.A. MARTIN: The follow-up is done here in Perth.

The CHAIRMAN: The member for Kwinana. I am terribly sorry; I am suffering from temporary dyslexia of the members. The member for Nollamara.

Mr R.H. COOK: I think Madam Chair was just about to start a revolt.

Dr K.D. HAMES: I used to hate it when I was shadow Minister for Health; I was responsible for health and other members would come in and ask questions all the time. It was frustrating!

Mr R.H. COOK: Our lot is an unhappy one, minister!

Ms J.M. FREEMAN: I refer to page 145 of the *Budget Statements* and the reference to the Osborne Park Hospital reconfiguration stage 1, which is listed under the works in progress in the asset investment program. I

was born at Osborne Park Hospital, I gave birth to my son at Osborne Park Hospital, my mother and aunt worked at Osborne Park Hospital, and the Nollamara electorate uses Osborne Park Hospital.

Dr K.D. HAMES: I did many deliveries at Osborne Park Hospital. I did not deliver the member for Nollamara, did I?

Ms J.M. FREEMAN: No, and the Minister for Health did not deliver my son, because I did not have a doctor in the room. Can the minister explain why this development was underspent in 2010–11 and is underfunded in 2011–12 and 2012–13, with the majority of funding not coming until 2013–14? As I understand it, the government estimated spending $2.8 million in 2011–12 but spent only $80 000. I am interested to know how the funding seems to have shifted across in each subsequent year.

Dr K.D. HAMES: I will ask Dr Russell-Weisz to answer that question.

Dr D. Russell-Weisz: The Osborne Park Hospital redevelopment is now on track. We had to review the business case for the mental health unit with the Mental Health Commission. The Mental Health Commission has reviewed the business case for the 50-bed mental health unit at Osborne Park, which relates to the bulk of the funds in providing 50 beds at Osborne Park Hospital. The commission has endorsed that and we are now on track to have that unit opened in mid-2013.

Ms J.M. FREEMAN: When will it open?

Dr D. Russell-Weisz: October 2014 is the actual planned date, but that has been moved from 2013.

Ms J.M. FREEMAN: Is that the completion date of the hospital?

Dr D. Russell-Weisz: Yes.

Ms J.M. FREEMAN: The same funding amount covers that particular project and the two additional operating theatres and surgical centres at Osborne Park Hospital; is that coming from the federal government?

Dr D. Russell-Weisz: The expansion of Osborne Park Hospital with the surgicentre will come through the commonwealth government. We have just put forward the plans to the commonwealth government.

Dr K.D. HAMES: The commonwealth put up an amount of money for infrastructure funds across Australia. Each state was asked to bid, so we put in bids for those areas with the greatest need where we thought the money would be best spent. The surgicentre was one of those things we bid for and we were very pleased to receive funds from the commonwealth for it.

Ms J.M. FREEMAN: From my understanding of how that funding operates, reconfiguration stage 1 is funded with state money, and the two additional operating theatres and surgical centre at Osborne Park are funded with federal money. Therefore, there is no cost shift to use that $33 million; that money is additional to the moneys here.

Dr D. Russell-Weisz: That is correct, yes. The reconfiguration money ostensibly relates to the mental health unit. The majority of the money is for the 50-bed mental health unit.

Ms J.M. FREEMAN: In answer to a question earlier, the minister talked about a situation in which the state had withdrawn its money to use the federal money to fulfil a project that it planned. Is that the case here?

Dr K.D. HAMES: Definitely not. The commonwealth government is very strict on doing that on those distributions of funds. They must be clearly identified as separate, new projects.

Mrs C.A. MARTIN: I draw the committee's attention to "Infrastructure" on page 129 of the *Budget Statements*. In the fourth point from the bottom of the page, reference is made to the $47 million implementation of facility upgrades in East Kimberley. Can the minister give us a general breakdown of how that $47 million will be spent?

Dr K.D. HAMES: I hand over to Ian Smith to answer that question.

Mrs C.A. MARTIN: Can I have a copy as a pressie?

Dr K.D. HAMES: That is a separate question!

Mrs C.A. MARTIN: I will get some hard questions then!

Mr I. Smith: The $47 million will be spent on upgrades to the following health facilities: the Wyndham health facility, $3.4 million; the Kununurra hospital expansion, $20 million; the short-stay patient accommodation, $4 million; remote clinics at Warmun and Kalumburu, $5.5 million; environmental health measures at

Kalumburu and Oombulgurri, $4.3 million; sobering-up centres in Kununurra and Wyndham, $600 000; and some housing, $5 million.

Dr K.D. HAMES: The Oombulgurri fund is not likely to occur.

Mrs C.A. MARTIN: Is 1 July officially the centre's last day of operation?

Dr K.D. HAMES: I have not made that decision. At the meeting we recently had we said that the government needs to make a decision when to close that centre.

Mrs C.A. MARTIN: It is no criticism. However, if the minister has a date, I would like to know it.

Dr K.D. HAMES: I will not close the centre; the Minister for Indigenous Affairs will close the centre, so presumably he has set a date.

Mrs C.A. MARTIN: The adviser mentioned the alcohol rehabilitation centres in Wyndham and Kununurra.

Dr K.D. HAMES: Yes; we funded that before. We upgraded the hospital and funded the rehabilitation centre.

Mrs C.A. MARTIN: The rehabilitation centre in Wyndham was funded, but what about the one in Kununurra?

Dr K.D. HAMES: I do not know about the one in Kununurra.

Mr I. Smith: The sobering-up centres in Kununurra and Wyndham have been refurbished.

Mr P. ABETZ: Under "Infrastructure", on page 129 of the *Budget Statements*, reference is made to $1.18 billion for the new children's hospital, with construction to commence in early 2012. Could the minister advise us what planning has taken place so far and to what extent the parking issues around the Queen Elizabeth II Medical Centre have been addressed?

Dr K.D. HAMES: Yes, the progress of the children's hospital has been extremely satisfactory. A whole series of things have been required to come together in a row, particularly timings, to ensure that we get the facility open at the time that we committed to, and that is occurring. The original site that was chosen for the children's hospital turned out not be an adequate size—that is where the L, M and N buildings are—because of the required floor space. Therefore, the only place to move the children's hospital to was out on the major road. In doing that, the plant had to be removed; otherwise children's beds would have looked out over the plant. In moving the plant to the back, some parking space was lost. Given that not enough parking space is available at Sir Charles Gairdner Hospital, we had to build a multistorey car park.

We had to get the timing of all those projects right. The plant is currently under construction. We are very close to proceeding with the construction of that multistorey car park. The conclusion time of that is critical to when we start work on the new children's hospital. The new children's hospital will be slightly larger than was originally proposed. It was 246 beds, 75 per cent of which will be single rooms. There will also be a parking bay underneath and the Telethon Institute for Child Health Research—Fiona Stanley's baby—will be relocated next door to the children's hospital. It will also contain floors that will be available for state government research. All those things are progressing extremely well. Given it is held close to the heart of some of the staff members behind me, I will hand over to one of them, who I am sure would like to add to my comments.

[2.30 pm]

Mr P. Aylward: Planning for the new children's hospital is quite advanced. We are assessing three proponents, one of whom will be the successful tenderer for phase 1 of the managing contract phase. Detailed design will get underway during July. The expected timing to undertake physical work will commence early next year.

Dr K.D. HAMES: I gave the wrong number of beds—it was 246—it is now 274.

Mr R.H. COOK: I have a further question.

The CHAIRMAN: You are next anyway, but certainly have a further question.

Mr R.H. COOK: What are the increased logistical issues in no longer being able to use Rosalie Park and Highview Park as temporary parking facilities; how will the government get around those issues?

Dr K.D. HAMES: They have been difficult. As the member knows, we were looking for temporary car parking. Rosalie Park seemed a good option. We were aware that the users of Rosalie Park had been seeking considerable funding of, I think, about $5 million from the council to undertake a redevelopment of its building. We said that if we put up that money would they let us use that section at the lower end, which is only about a quarter of their total area, while the building was being constructed. The Rosalie Park people decided not to do that, so at the request from council we withdrew our offer. We kept looking for other options because another club had come to us suggesting it would be interested. In the end, that did not work out either. It is critical that we get our timing

right for parking areas. But I am aware that Dr Russell-Weisz and Dr Aylward are working on looking for alternative sites. They have one area in mind that is about to be redeveloped, which is under current discussion. Dr Russell-Weisz will talk about that.

Dr D. Russell-Weisz: Yes, we obviously were looking at Rosalie and Highview, but they did not come off. We have other options such as at Graylands and Shenton Park for some of our staff, albeit temporarily. We have capacity for probably an additional 350 bays at Graylands and 350 bays at Shenton Park. Obviously, this means staff would be off site but we would be able to bring them on site with adequate buses for a short time. The tough time will be between September 2011 and December 2012. By that stage the first stage of the multideck car park will be built. As the minister said, we are looking at two sites on the current QEII site—the remnant bushland between the Oral Health Centre of Western Australia and Crawford Lodge on Monash Avenue. We are also looking at doing some work on what is called car park 3, which is also on our site, and potentially putting some decking on it temporarily to alleviate the parking pressures on site. We are also developing a number of areas around the site to take car parking wherever we can get it. There are a number of small areas on site where we have refashioned the current car parks to increase the number of car park bays. But we will have to shift some staff off site in the interim to allow the new children's hospital and multideck car park to be constructed.

Dr K.D. HAMES: Car parking at Sir Charles Gairdner Hospital has always been a difficult issue, with lots of people parking in side streets and annoying everyone. That is why we have taken the step of building a multideck car park that will have sufficient bays to cater for future demand. While we are building it we are taking away lots of existing bays. I recall the previous minister's requirement, as part of the redevelopment of Sir Charles Gairdner Hospital, that the use of public transport be increased to some amazing level. What percentage was that?

Dr D. Russell-Weisz: It would have reduced the use of cars on site from 85 per cent to 60 per cent.

Dr K.D. HAMES: That would have meant that everyone else had to get there by public transport. It is a nice theory. My daughter used to work at the dental hospital next door to Sir Charles Gairdner Hospital. As a single mum with a child going to school, to travel by train and then bus to get the child to school and then get herself to the hospital to start work would have been impossible. I am sure many nurses and other health staff are in the same position. It is very difficult because the access is poor. The long-term solution obviously is the light rail that people have talked about.

Mr R.H. COOK: I have a policy the minister could look at. There is a lot of money in the City of Perth parking account that he could use straight away.

The CHAIRMAN: Deputy Leader of the Opposition, your question.

Mr R.H. COOK: Thank you, Madam Chair. I draw the minister's attention to line item "Enhancing Health Services for the Pilbara in Partnership with Industry" under "Other Projects" on page 146. If read in conjunction with last year's budget there appears to be a cut of around about $24.9 million, which I am sure is not the government's intention. There is a $5.45 million allocation in this budget. In the 2010–11 budget it was $30.4 million. That is a substantial reduction on that amount. Obviously, we are very keen to understand what is going on in relation to that line item.

Dr K.D. HAMES: I am told $33 million was capital and recurrent together. This is just the capital component of that, so the estimated cost was $5.4 million and that is the amount that will be spent. A list of things included in that are the construction of the Karratha helipad; a CT scanner at Nickol Bay, which has been done; emergency department medical equipment; and small hospital and planning infrastructure in Newman, Tom Price and Paraburdoo.

Mr R.H. COOK: Can the minister break down the recurrent component?

Dr K.D. HAMES: What was the original amount?

Mr R.H. COOK: The original amount was $30.4 million.

Dr K.D. HAMES: Take from that $5.451 million, which is the capital component.

Mr R.H. COOK: Can the minister provide documentation of what recurrent funding it relates to and whether that funding is ongoing. Obviously, if it is in a capital works line item it is confusing to say it is recurrent funding.

Dr K.D. HAMES: Sure. It is for things such as the cost of the obstetrician. It will be a very large cost in the recurrent budget for health for that region to employ the obstetrician.

Mr R.H. COOK: The minister must have a list.

Dr K.D. HAMES: I must have figures somewhere, or Mr Salvage must have figures to identify that.

We will provide as supplementary information reconciliation of the $30.4 million under the heading of "Enhancing Health Services for the Pilbara in Partnership with Industry".

[*Supplementary Information No A28.*]

[2.40 pm]

Ms J.M. FREEMAN: I refer to "SCGH — Mental Health Unit" on page 145 of the *Budget Statements*. A bit like Osborne Park Hospital, I note that the majority of funding will now not be allocated until 2012–13.

Dr K.D. HAMES: Which line?

Ms J.M. FREEMAN: I refer to page 145, "Asset Investment Program", "Works in Progress", "SCGH — Mental Health Unit". Can the minister please explain why the majority of funding will now not be allocated until 2012–13? They underspent in 2010–11 by $651 000 and were underfunded in 2011–12 by $9.734 million.

Dr K.D. HAMES: Sorry, my figures do not show that. If we follow the line item "SCGH — Mental Health Unit", we see a total cost of $28.9 million. Estimated expenditure to 30 June 2011 is $1.482 million, followed by $1.464 million.

Ms J.M. FREEMAN: I think it was when we looked at the previous year's expenditure, what I understand now —

Dr K.D. HAMES: Dr Russell-Weisz knows what the member is asking and seems to have an answer.

The CHAIRMAN: That is extrasensory perception!

Ms J.M. FREEMAN: That is very good. Thank you.

Mr R.H. COOK: Scary, but impressive!

Dr D. Russell-Weisz: I hope I can answer it! I think the question relates to the potential delay in expenditure for the Sir Charles Gairdner Hospital mental health unit.

Ms J.M. FREEMAN: Yes.

Dr D. Russell-Weisz: This has been caused by a number of issues, but more to do with the number of projects actually occurring on the site. We have 13 projects in total on the site—some small, some large. Some are quite small, but they all cause significant demand on the site. They have to be coordinated well. There has been some delay in the Sir Charles Gairdner Hospital mental health unit. The actual planning is underway. It is due to open in September 2013. It will be a substantially enhanced mental health unit because we will have approved beds on site, which we do not have at the moment.

Ms J.M. FREEMAN: When we were talking about Osborne Park Hospital, it was explained that it was partly because they were doing a mental health business plan. Was there any impact in terms of business plan for this or was it all due to the number of projects on the site?

Dr D. Russell-Weisz: There has obviously been some discussion with the Mental Health Commission on both projects. We had to go through the normal process with Treasury to get approval for the business cases, which we now have. That discussion contributed to some slight delay in the mental health unit at Sir Charles Gairdner Hospital, but the majority is due to the volume of projects on site and us being able to do the projects in the right order. For example, the central plant on the Sir Charles Gairdner Hospital site is a critical large project to establish on site; that is, to get the tunnels done before the multideck car park and the new children's hospital comes on board. We had to start that before we could do the mental health unit because we had to demolish a couple of buildings. We have had to move things around slightly to get the best outcome for the site.

Mrs C.A. MARTIN: I draw the minister's attention to "Major Spending Changes" on page 127, the line item "Enterprise Bargaining Agreements". Does the amount of $49.1 million include district allowance back pay for midwives in the regions? I understand there is a problem; midwives will not be paid.

Dr K.D. HAMES: I am advised that is separate.

Mrs C.A. MARTIN: It is not on that line?

Dr K.D. HAMES: It is not in our budget because it is coming. It applies to all government agencies. We get it once they have sorted it all out. The government is negotiating that. When that is agreed, it will come out of Treasury. They will give that to whichever departments are relevant. We will then be given that money, which will add to this amount.

Mrs C.A. MARTIN: The nurses as well—is that the same thing?

Dr K.D. HAMES: Yes.

Mrs C.A. MARTIN: I now draw the minister's attention to "Indigenous Health/'Closing the Gap'" on page 131 of the *Budget Statements*. The first dot point states —

> WA Health has set targets to add 100 additional Indigenous people to its workforce per year …
>
> A range of culturally secure recruitment and selection strategies will be adopted to facilitate this employment process.

Can the minister please explain what these recruitment and selection processes are? Will many of these positions be in regional areas?

Dr K.D. HAMES: We are very keen to increase Indigenous employment across health. The member will recall that when I was in opposition, I was part of the parliamentary committee with Hon Tom Stephens and others. One of the issues we raised was looking at departments across the board and seeing what their Indigenous employment was. With some notable exceptions, it was pretty ordinary. Health was one of those. Health is about one per cent. Our recommendation from that committee was to get Aboriginal employment up to the population figure, which is about 3.5 per cent. We established that as a target. I am pleased to say it is one of the key focuses of the new director general. He will answer the question from the member in detail soon, but one option that I have asked the department to consider is Aboriginal employment. I had a meeting not too long ago with the Challenger Institute of Technology. For $1 000, an Aboriginal person can be sponsored to do a course through the institute. That is the first stage of either being an aged-care worker or going on to be an Aboriginal health worker, or in fact a nurse. I have asked the department—I have not had an answer yet; I am hoping to get one soon—for $50 000 to sponsor 50 000 Aboriginal people to do that course. It is not just in the metropolitan area —

Mrs C.A. MARTIN: Fifty Aboriginal people—we cannot fill 50 000 positions!

Dr K.D. HAMES: Yes, 50 Aboriginal people, but across the state. The courses are done in Broome as well, through the University of Notre Dame.

Mrs C.A. MARTIN: Send them all up to Broome; we will be happy!

Dr K.D. HAMES: We want more people to get in. We need to do that. I have had talks with "Twiggy" Forrest about the covenant to see if he will commit to a certain number of Aboriginal employees as part of that program. In my view, we have to do a lot. One per cent is not necessarily the number of Aboriginal employees. It is not a requirement that people identify themselves as Aboriginal. A lot of Aboriginal people choose not to specifically identify themselves—if they are a nurse, they are a nurse. We encourage people to do it because it gives us some idea of how well we are tracking. I will now hand over to the director general to talk about specific things he is doing to make sure we have sufficient levels of Indigenous employees in Health.

[2.50 pm]

Mr K. Snowball: There is an enormous effort going on within the health system. We think the most important thing we can do as a health system to improve health outcomes for Aboriginal people is employ more Aboriginal people right through the health system, involving more people in decision making and planning at all levels. An employment strategy was released by the WA Country Health Service probably four or five months ago, which is there to guide Aboriginal people. That has been developed in conjunction with the Aboriginal medical services. We turned to those services as a source of advice to us about how we can become a better place for Aboriginal people to work in. The Aboriginal health services certainly are good employers, and they shared quite a lot with us about how we can improve in that area. We have talked to our own employees as well about how we can attract more people to work for us. We have done what might seem to be quite straightforward things. One of those things is that advertising positions online does not get to Aboriginal people. We have therefore changed our policy, which required us to advertise everything online, to make sure that we can advertise in different ways to get that information to the people we are trying to attract to these positions.

That target of 100 is a minimum, by the way. We hope it will be well in excess of that. We are also developing that further through our performance agreements. I have a performance agreement with every chief executive who directly reports to me. All those chief executives have, as one of their criteria, the employment of Aboriginal people. They have to report to me on what they are doing about that, what their base line is, and what their strategy is to improve the recruitment and retention of Aboriginal people. A huge effort is going on, as I have said.

I have also contracted our Office of Aboriginal Health, through Jenny Collard, who has recently been appointed to that office, to work for us so that we can have a statewide strategy that builds on the work that the WA Country Health Service is doing. We are very keen to be better engaged in a very different way with the Aboriginal community, not only in delivering health services, but also in being a source of employment.

Mr P. ABETZ: While we are on the Closing the Gap strategy, can the minister indicate what has been planned to assist in the treatment of Aboriginal women across the state?

Dr K.D. HAMES: Some funding has been allocated specifically for that. There is now a new unit at King Edward Memorial Hospital for Women, the Aboriginal maternity services support unit. That unit opened on 28 April, with $3.28 million worth of funding under the COAG national partnership agreement as part of the Closing the Gap funds. Both the state and commonwealth governments have put in a lot of money to fund a range of services under the Closing the Gap strategy. They include tackling smoking, $6.9 million; primary health care, $35.35 million, fixing the gap in the patient journey, $20.5 million; making Indigenous health everyone's business, $9.78 million; and health transition to adulthood, $44.78 million. That is a total of $117.42 million over four years designed to improve Aboriginal health care.

I have to say, though, with regard to the previous question about employment, that the proof of the pudding is in the eating, obviously. What I would like to get—I am putting this question to the department right now—is the Aboriginal employment figures that came out of the study that we did when we were in opposition, and how those figures have tracked through the years until now, so that we can see exactly where we are at and where we need to get to. That will help us when we sign up to the target. I will not ask for a supplementary on that, but that is what I will be requiring!

Dr G.G. JACOBS: The minister mentioned funding of $35.35 million to improve access to primary care services for Aboriginal people. Is that for the provision of Aboriginal health services for people in certain regions, or is that for improving access to primary health care for Aboriginal people services? I ask that because, as the minister knows, there are some issues about getting Aboriginal people to access the services that we provide. How much of that funding is for infrastructure, and how much of that funding is for improving access?

Dr K.D. HAMES: I think I know the answer to the question, but I am not positive, so I will hand over to Mr Snowball in a moment. A lot of the focus of that funding for better access to primary health care is due to my saying that the health department does not need to be the be-all and end-all of service provision, and we need to make sure that we use those funds in the best way that we can. In my view, a lot of that work can be done, particularly in the northern part of the state, by using the Aboriginal health services. Those services are funded by the commonwealth, and they have clinics everywhere, and they seem to have a better ability to attract staff than we do, particularly dentists, and get them into remote areas. We have had a lot of discussions with those services, and with people like Sandy Davies from the Geraldton Regional Aboriginal Health Service, and we are providing extra funding to those services so that they can provide services to people in the bush who otherwise would not be able to access general practitioners, a lot of the time because there are no general practitioners there.

Mr K. Snowball: We are working through a couple of avenues. I will start with how we decide what services will be provided out of that $35 million. We have regional planning forums. Those forums involve Aboriginal medical services, and our own area health services. Large non-government organisations, such as the Royal Flying Doctor Service, will also be at the table. They share what are the health issues for that region. This includes the metropolitan area, so there are nine of them. They look at the health data to see where they should be targeting their intervention, including primary health care. They then decide among themselves who is best placed to deliver that service. One very interesting outcome from these planning forums is that almost 40 per cent of the funding for primary health care has gone to the Aboriginal medical services, as they are the best vehicle to get improved access for those communities. But it is shared across the board. Everyone knows what everyone else is doing. They are not all providing the same service to a community and passing each other on the road. It is coordinated. They are all holding each other to account. Each service is accountable to the planning forum as a group to say whether it has or has not achieved a result. That means that the visiting services are now focusing more on chronic disease prevention in particular—which is the scourge for Aboriginal people in this state in terms of acute health outcomes—through primary health care. There is a very strong focus on that. But it is region by region. The issues in the Goldfields are different from those in the Kimberley and the Pilbara. It is very much tailored to the needs of particular areas. There are over 80 projects in this area. That is why I have not named them all. It is a very widespread program, but it is targeted region by region.

Dr G.G. JACOBS: While we are on that region-by-region approach, my town of Esperance does not have an Aboriginal health service. The question is whether we should use that as an integrated model as part of the

hospital upgrade, or whether we should have a stand-alone service. What part of this funding is likely to deliver an Aboriginal health service on the ground in my region?

Dr K.D. HAMES: Mr Snowball.

Mr K. Snowball: I am aware of a proposal to establish an Aboriginal health service in the member's region. We are basically providing, to the people who are seeking to set that up, advice about where they need to go to get support to do that. That will not prevent us from providing services through Aboriginal service providers. They do not necessarily need to be an Aboriginal medical service in the traditional sense. We have, for example, the Wheatbelt Aboriginal Health Service and the Great Southern Aboriginal Health Service, which is run under the auspices of the WA Country Health Service but essentially employs Aboriginal health workers who run the entire service. So either of those models can deliver what I am describing under the Closing the Gap funding.

Mr A.P. JACOB: This is a very important area. I also want to refer the minister to page 129, the heading "Infrastructure", and the amount of $229.8 million for the Joondalup Health Campus redevelopment project. Can the minister please update us on how this redevelopment is progressing? In particular, has the opening of the new emergency department assisted with the subsequent increase in presentations?

[3.00 pm]

[Mr M.W. Sutherland took the chair.]

Dr K.D. HAMES: Mr Chairman, Joondalup hospital is progressing very well, as we all know, and we were recently out there to open the new emergency department, which is just amazing in terms of its size and the services it provides. We do not yet have all the backup beds available, but they are close. Significant changes have occurred. Although there has still been some ambulance ramping at Joondalup Health Campus, remembering that it was the worst of all the hospitals for ramping, it previously had significant numbers of diversions as well as ramping; however, there are now no diversions from that hospital as it takes all patients who present. Initially, although ramping was down, it was still significant, but when I questioned the hospital about that aspect, the reason I was given was that some of the wards that will provide the bed capacity had not yet been opened. In addition, a 10 per cent surge in demand had occurred; that is, a surge in the number of people coming through the door, which is amazing. Where do all those patients come from? One could think that they are patients who would otherwise have gone to Sir Charles Gairdner Hospital, but demand on that hospital has increased as well. It is as though they are new patients. Now that Joondalup hospital is bigger, people who cannot get to their general practitioner are perhaps attending the hospital. Maybe there are not enough GP services in the area. The way to test that is to look at the types of patients and the percentage of admissions required, and these are pretty much the same. We talk about us being a healthy lot in Mandurah, but you must be a sick lot up there in Joondalup!

Mr A.P. JACOB: Steady on!

Ms J.M. FREEMAN: It is the people from Dianella who are going up there.

Dr K.D. HAMES: Yes. I go to Royal Perth—a great hospital. Sorry; I have not yet finished my comments.

I want to offer my staff, who have been much more deeply involved in this project, the opportunity to make some comments, particularly about the progression of the construction and when those services will be opened. Who wants to do that? Dr Russell-Weisz.

Dr D. Russell-Weisz: Thank you, minister.

The Joondalup redevelopment program has to date been a great success. We opened the emergency department and the public ward block behind it ahead of schedule. The next stages of the Joondalup redevelopment look to be at least on, or in some cases ahead of, schedule. It is critical, as the minister said, that we bring on the additional beds, which is the next phase of the work. We have seen some spectacular increases in demand since the emergency department opened—noting that there has been a net increase in beds of about only 30 beds behind the hospital. Although we opened a 55-bed block, we had to take down some other beds while we do the extension to the older blocks. Since the new ED and ward block opened, we have seen an 18 per cent increase in ED attendances, which is quite significant. Probably more significant—we do not know whether this will continue—is a 33 per cent increase in what we call the triage 1 and triage 2 categories; that is, the most urgent categories in the emergency area. We are seeing more emergency surgery as well. However, the hospital retains most of its work and sends a very small percentage down to Sir Charles Gairdner or Royal Perth Hospitals.

As the minister said, we have not seen any reduction in demand at Royal Perth or Sir Charles Gairdner Hospitals, and we are looking very closely at those figures. Ultimately, we will end up with a hospital, in May 2013, that will have 471 public beds, and we will also have a 145-bed, stand-alone private hospital. That is a significant and very successful development on that site.

Mr R.H. COOK: I may have to beg the minister's indulgence; I guess the kernel of my question relates to the total cost of services outlined on page 127, although the minister may be able to correct me and say I refer to cost and activity growth. Obviously, we anticipate that with the commissioning of Fiona Stanley Hospital—as identified in the Fiona Stanley Hospital business plan that the minister made available to members of Parliament—over 950 nurses will come from Royal Perth Hospital. Of course, the document the minister provided was prior to his decision to maintain Royal Perth Hospital at 410 beds. I am interested to understand not only the quantum of recurrent funding for the commissioning of Fiona Stanley Hospital, but also how the minister will address the staffing issues, particularly with the nursing population maturing. How will the minister meet the staffing challenges associated with the commissioning of Fiona Stanley Hospital?

Dr K.D. HAMES: The provision of a 400-bed facility has not changed since we were in opposition. We said then that it would be 400 beds. As it turns out, in the reconfigured model, it will be 410 beds, but we always said it would be 400 beds.

Mr R.H. COOK: No, minister; I am saying that the quoted business case was drawn up prior to the minister making the decision to go to 410 beds. I think the business case, which is dated 2007, is predicated on a much lower activity level at Royal Perth Hospital.

Dr K.D. HAMES: Sure; that is right. The clinical services framework that we have just put out transitions those beds and costs from what is currently there today into the forward estimates.

Mr R.H. COOK: But that does not account for over 950 nurses.

Dr K.D. HAMES: It accounts for the total estimated expenditure listed under appropriations in the forward estimates and goes beyond 2014. It includes all the people required to staff those hospitals at the levels that we have predicted. The question is: how difficult will that be? Part of it is —

Mr R.H. COOK: I guess part of it is: where will the minister get them from?

Dr K.D. HAMES: Yes. I will talk about nurses to start with. In the days of the former Labor government nurses were exceptionally hard to find. Many were found driving Haulpaks in the Kimberley because the income was so high from that activity. We lost a lot of staff during that last boom as people began working outside the hospitals. I was lucky enough to find, when I came to government, that many such people came back to the hospital system. This was partly because of the dip or the global financial crisis, but we now find that as the activity in the mining sector increases, we are not losing those people again. I think people have been there and tried that type of work and found that it was not really what they wanted to do. Such mine work might provide more money, but it means being away from family and away from services. We are not finding a lack of nurses. A lot of nurses are coming through the system each year, and, to some extent, the challenge is to find enough nurses to retire to fit in the new nurses while staying beneath the full-time equivalent cap. Those FTE caps were set by the state government in anticipation of nurses needed when the extra hospital beds open. I do not know whether members have been through the numbers lately, but the number of tertiary beds reduce in the new model; I refer to the model under both the Liberal and former Labor governments. I used to know the figures off the top of my head, but I cannot remember them now. It was something like 1 300 tertiary beds across the tertiary system to reduce to in the order of 850 tertiary beds, whereas the number of secondary beds will increase significantly. The overall balance is a rise over the forward years of about 500 extra beds within the system, which the Australian Medical Association has been calling for, as the member knows, for a long time. We need those extra beds. We think that enough nurses are going through the system to staff those additional beds. It is the same situation for doctors. By then, we will have 310 doctors going through the system each year. One of the critical difficulties is getting the doctors who currently work at Royal Perth Hospital to work at Fiona Stanley Hospital. Many of them own houses in the northern suburbs and like to live north of the river, as the clever ones among us do! They are not so keen on south of the river.

Mr R.H. COOK: The minister is the one who kept the hospital open. I think the previous minister had a much more ruthless approach to that issue.

Dr K.D. HAMES: He did. He was ruthless. But our doctors want to stay at Royal Perth Hospital. I think we will find that there will be quite a few retirements. When it comes to moving, those people who are getting towards the end of their careers, many of whom work in both the public and private sectors, will be happy to return to the private sector only. We will have trouble recruiting the numbers needed because it is a new hospital, because it is south of the river and because it is a fair way from where people are. Nevertheless, we are now working through that and planning. We are talking to doctors to try to work out who is ready to go. When we recruit people from overseas, we say, "You are here now, but in 2014 you will be working at this hospital, so choose your accommodation carefully to ensure it is easy for you to get there." That will be the difficulty. The dollars are there to cover the activity growth in the future in the forward estimates.

[3.10 pm]

Mr R.H. COOK: Can the minister provide us with a copy of the Fiona Stanley workforce development plan put together by the workforce division and area allied health adviser of the South Metropolitan Area Health Service so we can see the scope of the plan and where it is up to?

Dr K.D. HAMES: I can ask the department. The plan is still being developed.

Mr R.H. COOK: With respect, under the business plan, the workforce plan was supposed to be completed by mid-2008. It should not be in development; it should already be gathering dust.

Dr K.D. HAMES: The director general will provide a detailed, salient answer to the question.

Mr K. Snowball: With the draft workforce plan, and particularly the detailed workforce plan behind it, it is not just about how many nurses we need, but how many nurses with particular skill sets we need. A lot of additional work still needs to go into the plan that is in front of the member now. That plan is very much a broadbrush plan; I certainly would not want to use it as the vehicle to transition Fiona Stanley Hospital and Royal Perth Hospital and so on. There is a lot more work to be done at that detailed level. That is my first point.

My second point is that major events radically and quickly change the workforce supply side. The global financial crisis utterly changed the dynamics of nursing. Our turnover of nurses reduced so quickly, that we basically had surplus nurses. That is our prospect. It is really a case of working through this plan, getting the detail right and getting the target; that is, making sure of our supply side and that our overseas and interstate recruitment satisfies that. At the same time we have to keep an eye to what is happening in the broader health system. We find that the closer we get to the final plan, the more we start to build that workforce information. We do not have to pull the trigger on any of this until such time as we are in trouble. For example, if we find we are two years out, that is not enough time to train nurses with particular skills. Therefore, that is the timetable. By mid-2012 we need to have all of that detailed work completed and that is what is happening. As I said, currently the plan is still a work in progress.

Mr R.H. COOK: I appreciate that and I thank the minister for the answer. I understand this plan is a dynamic document. Could we please have a copy of the workforce plan for Fiona Stanley Hospital as it currently exists?

Dr K.D. HAMES: I will hand over to the director general. This is not a political issue for the government; I have no problem with giving the document. It is a matter of the organisation —

Mr R.H. COOK: It is a political issue. The government is trying to privatise a significant portion of the health sector workforce; I can assure the minister that the matter is political.

Dr K.D. HAMES: The government is not privatising the workforce. We are contracting out support services for that hospital, and we should note that I have corrected my previous language, which made them so upset. The detailed workforce issues we have to deal with will not be about those support services that the member is so concerned about politically; the issues will concern nurses, doctors, physiotherapists, occupational therapists and all the rest of the service staff who will be employed by the government and will provide a public service. The detail about those workers is what the member asks for, not the detail about the other workers who will not be at Fiona Stanley Hospital—they will still work at Royal Perth Hospital.

Mr R.H. COOK: If my question is not political, the minister should have no problem handing over the workforce plan.

Dr K.D. HAMES: I will give the member that which it is practical for a government department to give, not a response to any political concerns.

Mr K. Snowball: The department has no fundamental objection to releasing the information, but I would like to put some riders on it so that it is very clear what it represents and what additional work needs to be done. I would hate to see our work in progress taken as the final picture of our workforce plan for Fiona Stanley Hospital.

Dr K.D. HAMES: I suggest that the member work with the director general. The director general will provide the information and discuss with the member what it relates to and what it does not.

Mr R.H. COOK: Will that be supplied by way of supplementary information?

The CHAIRMAN: It is not supplementary information at this stage. I understood that the member would contact the director general. If the member wants supplementary information, that is perhaps more difficult to arrange than him meeting with the director general. I do not know what the member wants.

Mr R.H. COOK: This is a bit like deja vu. I was promised a number of documents during last year's estimates period and I took it on faith that they would come, and they never did. Therefore, I ask the minister if he could supply the plan as supplementary information.

Dr K.D. HAMES: I am not aware of any documents that the member did not receive. If we agreed to provide them as supplementary information —

Mr R.H. COOK: The documents were about Indigenous health; the director general agreed offer to provide several documents and did not.

Dr K.D. HAMES: If we agreed to provide documents as supplementary information, it is a requirement that we provide them. All the member needed to do was raise the matter in the house, because I am obliged to supply them.

The CHAIRMAN: Will the minister supply the workforce plan by way of supplementary information?

Dr K.D. HAMES: I will not. I offer a direct personal briefing on the plan for the member by the director general.

The CHAIRMAN: That is what I understood. Is the member happy to have a personal briefing with the director general?

Mr R.H. COOK: The minister has made it clear that he will not provide the plan by way of supplementary information. I am clearly at the mercy of the government on this matter.

Dr K.D. HAMES: If I do not wish to provide it by way of supplementary information I am not obliged to. A briefing is available to him; I would be keen for him to have it, because this is an issue we want to work with the opposition on, not be at loggerheads.

Ms J.M. FREEMAN: I refer to doctors going to Fiona Stanley Hospital and the minister's comments about them being from the leafy green suburbs, and not wanting to move to the part of the city where Fiona Stanley Hospital will be. I have heard anecdotally from a few friends of mine who are doctors at Royal Perth Hospital that there is a feeling that Royal Perth Hospital is being run down as an incentive for doctors to go across to Fiona Stanley Hospital. It has been said that there will be better facilities at Fiona Stanley Hospital. Is that the case?

Dr K.D. HAMES: I doubt that very much. People make their own judgements that they would expect the services in a brand-new hospital to be better. I do not know that I will be yet be able to put together the $600-odd million required to build the west wing of Royal Perth Hospital. If we do not build it, the alternative is to do a major redevelopment, and they are often of a very high quality and standard. I have made a commitment to those doctors that Royal Perth Hospital will remain one of the three major tertiary hospitals. The major trauma unit will still be there, as will the heart and lung transplant unit. As we discussed when I mentioned that I had had a meeting at Royal Perth Hospital in the last couple of days with senior clinicians, nurses and ward staff, collectively, about the four-hour rule, they told me that they were very proud of their hospital. They were very happy that Royal Perth Hospital would be kept as a tertiary hospital. I am not sure whether the member knows, but I was recently unwell and the first place I went to was Royal Perth Hospital—not to any other hospital. I am very determined to keep Royal Perth Hospital as a significant force in tertiary hospitals in this state.

Ms J.M. FREEMAN: I refer to the minister's response to my first question. Can the minister confirm that unless he gets the money to rebuild the west wing of Royal Perth Hospital, there will not be the facilities needed to keep many of those doctors at Royal Perth Hospital, and that they will have to relocate to Fiona Stanley Hospital in order to be able to work with the facilities that they need and to work in the tertiary hospital area that they want to work in?

Dr K.D. HAMES: That is not the case. Royal Perth Hospital exists as a tertiary hospital with all the facilities required to operate as a tertiary hospital—those facilities are there now. Some of the facilities are a bit tired, but not all of them. The former Labor government spent a lot of money on upgrading sections of the hospital, for example, the coronary care unit and the burns unit. Those are high-quality areas within the hospital. The worst thing that could happen is that the government does nothing, and even then the hospital will still have all the facilities it has now. The hospital will not be downgraded in any way. It will remain the tertiary hospital that it is now. I would much prefer to improve the standards of service at Royal Perth Hospital, not to leave them as they are at present. That is my plan, and I will need to develop it by the next election so that people can clearly see what it is. We should remember that at present, the standards at Royal Perth Hospital are probably not that different to those of Sir Charles Gairdner Hospital. The standard of buildings, rooms and wards at Royal Perth Hospital is similar to what is available at Sir Charles Gairdner Hospital. But these hospitals will be in competition with Fiona Stanley Hospital, which is a new state-of-the-art hospital. Therefore, there will be a balance between doctors who want to stay in an old hospital and those who want to move to a new one. I want to try to encourage the doctors to remain at Royal Perth Hospital by improving the standards beyond what they are at present.

The member obviously has another little question that is bubbling to get out.

[3.20 pm]

Dr G.G. JACOBS: Minister, while we are on hospital infrastructure, on page 129 there is an impressive list of infrastructure for hospitals in Western Australia. Under the Midland health campus, though, is listed $360.2 million. When will the construction of the new hospital commence? Is the planning complete? Where is this time line? Does the minister see the progress of this to a new hospital in Midland to replace, I believe, Swan District Hospital?

Dr K.D. HAMES: I thank the member for the question. Work is progressing well on the construction of Midland hospital. We now have two short-listed proponents, as we previously announced. One is Ramsay Health Care, which manages the Joondalup Health Campus. The other is St John of God Health Care. Those two proponents are going through the final stages of analysis before one is chosen as the preferred tenderer. We remain on time to complete the hospital. Work will commence in mid-2012 and be completed in 2015. As the member knows, it is $360 million—$180 million of that is state government money and $180 million of that is commonwealth government money. We are very confident that that process will provide an excellent service. That is going to be a design–build operation and we will maintain public–private partnership with one of those companies, although the option of funding is still available as part of our discussions with those companies.

Dr G.G. JACOBS: As a follow-up question, can the minister tell us about hospital beds and services? Will the Swan District Hospital Campus have more services?

Dr K.D. HAMES: The member may recall that the original proposal from the Labor government when we were in opposition was to redevelop the old Midland hospital. I looked at that and it has gone beyond its time span. It is sprawling; it is old methodology. To try to turn that into a modern, vibrant hospital, in my view, is impossible. We then put out a document to say that, if we were in government, we would relocate and build it in the heart of Midland next to the railway line. I am very pleased to say that a month later the then minister decided that his government would do exactly the same thing. Labor offered different timetables for completion—earlier timetables, I think, commencing in 2012. When we came to government, nothing had been done in the design or planning for that hospital. Certainly the funding was nowhere near adequate for the timetable or the scale that was proposed. There will be more beds. I do not have the exact number here. I have a list, and the member can add them all up. Prior to 2010–11 there will be 428 beds at that location: 90 multi-day beds, 28 obstetric beds, 28 assessment short-stay beds and 46 restorative rehabilitation/stroke beds.

Ms J.M. FREEMAN: Minister, can we move on?

Dr K.D. HAMES: I am happy to provide that detail to the member for his information.

Dr G.G. JACOBS: What about mental health?

Dr K.D. HAMES: Yes, there are 56 acute mental health beds, which is a tremendous number. Do we know what the current number of beds is?

Dr D. Russell-Weisz: Minister, it is about 180.

Dr K.D. HAMES: There 180 beds currently. That will go to 428. This will be a major —

Mr W. Salvage: It is 307.

Dr K.D. HAMES: Sorry, I am getting that confused. The final number of beds will be 307 , up from 180 currently. This will be a major regional resource centre.

Mr R.H. COOK: A representative of the minister's department was in the newspaper quite recently saying that the department is looking at the two bids, and then it would decide between the three players in the bidding process—that is, the public system and then the two private bids. The minister has just said that he is going to go with the private bids. Will he make the public–private comparator, which he has obviously done as a result of that, available to the Parliament, or has the minister turned his spokesperson for the Department of Health into a liar?

Dr K.D. HAMES: No, and I have not. Please note that a dot point here says that Pfizer will develop a public–private comparator for the project in line with the department's public–private partnership policies.

Mr R.H. COOK: But the minister has just said that he is going for a public–private partnership. Has the minister done the comparator or not?

Dr K.D. HAMES: The final decision regarding the company that proceeds with that will be made on the advice of those who are involved in doing the assessment. Part of that assessment before they make that recommendation is to do a public–private comparator. If I have said in the words I have used earlier that we will

go with one of them, then I will retract those words and say that we will go with them, subject to the recommendation being made to do so. That will obviously then come to cabinet.

Mr R.H. COOK: That is a bit cute.

Dr K.D. HAMES: I think I am being more accurate.

Ms L.L. BAKER: At the bottom of page 145 of Budget paper No 1 reference is made to the Sir Charles Gairdner Hospital redevelopment stage 1.

Dr K.D. HAMES: Yes; $57.708 million.

Ms L.L. BAKER: That is the figure I am interested in, because when I checked back to last year's budget papers, the total cost of building stage 1 was estimated as $83.954 million. Could the minister explain to us why there is a funding cut of $26 245 000?

Dr K.D. HAMES: Yes, I can. I need to get someone to go through the details, because I forget, because it was well over a year ago that we did this. A budget for Sir Charles Gairdner Hospital was developed by the previous government. We changed that some time ago to look at what we were going to build and how we were going to build that. The original funding was developed when Royal Perth Hospital was going to close as a tertiary hospital. There was going to be 1 000 additional beds on that site, and they had to be developed. Part of that original funding was for a surgical unit to take over elective surgery from the hospital. Jodie South has the information on the change.

Ms J.E. South: The total redevelopment money for Sir Charles Gairdner Hospital was reported in last year's budget. That is a pool of money. As a project gets approved, it gets put into a separate line within our budget papers. What can be seen in the budget paper now is the remainder that is still to be allocated to projects.

Dr K.D. HAMES: Can I just interrupt there; obviously the answer I gave was incorrect. What I was talking about was what happened a year previously when we did significantly change that. If I could just get that on the record and then we can go back to Jodie.

Ms L.L. BAKER: An amount of $83.953 million was in the bucket, and now $57 million is in the bucket. Is that because the minister did a really expensive plan?

Ms J.E. South: Through the minister, that is because a range of projects have been approved out of that bucket since last year's budget. Those projects are now reported separately in the budget papers.

Dr K.D. HAMES: Such as?

Ms J.E. South: Examples would be a high-priority remodelling stage 1.

Ms L.L. BAKER: Is this for Sir Charles Gairdner Hospital?

Ms J.E. South: It is at Sir Charles Gairdner Hospital. That is correct.

Ms L.L. BAKER: These are all extra projects at Sir Charles Gairdner Hospital.

Ms J.E. South: That is exactly right.

Dr K.D. HAMES: Before we proceed, I ask the Deputy Leader of the Opposition what he wants to do in terms of timing and when he wants to move to the next division?

[3.30 pm]

Mr R.H. COOK: I am conscious of the fact that we need to move on. It looks like the member for Nollamara needs to ask a question.

Dr K.D. HAMES: We have an hour and a half to go for mental health and this division. I would be happy to spend all my time on this.

Mr R.H. COOK: The minister and I both, but we will get into trouble.

Ms J.M. FREEMAN: I refer to the "Health Services Development Fund" on page 145 of budget paper No 2, which is perhaps not the best place for this question that relates to the land at the corner of Milldale Way and Mirrabooka Drive, Mirrabooka. The minister was not going to leave this place without answering me!

Dr K.D. HAMES: It would have been hard to find a line, so I appreciate the member's difficulty.

Ms J.M. FREEMAN: I did find a line. Given that that land swap has occurred and the department has the lot on the southern side of Milldale Way, what are the plans for that land and when will those plans be implemented, or do I have to put up with degraded land for even longer?

Dr K.D. HAMES: I am surprised that the member did not include some criticism of a previous minister, because she will recall that, as the former Minister for Health, John Day had planned to build a day surgery centre; he had funding for that, and then it was cancelled.

Ms J.M. FREEMAN: What are the plans now, minister?

Dr K.D. HAMES: We have been through some difficulties working with the Department of Housing trying to get that land. I had a meeting with the member for Bunbury when he was Minister for Housing and got agreement on changing that. It has taken us a long time to do it.

Ms J.M. FREEMAN: It is a done deal now.

Dr K.D. HAMES: Now I will get to the member's answer. I do not know the answer, so Ms South will tell me exactly what will be there and when we are going to do it.

Ms J.M. FREEMAN: It is a done deal. They have the land. They are doing the redevelopment. What is the minister doing?

Ms J.E. South: Through the minister, the idea of the Mirrabooka land was always to be a land bank for health. As part of our strategic asset plans, as required by government, we need to look ahead in relation to how we purchase land for the future for areas of need. Mirrabooka was always one of those sites. If the member looks at the northern corridor, there is a large area, particularly in the middle, that is not serviced by a hospital and people have to go as far north as Joondalup, as far east as Swan District or down to Osborne Park. I could not give the member a definitive answer to when we will build a particular facility there, but it is definitely part of our asset plan in the next 10 to 15 years to look at some kind of facility to support the northern hospitals.

Dr K.D. HAMES: I have a plan. In the lead-up to the next election, the member for Nollamara can get the Deputy Leader of the Opposition on her right to commit to something that is appropriate and then I will match his election commitment because I will have to also keep our votes up in that area. I think something needs to go through and one way or the other we will get it done.

Ms J.M. FREEMAN: Meanwhile, the good people of Mirrabooka get degraded land.

Dr K.D. HAMES: I think that some sort of day surgery centre would be the most appropriate use for that site.

Ms J.M. FREEMAN: It is not going to happen.

Mr R.H. COOK: I will get the chequebook!

Dr K.D. HAMES: If the member has not worked it out, commitments before an election are worth their weight in gold.

Ms J.M. FREEMAN: There is enough land for the minister to rent out there; he is just banking on that land and using it as an asset, and nothing will happen to it. The people in that area will have to put up with land that is degraded.

The CHAIRMAN: We have a little bit of banter on that.

The appropriation was recommended.