Division 30: WA Health, $5 244 127 000 —

Mr M.J. Cowper, Chairman.

Mr J.H.D. Day, Minister for Health.

Dr D. Russell-Weisz, Director General.

Mrs R.A. Brown, Deputy Director General.

Ms A. Kelly, Assistant Director General, Purchasing and System Performance.

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

Mr A. Joseph, Group Director, Resources.

Professor F. Daly, Chief Executive, Child and Adolescent Health Service; Perth Children's Hospital Commissioning.

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

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

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

Dr R. Lawrence, Chief Executive, South Metropolitan Health Service.

[Witnesses introduced.]

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

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

The minister may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. I ask the minister to clearly indicate what supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the principal clerk by Friday, 3 June 2016. 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.

The first member with the call is the member for Kwinana.

Mr R.H. COOK: On page 336 of the budget papers, I refer to the line item "Perth Children's Hospital" under the heading "Works in Progress". On 26 March, in response to a question asked by Hon Adele Farina in the other place, the minister advised that he did not know when practical completion of Perth Children's Hospital would be achieved. Can the minister tell us today on what date practical completion will be achieved and the hospital handed over to the state government?

Mr J.H.D. DAY: That was a question asked on 26 March.

Mr R.H. COOK: I believe so. Actually, it was 23 March.

Mr J.H.D. DAY: That was about a week before the changeover, but I assume it would have been answered after the changeover.

Mr R.H. COOK: On behalf of the government, yes.

Ms J.M. FREEMAN: Has it got better since the changeover?

Mr R.H. COOK: It has—it is so much better!

The CHAIRMAN: I remind members that a quick question evokes a quick response.

Mr J.H.D. DAY: Perth Children's Hospital is obviously a very large and complex project. A lot of progress has been made in recent weeks with the managing contractor completing the building. The intention of the government, and certainly the aim of the government, the Department of Health and the Child and Adolescent Health Service is that it be fully operational before the end of this year. I do expect that to occur. The date of handover by the managing contractor and the opening date have not been finalised, but based on the briefings that I had recently, I am confident that the hospital will be operational before the end of the year. The opening will be in a staged manner, similar to the opening of Fiona Stanley Hospital, but we expect the emergency

department and inpatients to be moved before the end of the year, subject to everything being on track and subject to no major problems occurring. Obviously, patient safety is paramount.

Mr R.H. COOK: The word around town amongst the construction industry is that we are looking for a practical completion date around August. Can the minister confirm that it will be around that time?

Mr J.H.D. DAY: I will ask the director general to comment. As I said, the dates have not been finalised at this stage.

Dr D. Russell-Weisz: The dates have not been confirmed, but I can confirm that we are doing a lot of work prior to practical completion. Practical completion is a handover date, but certain tranches of work have already been handed over to the commissioning team. Some wards and areas within the hospital are already accessible to the commissioning team. We are putting in computers, furniture and other fittings and equipment as we speak. The actual date of practical completion is not yet defined, but we are hopeful that it will be as early as possible. It will need to be at a time that allows the clinical commissioning to take place, but we can commission the hospital prior to that by doing those basic commissioning tasks first, and that is happening at the moment. Bits of the hospital are already being handed over.

Mr R.H. COOK: Prior to any patients occupying the building, one assumes that the contract for clinical cleaning services that was put out to tender some time back needs to be completed. The project management plan for clinical cleaning services shows that prior to any patients entering the hospital, that contract has to be completed. It is a 26-week contract. Can the minister confirm whether that is the case?

Mr J.H.D. DAY: I will ask Professor Daly to answer that.

Professor F. Daly: Thank you for the question. The cleaning contract is to do the specialist clean that needs occur in all our clinical areas to take the building from a finished or a final builder's clean to a clinical clean. That has to occur in a wave across the areas as we accept them and begin our clinical commissioning program. We hope to do those clinical cleans in the long-lead commissioning areas—for example, the operating theatres, the sterilising units, medical imaging and pharmacy—as early as July.

Mr R.H. COOK: If the clinical clean does not begin until 26 July and it is a 26-week project, how will the department get any patients into the hospital before Christmas?

Professor F. Daly: No, not 26 July; we want to start that program in early July.

Mr R.H. COOK: But July is the seventh month, so 26 weeks from July bangs straight into Christmas.

Professor F. Daly: We currently have a very detailed map of a 20-week commissioning process as soon as we have access to those key areas. The longest commissioning periods are 20 weeks. For many areas, such as the generic wards and open-space areas, we plan to commission in a 16-week time frame. For the longest lead-time areas—the ones I listed in my answer to the previous question—it is a 20-week program.

Mr R.H. COOK: Can the minister confirm that the department is looking to admit patients to the hospital prior to the specs of the contract? The contract is for a 26-week clean, but it will now be jammed into a 20-week clean; is that correct?

Mr J.H.D. DAY: I ask the director general to answer that.

Dr D. Russell-Weisz: I will make one comment and then maybe, through the minister, Professor Daly can answer too. We will not put patients in any of our hospitals unless the appropriate cleans have been done. There is number one, a builder's clean, and then a hospital clean. Some areas in the hospital have to be cleaned a number of times. At one of our other hospitals, areas needed to be cleaned three or four times before patients went into the hospital. The hospital is aimed to be opened in stages, not through such a long period as was the case with Fiona Stanley Hospital, but over a four to five-week period, and we would obviously have the cleans done appropriately and would not let patients in until the cleans were done and it was safe to let them in. Professor Daly might be able to give further details about the question.

[2.10 pm]

Professor F. Daly: All I can say is that I do not have the contract in front of me, or its terms.

Mr R.H. COOK: I do, if Professor Daly wants to have a look at it.

Professor F. Daly: I would say that the duration of the cleaning contract does not in any way prescribe the commissioning procedures or activities that we will need to undertake. The term of that contract has been determined such that it gives us the greatest flexibility to deploy those cleaning services across the hospital as we need them, and a six-month contract allowed us the scope to do so.

Mr R.H. COOK: With respect, minister, the contract goes into some detail about the actual cleaning process.

Mr J.H.D. DAY: Is this the contract for the construction of the building?

Mr R.H. COOK: It is for the clinical clean.

Mr J.H.D. DAY: What date is it roughly?

Mr R.H. COOK: It runs from practical completion.

Mr J.H.D. DAY: But what date does the contract state?

Mr R.H. COOK: The contract closed on 15 March 2016, so it is not a historic document; it is a very recent document. It runs from practical completion and it has a very detailed layout of the cleaning process up to what it refers to as "move day". Can I say also that this is the first time we have heard about a staged commissioning of the hospital—to date, the minister has talked only about a single move, so this is new information that we will come back to in a jiffy. In this very detailed project management plan there is a 26-week program that then refers to "move day". I assume that "move day" is when patients are brought in. If practical completion is not to be before July and there is a 26-week clinical cleaning project that takes us up to "move day", how will the latest so-called deadline of the end of 2016 be met?

Mr J.H.D. DAY: As we have mentioned, access to the hospital is being obtained now, so some of the commissioning is starting. It is not a matter of waiting until July or August for the health system to get access. That is already commencing, and a large part of the hospital is now available for equipment, information technology services and so on to be installed and commissioned. In relation to the question about the 26-week period for the cleaning contract, I will either need to take that on notice or seek further information from Professor Daly, if he can make any more comments.

Professor F. Daly: I think that if the member's question is about the contract and the actual stages of the cleaning process, and what that dictates for our commissioning process, we will need to take it on notice.

Mr R.H. COOK: This is the government's single biggest project. I mean, the government is spending a lot of taxpayers' money promoting itself around the new Perth Children's Hospital through its Bigger Picture advertising campaign, which we will discuss shortly. I refer the minister to a tweet from 720 ABC that came out of an interview with the director general. It quotes the director general as saying that every effort is being made to open the new children's hospital by the end of the year but it is dependent on the builder. Is the minister not talking to the builders? Why is he so incapable of giving us an opening date? Given that a significant contract is in place, why is the minister so confident that the hospital will open in 2016 when there is not yet practical completion and he cannot tell us when practical completion will be?

Mr J.H.D. DAY: That is based on the best advice I have been given. I assure the member that there is a very large amount of communication between the government and the builder, John Holland. John Holland has been later in delivering the project than we would like, and I think that has been well publicised, but in the last couple of months in particular, from all that I am advised, a very big effort has been put in to try to ensure the hospital is completed in a timely manner and will be open for patients before the end of this year. The agency that has direct responsibility for communicating and liaising with, and providing directions to, John Holland, and so on, is the strategic project and asset sales section of the Department of Treasury. It has a substantial team very actively engaged on this project, as does the Health portfolio.

Mr R.H. COOK: Yet even they cannot give the minister an actual date. Even my builder could give me a date, and there was only one person. The minister has a whole bunch of departments, and he cannot tell me when he will get the building handed over to him by the builder.

Mr J.H.D. DAY: That is because it is a very large and complex project. We are fairly close to being able to finalise a date. It has been very much literally a work in progress, obviously, and a bit of a fluid situation in the last 12 months. However, based on all that, I am advised that there is a high level of confidence that the hospital will be able to be fully opened before the end of this year, and the next few weeks will be very important in achieving that target. The way things have been progressing for the last few weeks, we are confident that that target will be reached, but I will not give a precise date here without having formal advice from strategic projects or the Department of Health.

Ms J.M. FREEMAN: As part of the fluid situation with the building, I have just been informed by a colleague that all the operating theatres had to be redone because they did not meet the specifications required. There was also an issue with having to put in one or two more theatres, so the theatres that had been built had to be ripped out and replaced.

Mr J.H.D. DAY: Can I ask which aspect of the operating theatres?

Ms J.M. FREEMAN: I assume they are the theatres that surgeons operate in—the operating theatres, not an operatic theatre, minister. We are not doing arts; we are doing health.

Mr J.H.D. DAY: What I asked is which aspects of the operating theatres. I know what an operating theatre is.

Ms J.M. FREEMAN: My understanding is that two more theatres were needed. There was not enough room, and the whole thing in the building had to be remodelled.

The CHAIRMAN: Member, what is the question?

Ms J.M. FREEMAN: Was there or was there not a delay because all the operating theatres had to be remodelled? Were an extra one or two theatres required on the specifications that the government had; and has that delayed the project?

Mr J.H.D. DAY: If that was the case, that decision would have been made two years ago at least, but I will ask Professor Daly to comment.

Professor F. Daly: I am not aware of that rumour. The theatres were completed according to the process and the program. The number of theatres, operating suites, procedural rooms and intraoperative MRI have been on the plans and completed for a number of years, and they certainly predate my involvement with the project.

Mr R.H. COOK: A little while ago, the minister talked about John Holland, the head contractor, with whom he has had little relationship.

Mr J.H.D. DAY: I did not say that at all. The government has a very active relationship with John Holland.

Mr R.H. COOK: The minister does not talk to John Holland. Seemingly, he does not know what John Holland does, but that is okay.

Mr J.H.D. DAY: I have a pretty good idea about what John Holland does—it builds things.

Mr R.H. COOK: All right, good. On that basis, can the minister please advise us that all subcontractors, many of whom were owed substantial amounts of money by the head contractor, John Holland, have had all outstanding payments owed to them paid in full?

Mr J.H.D. DAY: That is really a question that should be directed to the Treasurer, because that is the responsibility of strategic projects within Treasury. However, from a conversation I had three weeks ago in relation to this issue, which involved the Treasurer and the Department of Treasury, the comment made to me or the Treasurer when this issue was raised was that John Holland had been doing everything it could to accommodate subcontractors and to try to ensure that they are supported in an appropriate way. That is not a definitive answer. The question should really be directed to the Treasurer. It is not the responsibility of the Department of Health or the health portfolio to deal with that issue. The government, through the health department, is the client in this case and the Department of Treasury is the agency directly engaged with John Holland.

[2.20 pm]

Ms J.M. FREEMAN: Is the Telethon Kids Institute office fit-out part of the construction costs for the Perth Children's Hospital? Who is undertaking the fit-out? What is the cost of the fit-out? Was this contract subject to a tender?

Mr J.H.D. DAY: Similarly, it really should be directed to the Treasury portfolio, but I will ask Professor Daly to comment.

Professor F. Daly: The fit-out of the Telethon Kids Institute area on the top two floors of the hospital was to be done by the managing contractor, John Holland. Work had been done for a guaranteed cost contract of approximately $53 million in value. Recently the managing contractor—through Strategic Projects—informed the state that it was unable to complete the works on schedule and decided to withdraw from that contract. We are working with TKI. That contract for the fit-out will now go out to tender. The work is being done at the moment by Strategic Projects to work out the tender and procurement process. It anticipates that that will be going out to tender in coming months. The works for the TKI fit-out on the top two floors of the hospital can be quarantined from the rest of the hospital. It is not part of the practical completion of the whole hospital.

I will refer to the funding arrangements. I do not have the exact notes to bear, but the state has previously provided $5.4 million for the fit-out. Largely through commonwealth funding, TKI is providing a sum of approximately $38 million for the fit-out. The difference between that $40-odd million and the total cost of the fit-out is in the Strategic Projects budget and in the quantitative risk assessment process; it will be paid for out of existing contingency.

Mr R.H. COOK: This relates in part to budget paper No 3 and it is to do with the information and communications technology at Perth Children's Hospital. The government's budget shows a significant retraction of investment in ICT at the hospital.

Mr J.H.D. DAY: Which page is the member on?

Mr R.H. COOK: Page 168 of budget paper No 3 states —

> **Perth Children's Hospital (Information and Communications Technology)**
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> ...
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> This comprises a reduction of $46.8million as a result of the decision to defer the procurement of the IHS, and reallocating $28.5 million of this funding to support critical PCH ICT systems that will ensure the delivery of safe and effective hospital ICT systems and prevent further delays to hospital commissioning.

What is going on with that? We have previously been told that we were simply either buying off the shelf for Perth Children's Hospital or just using the Fiona Stanley Hospital bespoke model. The government now seems to be abandoning both those ideas. Firstly, what is going on? Secondly, does this impact upon the capacity for records from different hospitals to be reviewed in relation to the Perth Children's Hospital?

Mr J.H.D. DAY: I will ask the director general to comment. He had a lot of experience in this area with the commissioning of Fiona Stanley Hospital.

Mr R.H. COOK: He still has the scars.

Dr D. Russell-Weisz: In a minute I will ask whether Professor Daly would like to comment on this. The first question was on the integrated health solution. The procurement process for an integrated health solution is very complex. Western Australia has not done an integrated health solution before. Some hospitals in the eastern states have a one-size-fits-all integrated health solution. The market is changing at all times. We also have in the background the government's direction for GovNext. I am no ICT expert, though I might try to sound like one, but we are putting much more into the cloud.

A decision was made that when—not if, but when—Perth Children's Hospital goes to an integrated health solution, it should occur after commissioning. To put in an integrated health solution to basically replace the majority of ICT systems—WA Health has many legacy systems—would put so much strain on the project. To put that in prior to opening the hospital would provide quite a risky commissioning. Therefore, we decided to defer the integrated health solution, but we will bring into Perth Children's Hospital our new patient administration system, webPAS, which is already in Princess Margaret Hospital for Children. WebPAS is in the current children's hospital, if I am correct. Post commissioning we will also bring in Bossnet, which is a digital medical record solution at Fiona Stanley Hospital. The integrated health solution is a very, very big departure. However, it is a very large decision for any health system to decide to put that in a hospital. Perth Children's Hospital will still be our first hospital with an integrated health solution when we do it, and we made the decision to wait on the grounds that it would otherwise make the commissioning process much more difficult. It is not as simple as saying that we will take something off the shelf, go to procurement, put it in and it replaces everything. Multiple existing solutions need to integrate with the new system or be replaced by it. It is a huge detailed process. A decision was made to do that post commissioning.

Through the minister, I ask Professor Daly to provide some more intricate comment.

Professor F. Daly: I am not sure whether I can add to my director general's comments. I think he summarised the issue very well. The business case for Perth Children's Hospital was predicated on a new breed of integrated health solution software, which is essentially a sophisticated medical record that brings all the information around the patient together in one place. It is not a suite of applications that we open and close; it is one integrated solution. The major business case for this large investment is to improve safety. A number of children's hospitals around the world have made this large investment.

I am absolutely committed in the medium term to the procurement and implementation of an integrated health solution. I think it is a wonderful step forward for young patients in Western Australia and I would be very proud for Perth Children's Hospital to be the first site. A team from Western Australia explored this almost exactly 12 months ago; we went to two children's hospitals in the eastern states where this was being undertaken. The very strong message we had was not to try to implement this kind of system at the same time that we commission a new hospital. This needs to be the singular reform endeavour and reform effort of a large group of clinicians, because it needs to be clinically led. It needs to be the singular focus of the area health service for at least two to three years to be done successfully. The procurement process that we were nearly at the end of completing did not allow us to do it within safe time frames. We halted the procurement process and postponed

the IHS until after we commissioned the hospital to allow us to do this safely, and then we will embark on the process again.

The director general made an important point; that is, the models of delivery of an integrated health solution are changing very rapidly, as are the cost structures that underlie them. We are moving from an off-the-shelf CD-ROM, if you like, that is plugged into a computer, to a cloud-based system that is much more fluid. I think it was a very wise decision to postpone this until we have safely moved into the new hospital.

[2.30 pm]

Ms J.M. FREEMAN: We will just leave it to the Auditor General.

Mr J.H.D. DAY: I think that was a very comprehensive answer. I hope it does answer the member's question.

Mr R.H. COOK: The minister could give us a summary now of what he said!

Ms M.M. QUIRK: I understand that there have been a number of contract variations for Perth Children's Hospital. By way of supplementary information, could the minister provide a list of those variations and the additional costs that that will impose on the Department of Health?

Mr J.H.D. DAY: I suspect on a project of this scale there is a very large number, but that is just off the top of my head.

Ms M.M. QUIRK: There should be a record of them somewhere, surely.

Mr J.H.D. DAY: Yes. Maybe we could provide the most substantial ones, but I will ask the director general to comment.

Dr D. Russell-Weisz: I presume the member is referring to construction variations?

Ms M.M. QUIRK: Yes.

Dr D. Russell-Weisz: I would concur with the minister that the Office of Strategic Projects and Asset Sales in the Department of Treasury would have those in detail. Some of those would still be on foot and some would be still to be considered. Thinking about Fiona Stanley Hospital, there are a number of contract variations both in and out that would occur on a project of this size.

Ms M.M. QUIRK: Is that a yes or a no? If it is a yes, can the minister provide them?

Dr K.D. HAMES interjected.

Ms M.M. QUIRK: I am sorry, is the member for Dawesville the minister?

Mr J.H.D. DAY: It is a question that should be directed to the Treasurer.

Ms M.M. QUIRK: I will put it this way: by way of supplementary, is the minister able to provide the additional costs that will have been created by payment for the variations? That is something within the health budget.

Mr J.H.D. DAY: I am happy to seek to provide through supplementary information a summary of key changes that have been made and an estimation of the costs involved. I make the point that the overall cost of the project is about $1.2 billion. I do not think that has changed since the project was initially committed to, but that is a broad figure. I seek to provide that information, subject to it not putting the state's position in jeopardy—that is, the public interest in relation to any negotiations with John Holland. This is still very much a live project and there would be negotiations going on. Subject to that qualification, I will see what information is available by way of summary of any major changes that have been made.

[*Supplementary Information No A43.*]

Ms M.M. QUIRK: Would it assist if we said every variation that cost over $50 000 or $20 000?

Mr J.H.D. DAY: We can take that as a guide, perhaps. I will see what comes back.

The CHAIRMAN: Next question—it has taken us a bit over half an hour for the first one. Member for Mirrabooka.

Ms J.M. FREEMAN: I defer my question to the member for Eyre on the basis that we have had a good go.

Dr G.G. JACOBS: I draw the minister's attention to about halfway down page 322 and the second dot point under "Other Patient Safety and Quality Initiatives", which is about the capital grant of $10 million to PlusLife. Can the minister tell us the status of the bone and tissue bank services now and what they will look like after the development of the processing and laboratory facility with the $10 million grant for PlusLife?

Mr J.H.D. DAY: PlusLife, as I said in this chamber a week or two ago, is a non-government not-for-profit organisation that was originally established in 1992 as the Perth Bone and Tissue Bank and is Western Australia's only bone and tissue bank. It is now an essential part of the health system in the state. Bone and tissue grafts are used, as the member is probably aware, for people with bone tumours, joint problems and traumatic injuries and also for children and adolescents who have spinal deformities and need surgery to correct those problems. PlusLife, as it is now known, has been located on the Hollywood Private Hospital site. It needs to vacate there by around the end of next year and the government has provided assistance, initially through the Metropolitan Redevelopment Authority. This was subject to a cabinet decision. In my previous role as the Minister for Planning it was something I was involved with, in making the building owned by the MRA in the Midland precinct—a heritage building, part of the old Midland railway workshops site—available to PlusLife. As well as having access to that at an affordable rent, PlusLife also needed funding of about $10 million to fit out the building with freezers, laboratory facilities and other aspects that need to be provided for, including clean rooms. Therefore, $10 million has been allocated in this budget. It is a substantial decision and commitment by the government and is another aspect of how even in difficult financial times we are making a very strong commitment to try to ensure that world-class services are provided in Western Australia's health system.

Dr G.G. JACOBS: What is in the building at the moment? Is it a building that is already there?

Mr J.H.D. DAY: Yes, it is a heritage building that is part of the Midland railway workshops on the corner of Yelverton Drive and Helena Street, just near the traffic lights. It is very close to Midland railway station and it is where the MRA's Midland office is. It is where the previous Midland Redevelopment Authority was based, so the MRA at some stage will be vacating it. It is a lovely building, in fact. I have been in there quite a number of times and it will be of great assistance to PlusLife, I am sure. It is also of great benefit to the Midland region. It is close to the new Midland Public Hospital, but it does add to the commitment being provided by the government to encourage economic and other development in the east metropolitan region.

Dr G.G. JACOBS: Can I ask another question?

The CHAIRMAN: Further question, member.

Dr G.G. JACOBS: This is not added to the budget, but what is —

The CHAIRMAN: Clarification, member, are we talking about the same subject?

Dr G.G. JACOBS: Yes. It is on the operating expenses of the processing and laboratory facility. What does that look like as far as a quantum?

Mr J.H.D. DAY: I am not sure what PlusLife's annual operational expenses are. My understanding is it certainly has philanthropic support. Presumably there is some fee-for-service arrangement. PlusLife provides bone and tissue grafts for not only Western Australia, but also other parts of Australia. The member would need to go to its website or get information from PlusLife or we could provide it to the member just to check its operational expenses. I presume its annual report is on its website.

Ms M.M. QUIRK: I refer to the total appropriations at page 317 of budget paper No 2. Are any public metropolitan hospitals currently estimated to be in deficit; and, if so, which hospitals? What was their allocated hospital budget for 2015–16? For those hospitals with the deficit, does the deficit carry over into the next budget? Do any cost overruns over the hospital's existing budget come out of its budget for 2016–17 or is the slate wiped clean at the end of the financial year?

Mr J.H.D. DAY: In relation to the possibility of a deficit across the health system overall, a lot of work is being put into trying to ensure that by the end of the financial year there is not a deficit. I cannot remember what was predicted in the midyear review, but I will ask the director general to comment in a moment. A lot of work has been done to ensure that any projected deficit is brought down to within $100 million or so out of an $8.6 billion budget. It is not a large variation, but the aim is to ensure that it is as close to zero as possible across the system by the end of June. I will ask the director general to comment on any hospitals specifically. I am not sure whether we can answer that, but perhaps the director general can advise whether it is carried over or not.

[2.40 pm]

Dr D. Russell-Weisz: If I can put it into context, it was very evident at the beginning of the financial year that there were significant risks to the financial settings for health. However, expenditure growth has been reduced to below five per cent and our full-time equivalent or our staffing numbers have been brought under control, whilst accommodating activity growth above the target. We had target activity growth, but we have actually done more. We have done two per cent more than we thought, because more activity is coming in. We have done eight per cent more elective surgery than we did this time last year. Also, our elective surgery performance has improved over that time. That is around what we call our weighted activity unit; there are about 20 000 weighted

activity units, which is actually very substantial. At the end of July, we were predicting over $300 million in deficit—this was not kept secret. At the midyear review, debt was reported at around $176 million, and we are slowly paring that back. There is a lot more work to be done in May and June. A lot of the health services have put in substantial strategies over the course of the year, and a lot of those are back-ended, so they will come to fruition in May and June. We have not sought any funding supplementation. It is very clear that we aim to come in on budget, or as close to budget as possible, and to manage any deficit—if there is any deficit—within our current settings. We have done a lot of work on saving measures, and good control of our FTEs, overtime, and recall and rostering practices. A few outstanding hospitals have shown new rostering practices that are probably safer than we had in the past. As the member would be aware, we have also had a voluntary severance scheme. We had 8.6 per cent expenditure growth last year; this year, we are expecting 4.7 per cent. We have done around 4.5 per cent activity over the last year, which is two per cent over what we expected.

Ms M.M. QUIRK: Mr Chair, neither the minister nor the director general have given a response. My question was about particular public hospitals.

Dr D. Russell-Weisz: In relation to hospitals, we look at our area health services. In area health services currently, yes, there is a deficit. I may pass to Angela Kelly to give any details that we have today, or we can take it on notice. There are still deficits within the South Metropolitan Health Service and the North Metropolitan Health Service, which are our biggest health services. There are strategies to address those deficits. We are expecting the WA Country Health Service and the Child and Adolescent Health Service to come in very close to budget. Remember, that is not just the area health services. There is obviously money in other parts of health, and that will enable us to get close to balancing our budget.

Ms M.M. QUIRK: Before the minister passes on, does he concede that the hospital deficits are likely to be large drivers to why the area health services are in deficit?

Dr D. Russell-Weisz: Generally, yes. The pressures come from hospitals, there is no doubt, and the system has been through a significant reconfiguration over the last six years, but really over the last 12 months to 18 months. We brought on additional staff through the reconfiguration process to make sure that we reconfigured safely. However, we need to stay within budget and that is why we have not sought any supplementary funding.

Mr J.H.D. DAY: I will ask Angela Kelly to comment further.

Ms A. Kelly: At the moment, the area health services are forecasting some deficits and they are varying. As the director general indicated, we have some strategies in place. We can provide that information in detail as supplementary information, rather than have me go through it and perhaps not get the numbers right. In answer to the member's question about a deficit carryover, each year starts as a new year. We allocate an activity target and a price to health services, as well as some block funding for particular services. Each year starts a new year, to answer that question.

Ms M.M. QUIRK: Thank you.

Mr J.H.D. DAY: That is the current projected deficit per area health service, but we would expect that the situation now will not be the situation at the end of the financial year. That needs to be remembered. We will do that to the extent indicated.

The CHAIRMAN: Minister, would you like to clarify what information you will provide?

Mr J.H.D. DAY: Information regarding any projected deficits for the current four area health services, as is the situation at the moment.

[*Supplementary Information No A44.*]

Mr R.H. COOK: I think we now have the principle—the minister is saying that even if an area health service runs at a deficit, the slate will be wiped clean and it will start afresh on 1 July; that is correct. Also, the department is not seeking supplementary funding; however, by the same token, the director general said that at the midyear review, the department had a deficit of about $176 million. Therefore, where is the money coming from?

Dr D. Russell-Weisz: At the midyear review, we were predicting. All hospitals and health services now have a suite of strategies in place, which we are measuring. Many of those strategies were back-ended to the last quarter. If we do end up with a deficit at the end of the financial year, regardless of whether we have sought supplementary funding—I am not seeking that supplementary funding—then, yes, there may be challenges going into the next year. However, as the member would be aware from the budget paper, the price that we got for our activity-based funding is different from the price that we got last year. Our strategies will not stop on 30 June; they will continue into next year to make sure that we continue that downward trend and better performance in our financial management.

Ms J.M. FREEMAN: It could grow though, could it not? The deficit will just be rolled into the next year and the department hopes that the strategies it has put in place will pay it off.

Mr J.H.D. DAY: We are not saying there will be a deficit at this stage.

The CHAIRMAN: What is the question?

Mr J.H.D. DAY: The aim is to get the deficit to zero across the system. There is another month and a bit to go.

Mr R.H. COOK: Is the minister saying that the public health system might prop up a hospital that is not running its budget properly, or preventive health might take a hit because the government needs to back up some other part of the system that is not managing its budget?

Mr J.H.D. DAY: There will be a lot of continued engagement between the Department of Health and the Department of Treasury.

Ms J.M. FREEMAN: So the department will seek additional money from Treasury if it is not able to bring the deficit to zero?

Dr D. Russell-Weisz: I am aiming not to do that and to manage within the budget and the cash that I have at the end of the financial year. In my view, we need to have a culture of sticking to our budget whilst optimising patient outcomes and services. This year, I think we have shown that we have done significantly more activity and we have managed to bring our budget down. It is tough at times—there is no doubt about that. I think we just need to carry that forward into next year.

Ms J.M. FREEMAN: If the department carries a deficit forward into next year, because it wants everyone to live within their budgets—the director general is hoping it will get to zero; but, if not, the deficit will be carried forward into next year —

The CHAIRMAN: The question, member, please?

Ms J.M. FREEMAN: Yes. If the deficit is carried forward into next year, does that not mean that some other part of the health system will have to pay for it? The department will go forward, but it will already be taking money out of its budget for next year.

Dr D. Russell-Weisz: We get one appropriation, so we are measured on that one appropriation and we are measured on our expenditure, revenue and net cost of service. So, yes, where there are gains and where we have more money in one area that is not expended, it comes to a final figure. When I referred to next year, I was referring to our efforts and our strategies, which will continue into next year.

Mr J.H.D. DAY: I do not think people can complain about the government's commitment to provide substantial funding to our health system. In the eight years we have been in government, the funding has gone up from about $4.8 billion to $8.6 billion; the commitment has almost doubled.

Ms J.M. FREEMAN: The government has not managed it for the last four years—we get that.

The CHAIRMAN: Members!

[2.50 pm]

Mr J.H.D. DAY: The member would like less spent on the health system; is that right?

Ms J.M. FREEMAN: We would like the government to manage what it gets.

The CHAIRMAN: Members! Do you have a further question, member for Eyre?

Mr J.H.D. DAY: I trust opposition members will convey that to all their friends across the health system.

Mr R.H. COOK: We are explaining to them how incompetent the government is in managing budgets, yes. It is a key part of our approach.

The CHAIRMAN: Members, this is unhelpful!

Mr J.H.D. DAY: The need to operate within budgets is the responsibility of governments.

The CHAIRMAN: The member for Eyre has the call.

Dr G.G. JACOBS: In relation to deficits, there is uncontrollable demand and the money is not going around and is not meeting the budget. In the last eight years, the number of emergency department presentations has increased by 30 per cent. My question about this activity demand is: has any thought been given to diverting patients who are not acutely ill away from emergency departments, otherwise that 30 per cent increase in emergency presentations over the last eight years will become increasingly unsustainable?

Mr J.H.D. DAY: In short, it is the case that the better we make the public health system, the more people want to use it. We have been seeing that over many years. For example, there have been well over 100 000 presentations to the Fiona Stanley Hospital emergency department since the hospital opened—in fact, I think it is now in the order of 125 000, so it is up to about 350 a day. A lot of them are not of a high level of acuity and could be seen elsewhere. To answer the member's question about whether any thought has been given to diverting people away from hospitals, for many years there has been and there are GP after-hours clinics in some locations. I am sure that there is one in Midland, for example. There was one at Swan District Hospital and there is one at Royal Perth Hospital. There is not one at Fiona Stanley Hospital. I am not sure whether that has been contemplated, but I will ask the director general to add to that.

Dr D. Russell-Weisz: There is a GP clinic next to Royal Perth Hospital. A lot of thought and actions have been put into this over the last few years, with our interactions with the non-government sector, with providers such as Silver Chain, to provide more hospital in the home. If we look back eight years, there was very minimal hospital or rehabilitation in the home, but that has increased substantially. The commonwealth recently announced the WA primary health networks. Area health services will be working with them to increase hospital avoidance and also to treat more patients in the home. They tell me that they get a substantial amount of money from the commonwealth, and it is up to the area health service to work with it to reduce the demand on hospitals. Fiona Stanley Hospital, I think, saw its largest number of patients recently, at 359 patients a day. A lot of them are triage 4s and 5s, but it is a huge volume, putting a lot of pressure on the system.

Mr R.H. COOK: Let us have a chat about the state pricing policy. Over the last three or four years at least, member for Dawesville, the budget papers have referred to the weighted average unit price and the elusive convergence to the national efficient price. On page 319 of volume 1 of the *Budget Statements*, under the heading "Continued Investment In Public Hospital Services", it refers a little to the weighted average unit cost, but the government no longer wants to talk about the national efficient price. Hidden within budget paper No 3 is a critique about how the government is decoupling itself from the national efficient price. I am sure that is a medical procedure in itself.

Mr J.H.D. DAY: What was that comment?

Mr R.H. COOK: Decoupling might be a medical procedure in itself. I wonder whether the minister can provide an explanation for why the government has failed to arrest the increase in the weighted average unit price and why the government has now failed and, indeed, conceded that it cannot meet this convergence to the national efficient price.

Mr J.H.D. DAY: As the member indicated, it has been the aspiration of the government, and within the Treasury portfolio in particular, to do everything it could to move towards the national efficient price and not have such a large differential between Western Australia and elsewhere. As the budget papers indicate, we are currently about 17.8 per cent above the average national efficient price across Australia. About half of that is explained by the fact that salaries and wages in the health system in Western Australia are, generally speaking, about 20 per cent higher than they are in other states. Health professionals here, whether doctors, nurses, or allied health professionals or others in the health system, are paid very well compared with what people are paid in other states, which explains about half of the differential. The large size of the state, its remoteness and so on explains some of it and some other particular characteristics. As I recall, Treasury's recommendation to the government, through the Treasurer, was that it was simply not realistic for us to continue having the national efficient price as the target. It is clear that we need to limit the increasing costs in the state's health system, given the enormous pressure it is having on the state's finances, together with all the other pressures.

As indicated in the budget papers, the Health budget is now almost 30 per cent of the overall state budget. That has gone up from about 24.5 per cent when we came into government. That indicates that there has been a lot of growth in salaries and wages, growth in the number of services provided and the fact that we generally have an outstanding system. A decision was made to move to a different target and, therefore, the increase in this year's budget for hospital services is about 2.4 per cent for increased activity due to increasing population growth on an age-weighted basis and 1.5 per cent for salary and wage increases. Therefore, the overall increase for hospitals, as I recall, is around 3.9 per cent. That is, therefore, essentially the target for this year. I hope that answers the member's question.

Mr R.H. COOK: I thank the minister for his response. The health department's own documents—for example, the health funding and purchasing policy guidelines of 2015–16—project a price of $5 676, but the average weighted price has gone up to $5 776, representing a community service subsidy of $491. This is the community service subsidy that was previously sponsored by the Department of Treasury and Finance and was part of what was described as a rock-solid contract between Health and the Department of Treasury and Finance for the convergence with the national efficient price. What are the consequences for health? It is great that we are

spending more on health, but it is not good that we are becoming more and more inefficient. In fact, the weighted average unit price is increasing year after year. It is not being constrained and we are certainly not getting anywhere near the national efficient price. As taxpayers, should people not be concerned about that?

Mr J.H.D. DAY: The rate of increase is slowing, and that is really the important aspect. I will ask Angela Kelly to comment on the community service subsidy and any other additional information on this general issue.

Mr R.H. COOK: The minister does not have to talk about the CSS because it is not mentioned anywhere in the budget papers at all. The government has given up any commentary around the CSS. We do not need any explanation about the CSS because it is clear that the government is not constrained by it at all; it is now just in an open-slather exercise of not holding itself accountable to any measure on the weighted average unit cost.

[3.00 pm]

Mr J.H.D. DAY: I disagree with that.

Mr R.H. COOK: Show me in the budget papers where it uses the words "community service subsidy" in relation to the Health budget. It is not there.

Mr J.H.D. DAY: That does not mean to say that we are not aiming to operate in an efficient manner. I am glad the member is very supportive of us putting in place changes that will lead to a more efficient health system and that is more financially sustainable and affordable for the community. I appreciate the bipartisan support.

Mr R.H. COOK: I am, but the minister is clearly not, because he has given up on any sort of pretence that Health can get towards the national efficient price. There are two reasons for that. Our health department's system is getting more inefficient and other systems are getting more efficient, so this mythical convergence in 2021 to the national efficient price —

Mr J.H.D. DAY: As I said, it has been largely driven by higher salaries and wages in this state.

Mr R.H. COOK: Is it true that you have failed and have given up trying to reach that?

The CHAIRMAN: Members! Hansard is looking concerned. I am assuming that means they are not getting this on the record, so one at a time please.

Member for Kwinana, you have the call to ask a question. If you would like to complete that question and then allow the minister to answer, that would be appreciated by all of us.

Mr R.H. COOK: The question is: is there no longer any regard for the national efficient price?

Mr J.H.D. DAY: I will ask the director general to answer on this issue.

Dr D. Russell-Weisz: There is great regard for the national efficient price.

Mr R.H. COOK: As you wave it goodbye, as it goes out the door!

The CHAIRMAN: Members!

Dr D. Russell-Weisz: No; not at all. As I think I said in my last answer, we are taking budget rigour very seriously. We have to stay within our means. I and the team here are committed to that.

Mr R.H. COOK: I do not mean to interrupt but what is the benchmark because you do not talk about the national efficient price? That is where I am trying to get to.

Dr D. Russell-Weisz: There is reference to the national efficient price in that we continually look at the pricing from the national efficient price in other states. We have seen that they have been declining. The estimates have declined just over five per cent over the last five years from five per cent to 0.86 per cent. That is because other states have become more efficient and they have had lower wage cost growth. As the minister said, we now know—we have done an analysis—why we differ so much from the national efficient price. We have just conducted that analysis. As the minister said, around 50 per cent, and probably more than 50 per cent, is wages growth. Does that mean we give up? Absolutely not, because another 50 per cent can be split into three areas. We think 25 per cent is due to under-coding. As patients come in, are we coding them well enough? We have seen a huge increase in activity in outpatients this year and with inpatients. Some of that is due to better coding. That will allow us to get more money next year from the commonwealth because it funds 45 per cent of the national efficient price, and that will continue. That is the 25 per cent of the gap that we have to make a difference on. Twelve per cent of the gap as we see it is attributable to factors under management control, such as longer length of stays. Already 37 per cent of that gap is within our control. There are unique factors due to remoteness—location-based factors—that may be outside our control but every effort is being made to close that gap. We know that between 35 and 40 per cent is definitely within our control.

Ms J.M. FREEMAN: Minister, thank you for that answer through the director. The director said the commonwealth funds 45 per cent of the national efficient price and it will continue, yet on page 343 of budget paper No 2, the National Health Reform Agreement shows a $52.12 million reduction in income across the forward estimates. Obviously, the federal government has cut the department's funding. Is that because the department is not meeting the national efficient price and that it is effectively a reduction on the basis that this state is not as efficient as other states in meeting those targets?

Mr J.H.D. DAY: Which line is that on?

Ms J.M. FREEMAN: It is commonwealth grants on page 343 under "Net Appropriation Determination". It shows reductions from $359 million, to $311 million, to $313 million, to $287 million and to $270 million. Given that over that forward estimates there is a $52.12 million reduction income across those forward estimates, I question whether the commonwealth is rewarding the department by continuing to fund it at 45 per cent of the national efficient price or is saying that we are not meeting it, therefore, it is reducing its funding. Is that what is occurring there?

Mr J.H.D. DAY: I will ask Dr Russell-Weisz and then Andrew Joseph to comment.

Dr D. Russell-Weisz: I will defer that question about the grants to Mr Joseph because I do not think that reflects the full picture of what we get under activity-based funding from the commonwealth. Because we have done more activity this year, we have seen an increase. Last year, in 2014–15, there was a decrease in what we received from the commonwealth because we did less activity than we predicted due to the reconfiguration. Because we have done two per cent more this year than we predicted, and because of the recent Council of Australian Governments agreement on 1 April this year to maintain activity-based pricing, that will flow into our budget next year. I might pass to Mr Joseph.

Ms J.M. FREEMAN: Before you do that, after years and years of doing estimates, when you defer, someone starts talking about where it is. We always have to give you the line items. If you are going to say that you can grab some other mystical money from somewhere else and take it into future years—I have always said Health is like a giant Ponzi scheme, and I will put that on record again —

Mr J.H.D. DAY: That is a bit rough is it not?

Ms J.M. FREEMAN: In a Ponzi scheme someone borrows from here to sort of spend there.

I want it to be clear. If the minister is saying that that is not what the commonwealth is giving us, he needs to show me where it states that the commonwealth is giving us money.

Mr J.H.D. DAY: I have been able to find some detailed information. In the commonwealth programs between the 2014–15 actual and the 2015–16 estimated actual, the decrease of $90 million is mostly due to decreasing the following programs: $36 million for capital programs, $24 million for Department of Veterans' Affairs, $22 million for treating public dental patients and $8 million for various programs, including the Australian immunisation agreement vaccinations, Indigenous early childhood and trachoma surveillance. From that information, it is not in relation to hospital treatment. The reduction of $48 million predicted from 2015–16 to 2016–17 is mostly due to a reduction of $28 million for multipurpose service units.

Ms J.M. FREEMAN: What are multipurpose service units?

Mr J.H.D. DAY: I think I am right in saying that they are a combination of aged care and hospital services in smaller country locations. I am getting a nod from the back. There is also a $13 million reduction for adult public dental services, $12 million for an aged-care assessment program, $5 million for capital programs, $4 million for organ tissue donation and $5 million for various programs, including home and community care and various other things. Why they have been reduced specifically I am not sure, but it is obviously part of the agreement and forecasting between WA Health and the commonwealth. Do you want to add anything to that, Mr Joseph?

Mr A. Joseph: The table the member referred to is not the funding received for activity-based funding. It pertains to funding received from the commonwealth through national partnership agreements. The national health reform funding is contained on page 340 of the budget statements, and we can see that that shows there is growth over the forward estimates.

Ms J.M. FREEMAN: Can you take me to the actual line item?

Mr A. Joseph: It is under "Income".

Ms J.M. FREEMAN: Yes. We go from a budget of $1.7 billion in 2015 and it went down to $1.6 billion, which is what the director was saying before; that is, it reduced and it goes to $1.7 billion, $1.9 billion and $2 billion.

[3.10 pm]

Mr R.H. COOK: Just on that point, is the incentive funding around the national emergency access target and the national elective surgery target still in place or has it gone under the federal government's new arrangements?

Dr D. Russell-Weisz: The original NEAT and NEST through the National Healthcare Reform Agreement have gone, but we have kept the targets which now have the acronyms WEAT and WEST—the WA emergency access target and the WA elective surgery target.

Mr R.H. COOK: I noticed that as part of the changing language; there is no longer any mention of the national efficient price—NEP—and there is no longer any mention of NEAT and NEST. It is cute!

Mr J.H.D. DAY: One thing I have noticed in the last few weeks is that the number of acronyms in the health system has grown commensurate with the increase in the budget!

Ms J.M. FREEMAN: Just as a clarification for those of us who are not dealing with them all the time, I understand that NEAT is the national emergency access target and NEST is the national elective surgery target. The minister is saying that we no longer comply with those acronyms and now do Western Australian acronyms. We have de-coupled from those and we are doing Western Australian acronyms.

Dr D. Russell-Weisz: No, that is not quite right. The national partnership agreements on those specific programs have ceased, so we have said that we are going to keep with the targets set and led by Western Australia over the last eight years and the four-hour rule. We know that the four-hour rule has benefits—that is for NEAT—and we have just given it a purely Western Australian slant because the national program has ceased, but the targets are the same.

Mr M.H. TAYLOR: I refer to page 322 of budget paper No 2 and the third dot point under the "Other Patient Safety and Quality Initiatives" subheading; the dot point makes reference to Fiona Stanley Hospital in my electorate and initiatives to provide safe and efficient patient care. Can the minister please tell me about the services that have been provided at Fiona Stanley Hospital and these new initiatives?

Mr J.H.D. DAY: Since Fiona Stanley Hospital opened fully in February last year, the services provided—in number and, overwhelmingly, in quality—have been outstanding. As with any major project or new service that is introduced in which there are large numbers of people involved, it is always possible to find some patients who will not have the experience that they either expect or, in some cases, deserve; but overwhelmingly, the experience of patients there has been very, very positive. I am sure my predecessor had positive comments coming through and I know that my office also has received some. It has been a very busy hospital; to the end of April, there have been about 126 000 patients through the emergency department, averaging from 278 per day up to, as we said earlier, about 350. About 30 per cent of those patients are admitted; a further 51 000 people have been admitted as inpatients; 386 500 as outpatient clinical appointments; and 22 600 surgeries have been performed. Since the hospital opened in February last year, there have been 11 heart transplants, 26 lung transplants and 47 kidney transplants; all of those are obviously very major undertakings. More than 3 000 patients have been admitted to the intensive care unit since the hospital opened—the ICU unit there is one of the five busiest in Australia—and nearly 3 500 babies have been born there. Overall, it is operating very well and providing wonderful services to many, many thousands of people. I think that reflects the commitment of both clinical and nonclinical staff there and the pride they take in the service they provide to people. That was certainly apparent to me when I visited the hospital a few weeks ago. It was unsolicited, but the leaders and other staff of the particular units that I met with took a lot of pride in the outstanding treatment and services they provide.

Mr R.H. COOK: Is it true that at the end of 2015 Fiona Stanley Hospital had a weighted average cost of around $7 600 compared with Sir Charles Gairdner Hospital at $6 500 and Royal Perth Hospital at $5 900? Although this is a great Labor project the government is implementing and we are really pleased about that, are there not some significant cost problems in relation to Fiona Stanley Hospital? The operations the minister talked about are great, but they come at a great cost, do they not?

Mr J.H.D. DAY: Are those numbers in the budget papers?

Mr R.H. COOK: No, sometimes shadow ministers find out —

Mr J.H.D. DAY: One way or another.

Mr R.H. COOK: It was certainly not from the minister's reports, which he cut; I have to find things out through other means.

Mr J.H.D. DAY: I will ask the director general to comment; I do not know whether we can confirm the numbers or not, but in relation to the general aspect of what the member is asking, I suspect the fact that there have been substantial commissioning costs would explain the higher per unit cost there initially, and I trust that the unit cost will come down. That is my immediate response, but I will ask the director general for comment.

Mr R.H. COOK: The government has been promising that unit costs will come down for some time now!

Dr D. Russell-Weisz: I cannot confirm those unit costs, but I can say that it is the experience, not only in Western Australia but right around the world, that new hospitals when they open—especially complex hospitals such as Fiona Stanley Hospital—do have some inefficiencies. I really do not apologise for that because when we commission a hospital, we want it to be safe and we want it to have extra staff. If we go back to 2009 and look at Rockingham General Hospital, it had a much higher unit cost than many of the hospitals around the nation and that has now settled.

Mr R.H. COOK: Yes, but it has a great local member of Parliament, so we could not criticise Rockingham General Hospital!

Dr D. Russell-Weisz: It is now down to an efficient cost. We expect those costs to settle, but I do not think we would be able to comment on those costs at this time.

Ms J.M. FREEMAN: I refer to page 336 of budget paper No 2 and the line item "Royal Perth Hospital Redevelopment Stage 1" in the table headed "Works in Progress". This morning when I chaired the Treasury estimates hearings, the Treasurer outlined a list of ongoing projects and made a particular comment—I cannot quote him word-for-word—that this project was on hold pending any policy decisions. I note that there are funds allocated under that line item. Given that Treasury says this is not a project at this point in time, what is that paltry funding allocation for; and given Treasury's comments, is this another sign that the minister has failed to implement the government's election promise to redevelop Royal Perth Hospital?

Mr J.H.D. DAY: I am not sure if the member is saying that $17.371 million as an allocation to capital works is a paltry amount; I do not think most people would consider $17 million to be a paltry amount —

Mr R.H. COOK: Compared with the $200 million the government used to have in there it is not a hell of a lot.

Mr J.H.D. DAY: Maybe compared with the $7 billion that is being spent by this government on major health projects across the state, the member might have a point, but my point is that we have spent about $7 billion overall, which shows a very strong commitment to rebuilding the health system in Western Australia and allowing it to grow. There is about $8.1 million for 2015–16, as it says in the budget papers, and $9 million for 2016–17. Those works include essential maintenance works such as replacement of the lifts and other aspects that are underway.

Mr R.H. COOK: That is maintenance, it is not redevelopment.

Mr J.H.D. DAY: It is replacement. I will go through some of what is being undertaken. There are 24 projects listed, in fact, including the upgrading of the lifts, as I mentioned; the replacement of central cooling towers; the replacement of the emergency generator with a new emergency generator to prevent overloading, and additional emergency generators to run a chiller during blackout conditions; replacement of emergency generator sets; improvement of fire services; replacement of the central steam boilers; refurbishment or replacement of the rooftop cold water storage tanks; replacement of high-voltage breakers containing SF6 gas; low voltage switch replacement; replacement of patient meal service; a re-thermalising system; infrastructure enhancements to the acute medical unit and acute surgical unit areas; and other safety and compliance projects. This will ensure that the hospital is able to operate in a safe manner, as it has done for many years.

[3.20 pm]

Mr R.H. COOK: The minister will be familiar with this Liberal Party–blue billboard that has been stuck outside Royal Perth Hospital at the Victoria Avenue entrance that lists some of those items. Would the minister agree with me that replacement of the chiller, the steam boiler and emergency generation are all maintenance issues that would be undertaken as an ordinary part of government? The billboard also refers to patient catering food delivery upgrades, which I assume means replacing the trolleys! I put it to the minister that this is not stage 1 of a long-forgotten election promise in 2008 but simply maintenance exercises that any hospital undergoes as a matter of course. I refer in particular to patient ward fire safety upgrades resulting from an audit of the building that showed fire safety fell short. If this is stage 1 of the redevelopment, what is stage 2 and what will it cost?

Mr J.H.D. DAY: I do not accept that those projects are something that happens as a matter of course and are routine maintenance. Routine maintenance goes on any day of every week over the year. A $19 million commitment for these substantial upgrades is very significant. Obviously, as I said, the government spent a very large amount of taxpayers' money rebuilding and expanding the hospital system in the state. As wonderful as new equipment and facilities are, what is most important is the commitment of the people and the standard of care that is provided within hospitals. I have no doubt that Royal Perth Hospital meets that standard of care and has a very strong level of commitment by the staff there.

Mr R.H. COOK: Could the minister clarify the allocation of $19 million, because only $9 million is contained in the forward estimates? Does the sign outside Royal Perth Hospital list things that have already been done and

that were previously under the title of "holding works" for RPH and that the government has now reinvented as its stage 1 redevelopment? I appreciate that the staff and services being provided are important, but so is the honesty of the government. The Barnett government has promised in two elections that it would redevelop this hospital; and, in fact, the previous minister said that this would be a second-term project. I am simply asking the minister why the sign refers to $19 million when the forward estimates contain only $9 million? Is the minister trying to embellish this maintenance program to make it look as though it is doing something there? I ask again: if that is stage 1, what is stage 2 of the redevelopment of Royal Perth Hospital?

Mr J.H.D. DAY: That is to be determined, in relation to —

Mr R.H. COOK: Then it is a single stage, if there is no stage 2.

The CHAIRMAN: Can the member let the minister answer.

Mr J.H.D. DAY: As I said, it is to be determined, and by definition stage 2 will follow stage 1, but exactly when and what it will include remains to be determined. In relation to what is on the sign, I have not seen it personally. I will go and have a look sometime. An amount of $17 million was allocated originally, and $8 million will have been spent by the end of this financial year, with another $9 million to go; so nine plus eight equals 17. I am very familiar with the Royal Perth Hospital facilities and precinct. I have spent a lot of time in that area over the years, but I have not seen that particular sign.

Mr R.H. COOK: It is a fairly new sign, minister. Again, I ask: has the minister rebadged projects that were previously maintenance projects to try to make it look as though the government is redeveloping the hospital?

Mr J.H.D. DAY: I would not have thought so; no.

Ms J.M. FREEMAN: Will Royal Perth Hospital get a mental health observation unit, as has been given to other hospitals and for which there is an expectation in hospitals that it is important in terms of dealing with emergencies, and for the safety of patients and staff?

Mr J.H.D. DAY: To the best of my knowledge there is one mental health observation area in operation now and it is at Sir Charles Gairdner Hospital, and it has been operation for about two years. Of course, the government announced a couple of weeks ago that one is going to be provided at Joondalup hospital. It is desirable that they exist in other major hospitals. As to the thinking of Royal Perth itself, I ask for some advice from the director general on that.

Dr D. Russell-Weisz: It has been seen as a priority and it is probably on the next list of four items that would be a priority for Royal Perth Hospital and other hospitals.

Mr R.H. COOK: Is that stage 2 of the redevelopment of Royal Perth Hospital?

Mr J.H.D. DAY: It could be—who knows?

Mr R.H. COOK: The minister clearly does not! Perhaps the previous minister can tell us.

Ms J.M. FREEMAN: If it is on the list of four items for Royal Perth Hospital, what are the other three items?

Dr D. Russell-Weisz: Not off the top of my head, but there are —

Ms J.M. FREEMAN: Can you give me that by supplementary information?

Mr J.H.D. DAY: No, we are not going to provide it. We have not made any decisions about what further development is going to occur there.

Ms J.M. FREEMAN: Something is being handed to the minister from behind him—it is the list of four items. I did not raise the list of four items. The director said that the mental health observation unit was one item on the list of four items that are priorities. I am happy to sit here and guess what the others are. What are the other items that are priorities for Royal Perth Hospital? Can the minister list them? I understand there is a bit of paper that lists them, or would the minister like to provide it as supplementary information?

Mr J.H.D. DAY: They are generally relatively small projects, I understand. One involves a helipad. What are the other two?

Dr R. Lawrence: The other two clinical things on that top four are some refurbishment of the acute care unit, which provides the acute facilities for medical and surgical patients, and some refurbishment of the A-block wards.

Ms J.M. FREEMAN: Is it the case that those four items are currently not funded?

Mr J.H.D. DAY: That is correct.

Ms J.M. FREEMAN: Those are four items on the wish list. If they get from the wish list into the budget to add to the $9 million for Royal Perth Hospital redevelopment stage 1 will they also get a sign?

Mr J.H.D. DAY: We would need to give that careful consideration.

Dr K.D. HAMES: I refer to page 318, the third dot point on the health system overview, and the increase in expenditure of five per cent that the minister referred to in an earlier answer. Can the minister tell me how much the Department of Health has grown since the government came to power and how this increase in 2016–17 translates into services?

Ms J.M. FREEMAN: The member cannot even give us the amount!

[3.30 pm]

Mr J.H.D. DAY: He is asking for dollars. As intimated in the question, there has been a very substantial commitment by the government since it came into office in September 2008 to ensuring that we have a very well-funded health system. The member for Dawesville, my predecessor, has been very successful in ensuring there has been substantial growth in the amount of taxpayer funding that is allocated. There has been 80 per cent growth, from $4.8 billion up to $8.6 billion, which is having a major impact on the state's finances, as I said, together with major growth in other areas of government as well. What that has provided for is a significant increase in the number of units of service. This forthcoming year's budget provides for 879 392 weighted activity units—that is what WA uses—which are estimated to provide for over 628 000 inpatient episodes of care, nearly 1.1 million emergency department episodes of care and over 2.5 million service events in outpatient clinics and community settings. As I mentioned earlier this afternoon, the budget provides for cost growth in line with the public sector wages policy of 1.5 per cent per annum for hospital services and for savings from the agency expenditure review for non-hospital services, which totals over $148 million over three years from 2017-18 to 2019-20, for that $148 million to be allocated to provide hospital-based services. There has been substantial growth. It does show a very strong commitment by the government over the last almost eight years to ensure that we have a very well-funded and provided-for health system in the state.

Dr K.D. HAMES: When the minister referred to the last time he was Minister for Health, he said that the budget was about $2.5 billion and it is up to $8.6 billion. Can the minister advise what the compounding growth increases have been on an annual basis since that time to get to that figure?

Mr J.H.D. DAY: From memory, in 2000–01 the budget was about $2.25 billion. This forthcoming year the budget is about $8.6 billion for recurrent services and about another $500 million for capital works items. From recollection and from what the member has discussed with me, I think the compound growth rate is about five per cent a year.

Dr K.D. HAMES: It is eight per cent.

Mr J.H.D. DAY: Eight per cent a year. It is much greater than any other portfolio—there is no doubt about that. As I said, it indicates a very strong commitment by the government to ensure that we have a well provided for health system in the state.

Mr P.B. WATSON: I refer to page 319 of the *Budget Statements*, which states that the number of scheduled child health checks increased by 14 per cent in 2014-15 relative to 2013-14, and a further three per cent in the first half of 2015-16. Can the minister break that down into the number of health checks in regional areas versus the number of checks in the metropolitan area? Those figures could not possibly be right for the Albany region. From the feedback I have received from my community, the number of child health checks is very low because we do not have a paediatrician or enough nurses. Can I get a breakdown of those figures, even if I have to take it on notice?

Mr J.H.D. DAY: It is good that an issue that relates to community health services as opposed to hospital-based services has been raised, because it is a very important aspect of the health system, I must say. I am not sure whether we have information about the number of checks provided in different parts of the state. I will ask Mr Moffet to comment.

Mr J. Moffet: I have information for the whole of country, but not for the regions specifically. I can talk to those and the child health check outcomes to date. There are three child health check parameters. The first is zero to 41 days, and the percentage of children entering school who had the child health check in November 2010 was 82 per cent. As at December 2015, that is 97 per cent. In the 18-month-old child health check category, in November 2010 the rate was approximately 30 per cent. As at December 2015, it is 64 per cent. Finally, in the three-year-old category, in November 2010 the rate was 20 per cent. As at December 2015, it is 57 per cent. That is for country as a whole.

Mr P.B. WATSON: Can the information for the age groups be provided for the regions?

Mr J. Moffet: Yes, that is possible. I do not have that information with me.

Mr P.B. WATSON: Can I have that as supplementary information, minister?

The CHAIRMAN: Minister, can you please repeat for Hansard what are you prepared to provide?

Mr J.H.D. DAY: We are prepared to provide a breakdown by various country regions the information that the member for Albany is seeking in relation to the number of child health checks.

Mr P.B. WATSON: And can that be compared with the rates from the city?

Mr J.H.D. DAY: I suppose we can give a percentage for the metropolitan area.

Professor F. Daly: Yes, we will be able to provide those figures.

[*Supplementary Information No A45.*]

Mr R.H. COOK: I refer to the recruitment freeze process. How much money did the department save as a result of the recruitment freeze? I note that the Treasurer announced the lifting of the recruitment freeze effective from 12 May. However, a number of hospital admin staff are reporting that they still need to seek exceptions to backfill vacancies or positions. Is that still the case?

Mr J.H.D. DAY: If they do, it is not because of the freeze. I will ask the director general to comment in a moment. I am not sure whether we can provide an amount of savings; I am not sure whether that is really available. I make the point that given the critical nature of a lot of positions in the health system, a lot of exemptions were sought and almost all of the requests for exemption were approved by the Treasurer. I will ask the director general to comment.

Dr D. Russell-Weisz: The freeze has been lifted; there is no freeze at the moment. But there is a process of approval. The process of approval was there prior to the Treasurer's freeze. That approval is set in place and goes through the normal channels of management in hospitals. It then goes to the chief executive for endorsement or non-endorsement and through the department to me to create a new position or appoint a new position. A process is in place, but it is not a freeze. If it is approved, then the area health service can go ahead and create the position and advertise the position. We need good budget control and we need good staffing control and other controls as well. It is basically continuing what was in place prior to the government freeze.

Mr R.H. COOK: On the issue of staffing, I refer to page 318 and to the revised 1.5 per cent public sector wages policy. I assume that this is part of trying to rein in budgetary costs. The budget papers show that the consumer price index is predicted to rise to 1.75 per cent in 2016-17, 2.25 per cent in 2017-18, 2.5 per cent in 2018-19 and 2.5 per cent in 2019-20. If the government is going to hold wages growth to 1.5 per cent, does the minister acknowledge that the department will be forcing a real pay cut for staff? In addition, given that some enterprise bargaining agreements fall due around September this year, will the government seek to protect the lowest paid staff from the impact of those real wage cuts?

Mr J.H.D. DAY: The overall government policy, as we have discussed, is to fund a 1.5 per cent increase over the next two to three years. Whether the forecast inflation rate is achieved is a matter for debate. As I understand it, Treasury sometimes overestimates the amount of inflation forecast compared with what actually occurs.

[3.40 pm]

Mr R.H. COOK: That is what is planned against; one assumes it is mandated by the system.

Mr J.H.D. DAY: We need to take into account not only what is forecast over the next two to three years, but what it is expected to be for the current financial year—and that is 1.2 per cent, which is obviously less than 1.5 per cent. We also need to take into account the fact that there have been increases provided for all the health sector employees well above that 1.2 per cent in the current financial year. In relation to doctors, it has generally been a 3.5 per cent increase this year, for nurses five per cent and for other allied health personnel about three per cent. All of those are well above the current rate of inflation. In short, it is necessary to look at more than just one year; it is really necessary to look at the last couple of years together with the next couple of years.

Mr R.H. COOK: My question was: does the minister acknowledge that this will represent a real pay cut in relation to those CPI, and will he seek to protect the lowest paid workers? Obviously, there are some extremely highly paid workers in the health system and there are some very low paid workers as well. For those higher paid workers, there is probably a bit of fat in the system, but those lowest paid workers are doing it tough already, and the government seeks to maintain any wages growth for them below the CPI. Will the minister seek to protect the wages outcomes of those workers?

Mr J.H.D. DAY: If we take into account increases that have occurred this financial year together with those of the next financial year, there would not be any real reductions. The figures indicate that there would still be a real increase. In relation to whether higher paid workers might give up some of their increases for some of the lower paid workers, it is probably an interesting industrial relations suggestion that I suspect one or two employee representative organisations would not necessary agree with, if I can put it as delicately as that.

However, the overall policy is that if there are any increases provided above the 1.5 per cent, they need to be funded from within the system—the portfolio itself—so there would need to be savings found in some other way. If there could be greater efficiencies found or greater productivity amongst parts of the workforce, perhaps there would be room for some discussion there, so long as there is not a net cost to government, and therefore taxpayers, of more than 1.5 per cent.

Ms J.M. FREEMAN: Just keeping with that thought about net cost across the health sector, one thing the minister could consider and argue for in cabinet to ensure that low-paid workers were not disadvantaged would be to grant wage increases as an amount and not a percentage. I am not sure of the figure for 1.5 per cent, but there could be a $10 increase across the board, which would then become a greater percentage increase for low-paid workers, but a lesser percentage increase for those who could absorb that cost. That way, greater fairness for low-paid workers could be achieved. I understand that the minister is limited because those things go to the central agency, but will there be any consideration in the minister's discussions to ensure that low-paid workers in the health system are not disadvantaged by the Treasury's decision on wage increases?

Mr J.H.D. DAY: That is an interesting suggestion, and perhaps the member would like to consult the Australian Nursing Federation and the Australian Medical Association about whether they would be supportive of such a proposition! I am sure there are a lot of altruistic people around who would be interested to have a discussion about that proposition. As the member indicated, I am not involved in industrial negotiations in any detail, but if there could be productivity improvements and savings found as a result of changes being put in place that allowed for lower paid workers to receive a higher increase, perhaps that could be entertained. But I do not want to go too far in this area, because as I said, industrial relations strategy is not something I am directly responsible for; the Minister for Commerce is.

Ms J.M. FREEMAN: Further to the recruitment freeze, which is now over, and the process of now filling vacant positions, whether they are new or those vacated by someone else during the freeze, what is the time line for that process?

Dr D. Russell-Weisz: We try to turn these things around very quickly, so during the freeze process and prior to it, my colleague Angela Kelly and the workforce team would get the requests in that had been approved by the chief executive. They would come up to me and I would sign them within one or two days. There is no delay; if they have been signed off by the chief executive in the area health service, they will go quickly. Obviously, there is a process to go through at the hospital level, but usually if it is supported by the chief executive, I will support it.

Ms J.M. FREEMAN: I refer to the Fremantle Hospital and health service reconfiguration in the works in progress listed on page 336 of budget paper No 2. In the 2015–16, there was a total budget for this project of $5.5 million, but in the current budget total allocation has been slashed by over $2.3 million to $3.2 million, and there is only $617 000 to be spent in the 2016–17 year and nothing at all in the forward estimates. Has the government abandoned Fremantle Hospital's reconfiguration? How many beds have been closed at Fremantle in 2015–16 and how many further bed closures are planned, mainly over the forward estimates? I have further questions, but I will stay with those at this point in time.

Mr J.H.D. DAY: I will ask Dr Lawrence to comment on Fremantle Hospital.

Dr R. Lawrence: Fremantle Hospital has undergone the reconfiguration that was necessary and is operating within its 300-bed capacity, which is what it was enabled to do. Its reconfiguration works from the capital perspective centred around the day procedure unit, some works around some theatres to facilitate ophthalmology at the site, plus some local works to allow the consolidation so we are not spread out right across the hospital. We continue to look at the function of Fremantle Hospital, and that will be an ongoing process as we move into the new South Metropolitan Health Service over the next coming years.

Ms J.M. FREEMAN: Can I just confirm that Ms Lawrence is saying that the reconfiguration is finished, and, if that is the case, I assume the department will not relocate Fremantle volunteer transport services vehicles to be based at Fiona Stanley Hospital because the reconfiguration is completed? Is the relocation proposed; and, if it is, why is it being proposed?

Dr R. Lawrence: There is no proposal to relocate the volunteer transport services to Fiona Stanley Hospital.

[3.50 pm]

Ms J.M. FREEMAN: Will the Royal Perth Hospital eye clinic be relocated to Fremantle Hospital?

Dr R. Lawrence: There is no ongoing proposal to move the Royal Perth Hospital service to Fremantle.

The CHAIRMAN: I suggest that it would be appropriate to break now, if that suits the minister.

Mr P.B. WATSON: I have a question.

The CHAIRMAN: Are you prepared to take one more question?

Mr J.H.D. DAY: I always try to be as accommodating as possible.

Mr P.B. WATSON: I have worked with the minister for 16 years and I agree with him for the first time!

On page 333 of budget paper No 2, Under "Prevention, Promotion and Protection", it states —

> Prevention, promotion and protection services describe programs implemented to increase optimal health …

That is the prevention of health issues. I notice that in 2015–16 budget the government had $541 million, but it spent only $528 million. We were talking about the budget increasing to $8.6 billion. Would it not be better to increase prevention, rather than decreasing it, and then we would not have the former minister asking questions about how big the budget is? If we are not spending enough on prevention, obviously it will go up on a regular basis.

Mr J.H.D. DAY: That is always an issue and we need to aim to put as much into preventing illnesses and diseases occurring as we can. There is no question about that and that is very much the philosophy that I support. I am not sure why there has been a reduction from the 2015–16 budget to the estimated actual amount of $528 million. I am trying to find the relevant information in the notes that I have here.

Mr P.B. WATSON: You can do it on notice, if you like, minister.

Mr J.H.D. DAY: I am sure we have the information here. Could Mr Joseph please provide some information on this and then I will ask Professor Weeramanthri as well.

Mr A. Joseph: I point the member to the footnotes that accompany that table, which state that the information has been adjusted —

> … to ensure comparability with the methodology applied in deriving the 2014–15 Actual, the 2015–16 Estimated Actual and the 2016–17 Budget Target.

That is the only information that I can provide now. I am happy to do more research into that.

Mr J.H.D. DAY: Can Professor Weeramanthri add anything?

Professor T.S. Weeramanthri: This output is a composite output of a number of different areas, so, for example, it is not only the public health division, but also the Office of the Chief Medical Officer, Aboriginal health and child and community health within the Child and Adolescent Health Service. To get a full accounting of the difference between those two numbers, we would have to get the ons and offs for each of those specific areas. This is an aggregate of those ons and offs, so we would have to come back to the member with some further information on that.

Mr P.B. WATSON: Can the minister provide that by way of supplementary information?

Mr J.H.D. DAY: We will provide an explanation of the reduction in the budget for prevention, promotion and protection, as on page 333 of the budget paper, from $594.666 million allocated in the 2015–16 budget to the estimated actual amount of $578.891 million. We will provide an explanation of that change.

[*Supplementary Information No A46.*]

Mr P.B. WATSON: Obviously, these strategies are not working overly well. Are there any plans to look outside the square or find other ways or look overseas or interstate? This is $8.6 billion; it cannot keep going up like that. Have any strategies been put forward by the Department of Health to try to bring this figure down?

Mr J.H.D. DAY: There are a lot of ongoing public health strategies, advertising campaigns, promotion campaigns and so on, whether it is providing support for anti-smoking promotion, which is very much an increasing issue in the community —

Mr P.B. WATSON: What about the Fremantle Dockers supporters; does the minister have anything for them?

Mr J.H.D. DAY: No. Maybe that needs to be given an increased amount of attention in the next couple of months, but increasing obesity in the community is obviously a major problem, and particularly in remote areas of the state, but not only.

Mr P.B. WATSON: I walked through the city today at lunchtime and it is not only up north; it is huge.

Mr J.H.D. DAY: Fair point. We could have an hour discussing that issue, but Professor Weeramanthri might want to provide some additional comment. Obviously, this is a very big issue.

Professor T.S. Weeramanthri: Investment in prevention and public health has a fantastic return. The state government's investment in this area has kept pace with inflation over the eight years I have been here. It is not

as though it has diminished; it has grown but at the rate of inflation. We continue to look at really effective ways to provide some services that have been for 50 or more years known as fantastic investments, such as immunisation or other core services. We are also looking at new ways of driving forward public health and one of the main changes that will, hopefully, occur this year is the new Public Health Bill. If passed, we will have a new act after over 100 years and a whole new framework for addressing new and emerging public health risks for the twenty-first century.

Mr P.B. WATSON: Professor Weeramanthri said it has kept up with inflation, but should it not be higher than inflation? It should be one of the major projects, so if it is going up only with inflation, we are just keeping it steady. Should more money be put into it?

Mr J.H.D. DAY: Of course, we would always like to do more, but we need to take into account that people who are ill need treatment and expect it, and the overall financial settings of the state. I appreciate the aspiration and I share that.

Ms J.M. FREEMAN: The Public Health Bill is in the upper house. Does the minister know whether it is listed and whether it will go through the upper house within a short period? Is the minister having discussions with his colleagues in the upper house to ensure that this very important piece of legislation that will give this new structure will get through and be pushed forward?

Mr J.H.D. DAY: I am not sure whether it is on the list to be completed before the end of June, as much as we all would like that to occur, but certainly I hope it will be fairly early in the resumption of sittings in August. We certainly want to get it through this year.

The CHAIRMAN: We will have a 10-minute break and resume at 10 past four.

Meeting suspended from 4.00 to 4.11 pm

Dr G.G. JACOBS: I refer the minister to the fifth line item on page 337 of the *Budget Statements* in relation to St John of God Midland Public Hospital. It is from time to time quite maligned by the opposition, but I know that the hospital is now open. Can the minister update members on the transition from the Swan District Hospital to the new $344 million Midland Public Hospital?

Mr J.H.D. DAY: The transfer from Swan District Hospital overall has gone very well. The hospital's formal opening was on 24 November last year—I have never been—obviously by the then Minister for Health, the Premier and quite a number of other members of Parliament. It is a very substantial investment by the state and the commonwealth governments in providing world-class hospital services to people in the east metropolitan region. A number of patients have been seen up until the end of April. More than 25 000 people have presented to the emergency department, there have been 28 000 outpatient attendances and over 650 births. Nearly 9 000 patients have been admitted to the hospital, and also there have been 130 sessions in March and April of this year at the chemotherapy unit that commenced services in December 2015. It is a public–private partnership project of course. Public hospital services are being provided by St John of God Health Service, and overall it is going very well. As I said earlier, particular examples can always be found of things that do not go as well as perhaps people expect; however, it is an outstanding facility, and I have no doubt people will be overwhelmed by the very high standard of care it provides. It has been a very welcome development. The $360 million project was roughly funded half by the state government and half the commonwealth government, and it is of great benefit to the east metropolitan region. It has very much added to the overall development in the Midland precinct, together with the major police facilities there, the commitment for the Curtin University facility, which will be there, and all of the other redevelopments that occurred under the Metropolitan Redevelopment Authority.

Mr R.H. COOK: In relation to that, I draw the minister's attention to the private sector contracts expense on page 340. Could the minister provide us with details of the contracts covered under this line item? Why has it increased by about $30 million, and what are the government's plans with regards to privatising further services in health?

Mr J.H.D. DAY: I think the best thing might be to go to Mr Joseph for this question.

Mr A. Joseph: Sorry, I missed the question.

Mr R.H. COOK: It is about private sector contracts expense under "Income Statement" on page 340 of the budget papers. Can details of the contract and their values be provided as a subset of the $671.7 million? What further plans does the government have for private sector contracts through privatisation?

Mr J.H.D. DAY: To my knowledge, we do not have any additional projects in mind that involve the private sector but that does not mean that it would not be a good idea at some stage. We have a hybrid model really, in

which some hospitals operate entirely through the public sector and others run in conjunction with the private sector, but that does not mean that any lower standard of treatment is provided, of course. I will ask Mr Joseph to comment on the change in the cost.

Mr A. Joseph: Thank you, minister. That line item obviously refers to the private sector contracts with the private providers in Midland, Peel and Joondalup. At this stage, I do not have the information to advise the member what other private contracts are included in that amount. In response to the member's question, I am happy to look into that, but bear in mind that there are some sensitivities in dealing with individual contracts and detailing contract values that are generally considered to be commercial-in-confidence.

Mr J.H.D. DAY: Is Mr Joseph able to give a general explanation as to why there is an increase from $648 million in the 2015–16 budget up to $671 million? I presume it is increased activity and is reflective of the increase in cost, which would be planned for.

Mr A. Joseph: Contracts are struck with respect to activity and price adjustment. They increase in 2016–17. It is a guess on my part at this stage, but it reflects increased activity that we expect in 2016–17, delivered through the private contract hospitals.

Mr J.H.D. DAY: I am advised that the change also reflects the fact that the new Midland Public Hospital started to operate under the new arrangements from November last year, not for the full financial year. That therefore explains some of the increase in 2016–17.

Mr R.H. COOK: I wonder whether the minister is offering to provide a breakdown of that line item by supplementary information.

Mr J.H.D. DAY: I was not; no.

Mr R.H. COOK: Okay. Mr Joseph said it would require further research.

Ms J.M. FREEMAN: Further to that, there was a concern around confidentiality but we are not asking for the amounts, we are asking for breakdowns of what the contracts are. We do not need the amounts but there should be transparency in what private contracts the public health system has with organisations.

Mr J.H.D. DAY: As has been explained, the main contracts are with Ramsay Health Care and St John of God Health Care. From my recollection, quite a bit of information about the contracts is available. It is probably not the figures, but —

Ms J.M. FREEMAN: Is it available somewhere publicly? No, it is not available somewhere publicly, so can it be provided as long as it does not have the amounts attached?

Mr J.H.D. DAY: I will seek advice about what can be provided. I agree that there should be as much transparency as possible but we need to ensure the public interest is protected, of course. It is not about protecting the government's interest; it is about protecting the public interest.

Ms J.M. FREEMAN: There was lots of nodding.

Mr J.H.D. DAY: I will seek advice about what further information we can provide about what is contained within the "Private sector contracts expense". It is on page 340 of the budget papers. I undertake to provide further information about what is contained within that line item.

[*Supplementary Information No A47.*]

Mr R.H. COOK: Can the minister clarify whether the private contractor expenses include payments to Capella Parking consortium? I want to know how much money Capella Parking put into the trust account in 2015–16, what the estimation is for 2016–17, and how much will be paid out of the trust account to Capella Parking consortium under the private sector parking contract for those two years?

[4.20 pm]

Mr J.H.D. DAY: Capella has the major new parking facility on the Queen Elizabeth II Medical Centre site.

Mr R.H. COOK: It includes all parking on the QEII site.

Mr J.H.D. DAY: That is the new facility and other parking on the QEII site. Essentially, there has been a big increase in the parking capacity available at that location, as is necessary with the development of the Perth Children's Hospital. For further information, I will ask Mr Salvage to comment.

Mr W. Salvage: Could I seek a clarification on the reference to "trust"?

Mr R.H. COOK: I understand that the way the contract with the Capella Parking consortium operates is that Capella, through its consortia, collects all the parking revenue at QEII. It is then required to put that money into a trust account and what comes out of that trust account is the agreed value of the contract and, therefore, the trust account is topped up by the government. As someone who holds great store in transparency and

accountability, I want to know how much Capella collected last financial year and will collect in this financial year, and how much will be paid out of that trust account to Capella in the last year financial year and this financial year.

Mr W. Salvage: We will have to take the details of that question on notice. There is an arrangement whereby the fees for parking at the QEII campus are actually set by the QEII Medical Centre Trust and there is a pass-through arrangement whereby the revenue collected is passed on to Capella. We can provide the member with advice on what the pass-through component of the contract is for this year and last year.

The CHAIRMAN: Minister, can you define for the clerk that supplementary information.

Mr J.H.D. DAY: We will provide as best as possible the information that Mr Salvage has just referred to. We will of course need to seek advice that any information we are putting out there will not go against the public interest. Within that constraint, we will seek to provide the information that has been sought in relation to Capella and parking at QEII.

[*Supplementary Information No A48.*]

Dr K.D. HAMES: I refer to page 328 and seek clarification about some of the figures in the line item "Efficiency Indicators". At the bottom of that page it states —

> **Explanation of Significant Movements**
>
> (Notes)
>
> 1. The variance between the 2015–16 Budget and 2015–16 Estimated Actual Cost Per Capita of Supporting Treatment of Patients in Public Hospitals is due to efficiency improvements.

The line item shows that, indeed, it has gone from $29 in 2014–15 to $28 per capita in 2015–16. When I look at that I think that that is pretty good, but how did we get there? Then three lines above at line item "Average Cost per Casemix Adjusted Separation for Tertiary Hospitals" the budget figure has gone up, albeit less than the actual. The budget figure for non-tertiary hospitals has also gone up, as has the figure for the "Average Cost of Admitted Public Patient Treatment Episodes in Private Hospitals" line item. How do net costs come down when the rest of the costs are going up? Perhaps the explanation is in the first line. Is it because there has been a decrease from the actual in 2014–15 of $8 286 000 to the estimated actual in 2015–16 to $7 917 000? If so, that would be reasonable.

Mr J.H.D. DAY: I will ask Mr Joseph to answer that question.

Mr A. Joseph: The efficiency measure line item "Cost per Capita of Supporting Treatment of Patients in Public Hospital" is not the same as "costs per national weighted activity unit". These are support costs. Included in those costs are costs such as those allocated to the Department of Health or the supporting infrastructure to support the delivery of hospital services. It is basically the overhead cost, and the cost per capita of those support costs in treating patient has reduced, reflecting the fact that non-hospital services costs or support costs have become less and, therefore, more efficient over that period.

Ms J.M. FREEMAN: I refer to the works in progress on page 336 of budget paper No 2 and the fourth line item from the bottom of the page "Remote Indigenous Health". The 2016–17 budget papers forecast that total project expenditure will reach a total of $13.9 million by 30 June 2016, with $6.8 million required to complete the project in the two subsequent financial years. However, the 2015–16 budget—last year's budget—expected total project expenditure to reach $18.7 million by 30 June last year. That project should have been completed by the 2016–17 financial year. Would the minister explain why there appears to have been a two-year delay in the completion of this important regional health project?

Mr J.H.D. DAY: What line is the member referring to?

Ms J.M. FREEMAN: I am referring to the line item "Remote Indigenous Health".

Dr K.D. HAMES: What page?

Ms J.M. FREEMAN: I am on page 336. I think there is a bit of mansplaining going on!

I refer to the fact that page 140 of last year's budget papers, which members will not have before them, shows that expenditure was to reach $18.7 million by 30 June last year. There has been a delay in this project. My question is: why has there been a delay in the completion of this important regional health project?

Mr J.H.D. DAY: This project will provide a number of new and extensive refurbished clinics and staff accommodation to assist in the delivery of improved health services to Aboriginal communities throughout the state. For example, a tender has been awarded for the Noonkanbah staff accommodation project. Construction has been on hold due to the road not being trafficable for large vehicles and due to the service issues that have

affected construction. Both of those issues are in the process of being rectified by the contractors on site in late April this year. I presume that explains in part why there has been a change in the expenditure. There has been a revised building conditional audit report for the Jigalong Health Clinic. I am advised that that is currently being refined for refurbishment works. A variation to the memorandum of understanding has been submitted to the Department of Regional Development. It is currently being finalised and that includes adjustment to cash flows and the objectives and priorities following a financial reconciliation. Planning is being done for other objectives, including staff accommodation at the Wangkatjungka and Looma communities and planning for security infrastructure at Lombadina and One Arm Point is due to be completed by August this year. There is other information here about identified unallocated program-wide dollar value of $2.4 million. I am not sure whether that fully explains why there has been a variation between last year's budget and this year's budget. I will ask Mr Moffet to add any further comments.

[4.30 pm]

Mr J. Moffet: This program has always had a scope, I guess, to deliver as many clinics in a prioritised order as possible. Given the delivery of these projects is in very remote areas, it is structured and planned to deliver clinic by clinic. There has not been too much parallel construction. We have recently finished Noonkanbah and Yandeyarra. Obviously, as cost plans were finalised, the projects were managed to their completion. We are now finalising planning for Wangkatjungka and Jigalong. I would not say there has been a delay in the program. The program was always going to be complex because of the nature of the clinics, the planning involved and the remote cost structures. I do not have last year's figures, I am sorry, so I cannot reference that, but in terms of program delivery, I think we have been fairly satisfied internally that we are delivering the right projects in the right time frame.

Mr R.H. COOK: One of the things that has struck me as unusual, and, hopefully, it is unusual from the member for Dawesville's point of view also, is that there is no mention of Aboriginal health in the commentary or in the major spending decisions in the budget, particularly the Footprints to Better Health program, which was championed by the previous minister. My understanding was that the Footprints to Better Health program was allocated about $16.5 million a year and that it would land next year and, I think, finish at the end of the 2017–18 financial year. It is not mentioned anywhere, so I seek the minister's assurance that there is $16.5 million, which had been budgeted in 2016–17, and $16.9 million for 2017–18, as was forecast in last year's budget. Where has this money gone under Aboriginal health services expenditure in the budget? What are the department's plans for this program going forward?

Mr J.H.D. DAY: There is a big commitment by both the state and commonwealth governments to improve outcomes in Aboriginal health. That is a very general statement but in relation to the Footprints to Better Health program in particular, I ask Mr Moffet to advise.

Mr J. Moffet: Funding is maintained as per the previous decision for 2016–17 and 2017–18, with some indexation. The total funding for footprints is $28.8 million for this year. The department itself —

Mr R.H. COOK: Is that $28.8 million for 2016–17?

Mr J. Moffet: It is for 2015–16—this financial year. Essentially, the government approved part funding for the program, and it is $15.98 million for this year. The former minister asked the department to review, and ensure that we re-funded all the good programs so 88 per cent of the footprints funding was assessed by Professor Holman. The total funding this year is $28.877 million and there is indexation for the next two years.

Mr R.H. COOK: One of the programs that was defunded was the Aboriginal maternity services program in Midland. Is there a particular reason why the department has decided not to fund that going forward?

Mr J.H.D. DAY: It was a commonwealth-funded program.

Mr R.H. COOK: I know it was a commonwealth program, but we took it over for 12 months. I wonder why we thought it was not worth continuing.

Mr J. Moffet: To be honest, I am not familiar with that program being funded by footprints. If it was defunded through the footprints review and re-funding process, it would have been because it was rated lower than good or above. That was a very consistent policy position from government.

Mr J.H.D. DAY: Mr Salvage can comment a bit further on that.

Mr W. Salvage: The Moort Boodjari Mia program was funded as part of the commonwealth's Indigenous early childhood development program. It was commonwealth funded. A decision was taken this year to continue funding for one year, with savings elsewhere in the budget to provide an opportunity for women enrolled in the program to complete their courses of care and to see whether there were opportunities to have some other provider pick up the program, but that has unfortunately not been the case.

Mr R.H. COOK: You could not find another provider for the program?

Mr W. Salvage: Opportunities were explored to have the program potentially taken up by other providers and that has not been successful to this point.

The CHAIRMAN: Member for Dawesville, have you got a further question in this line of questioning?

Dr K.D. HAMES: That was going to be my question. Why is it not visible within the budget? Why is there no commentary on the program within the budget documents?

Mr J.H.D. DAY: Is that the Footprints to Better Health program in particular?

Dr K.D. HAMES: Yes. Where do we find the figures in the budget that have just been mentioned, but there is no commentary?

Mr J.H.D. DAY: I am not sure whether there has been a change in that amount of detail this year compared with last year's amount. I will ask the director general to respond.

Dr D. Russell-Weisz: All I can say is that I can see the point in relation to no comment in the budget papers, but the focus is still there with a commitment to Footprints to Better Health and the amount of money put forward for this year for the good and above good programs. Although there is no comment in the budget, the commitment from the Department of Health is equally there.

Dr K.D. HAMES: Thank you. I suggest that it would be a good idea to have it in future budget papers.

The CHAIRMAN: I have an indication from the opposition committee that they would like to conclude this division. Is everyone happy with that?

Dr G.G. JACOBS: I have a question.

Mrs M.H. ROBERTS: We have two more divisions to do before six o'clock.

Dr G.G. JACOBS: I refer to the first dot point on better health, better care, better value on page 320. My question is about the enablers mentioned in the commentary, particularly around accountability, financial management and ICT. Since a lot of our discussion has been around value for money, what is being done and what will be done in light of the Auditor General's report into the central computing service project, released in February 2016, whereby 79 variations to the contracts added $81 million in costs, and many of those variations were not properly authorised?

[4.40 pm]

Mr J.H.D. DAY: The issues around that particular project have been well publicised through the Auditor General's report. It is well acknowledged that there was not the supervision and governance that really needed to be in place, and money was expended that was not a good return for taxpayers, to put it mildly, as I understand it. There has been a substantial effort within the Department of Health to ensure that there is much better supervision and oversight of ICT projects. I will ask the director general to comment briefly, and then the deputy director general, Rebecca Brown.

Dr D. Russell-Weisz: I acknowledge the member's question and the considerable work that was started by my predecessor, Professor Bryant Stokes, through Rebecca Brown as deputy director general, in relation to improving ICT governance. ICT governance has been substantially improved; there is now sound reporting and accountability scope and overall governance in ICT management. I think that is reflected in the fact that we have been funded this year with $53 million for a replacement radiology information system for the whole state. That has been a priority for Health; Treasury accepted our argument in relation to what are very tight financial times, and we now have that secured through this budget.

Mr R.H. COOK interjected.

Dr D. Russell-Weisz: ICT, as the member knows, has had some challenges. Because we now have robust governance, we can see what our priorities are—our radiology system, and our patient administration system. We now have a plan for the future. We also have an ICT strategy and an ICT executive board, and I am much more comfortable about the visibility we have going forward. We have done a very detailed review on top of what the Auditor General has done in relation to the particular contract the member is talking about. I will pass on to Rebecca.

Mrs R.A. Brown: Yes, just concurring with the director general, WA Health accepted all of the recommendations and, as the director general pointed out, it was the previous director general who highlighted these matters to the Auditor General and requested that the audit be undertaken. Significant work has been done over the last two and a half years in the governance, planning and decision-making around ICT, and also significant work has been done in rolling out a procurement reform agenda across WA Health, including the

establishment in mid-2014 of a robust delegations and authorisations schedule with regard to all matters of procurement and contract variations. In addition, it has been equally important to roll out an intensive training program across many areas of WA Health, but particularly the area that manages our ICT projects. In that regard, we have made a number of changes in that organisation to ensure that robust checks and balances are in place. We have separated the finances, procurement and contract management from the technical ICT area so that there is more robust governance of that organisation and of ICT more generally.

The appropriation was recommended.