Division 9: WA Health, $4 508 870 000 —

Ms W.M. Duncan, Chairman.

Dr K.D. Hames, Minister for Health.

Prof. B. Stokes, Acting Director General.

Mr R.W. Salvage, Executive Director, Resource Strategy.

Dr D. Russell-Weisz, Chief Executive, Fiona Stanley Hospital Commissioning.

Mr S. Matthews, Acting Chief Executive Officer, WA Country Health Service.

Dr S.P. Kelly, Chief Executive, North Metropolitan Health Service.

Mr I. Smith, Chief Executive, South Metropolitan Health Service.

Prof. D. Jones, Executive Director, Performance Activity and Quality Division.

Mr M. Morrissey, Acting Chief Executive, Child and Adolescent Health Service.

Mr G.A. Jones, Chief Finance Officer.

Dr A. Robertson, Acting Chief Information Officer, Health Information Network.

Prof. T.S. Weeramanthri, Executive Director, Public Health and Clinical Services Division.

Mr C. Allier, Chief of Staff, Office of the Minister for Health.

Mrs M.A. Robinson, Policy Officer, Office of the Minister for Health.

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

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

It is the intention of the Chair to ensure that as many questions as possibly 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 within the current division. It would greatly assist Hansard if members can give these details in the 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 to the committee which supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the committee clerk by Friday, 30 August 2013. I caution members that if the minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office.

I now ask the minister to introduce his advisers to the committee.

[Witnesses introduced.]

The CHAIRMAN: Are there any questions?

Mr R.H. COOK: I refer the minister to page 129 of budget paper No 2, volume 1. The budgeted increase of 4.5 per cent for line item of "Total Cost of Services" across the health budget stands in contrast to average growth over the previous five years that the minister has presided over of around eight per cent. Can we really take this document seriously and does the minister really expect to restrict growth in the health budget over the next 12 months to 4.5 per cent when he has not managed to do that any point during his time in this portfolio?

Dr K.D. HAMES: The real increase in budget for hospital services is seven per cent, and the member can see that at the fourth dot point on page 132. The reason for that is to do with accounting, and I will ask Wayne Salvage to clarify that in a minute. The difference is an accounting matter largely for stuff at Fiona Stanley Hospital that was capital and had to become recurrent. A large chunk of that funding—about $147 million—was in the 2012–12 financial year. In the table on page 130, under the line item for expensed capital, there was $140 million in 2012–13, which goes down to $18 million in 2013-14, which is just accounting terms. If the member can imagine that, down the bottom of each budget is a lump of money. The figure for 2012–13 is much bigger than the figure for 2013–14, and neither of those relates to actual hospital expenses; they are accounting figures. Above that is the budget that provides for health services. Over the big lump for 2012–13 is the total amount that we actually spent on health services. Under the much smaller lump for this year is the amount that we spent for health services. The difference between the top figure and the bottom figure is only 4.5 per cent, but the difference between the two amounts is actually seven per cent. I will ask Wayne Salvage to clarify.

Mr R.W. Salvage: That was a pretty good explanation. I will point to two factors in the construction of the Department of Health's budget that will explain the differential between the seven per cent and the 4.5 per cent. As the minister said, significant capital expensing occurred in 2012–13. I emphasise that these expenditures are approved as part of WA Health's capital works program but which are decided, in terms of their expenditure recognition, to be recognised as part of the Department of Health's expense. In 2012-13 there was recognition in the expenditure side of the budget of around $140 million. The minister has referred to some of those items. The most significant component of the $140 million was funding that was originally allocated as part of the Fiona Stanley Hospital budget, and which came across into the expenditure side of the budget in respect of the facilities management contract funding. Other significant components of that expensing include funding for the Western Australian Institute of Medical Research developments—one at Sir Charles Gairdner Hospital and the other at Fiona Stanley Hospital. Again, this is money that was allocated by the state as capital expenditure, but because it was then provided to a third party operator to build the buildings it became recognised as an operating expense. For example, as part of that $140 million, $25 million was recognised as an expense for the QEII Medical Centre for the WAIMR north facility, and $18 million for the WAIMR south facility. Those are quite exceptional expenditures and, as the minister said, the impact of having a difference of $140 million in 2012-13 down to $18 million in 2013-14 obviously depressed the overall expense growth. I have done a brief calculation and with the minister's concurrence I will show the impact of those adjustments. If we take out expense capital on both sides of the budget in 2012–13 and 2013–14, and if we also add back in the second factor I was going to refer to which is that there has been approved funding for the extension of the Closing the Gap program into 2013-14, that $31.8 million does not currently form part of the health department's budget that we are talking about today. It is held in a separate Treasury-administered account. It will come across into the health budget as a result of decisions that have now been made. If the member takes those two components—

[9.10 am]

Mr R.H. COOK: Is Mr Salvage saying that is off book at the moment?

Dr K.D. HAMES: It would normally be in our current budget for this year.

Mr R.H. COOK: What is that amount again, sorry?

Mr R.W. Salvage: It is $31.8 million. I refer the member to page 333 of budget paper No 2, which is part of the Treasury's appropriation. About halfway down, item 40 recognises the $31.8 million for Closing the Gap funding. It has been approved as part of the budget; it is not part of the Department of Health's budget at this point. If we take both the expense capital and recognition of Closing the Gap funding into account, the movement between last year's final estimated budget and this year's current budget is 6.8 per cent.

Dr K.D. HAMES: That is still tight. A seven per cent growth in budget is still difficult. We have seen this year's growth. Over the past year in presentations, particularly in the emergency department, we have seen growth start to flatten a bit so growth has not been as great in recent months as it was before. Our funding is now activity based, federally and state, so it will be difficult, but we have to manage within our means the same as everyone else.

Mr R.H. COOK: I still calculate that health is about $150 million out in terms of an explanation for the modest growth budgeted. The difference between last year's budget and this year's is around $309 million. That capital of around $140 million has been expended, which leaves about $187.4 million outstanding. The Closing the Gap of about $31.8 has been included, so there is $156 million that is not explained by the 4.5 per cent increase.

Dr K.D. HAMES: Wayne Salvage has been through these numbers over and over, so it might be easier for him to explain it. One per cent is about $70 million. There is $120 million in that line, plus the extra $30 million for Closing the Gap. That is $150 million, which is two point something per cent. A couple of other little things will come into the budget that are not here.

Mr R.W. Salvage: To pick up on the previous comment; if we are looking at underlying expense growth in the health department's budget, I think it is reasonable to recognise the Closing the Gap funding that will come into our budget, which is not in the framing the member has before him. Plus we need to take out the impact of the expense capital, which is an abnormal expenditure, if we like. If we take out expense capital both in 2012–13 and 2013–14 and add back Closing the Gap funding in 2013–14, the actual growth from year to year is $462 million compared to the $309 million headline growth the member can see in the budget.

Dr K.D. HAMES: Which is 6.8 per cent.

Mr R.H. COOK: Is the minister saying that even though the department has never achieved that 6.8 per cent growth, it will get it this financial year?

Dr K.D. HAMES: We cannot say we "never achieved" it. The previous budgets will show that every year shows an accounting anomaly. It drives us crazy trying to work out what we are getting to spend on health. Each time there have been accounting changes or accounting figures and adjustments that mean the actual health spend is a certain amount, our health spend has gone up by that sort of percentage. Wayne, have you worked out what the health growth spend has been each year for the previous period as opposed to our overall percentage change in budget?

Ms J.M. FREEMAN: Can you speak a bit louder?

Dr K.D. HAMES: He is giving me advice, not you; he is not answering the question, he is telling me something.

Ms J.M. FREEMAN: Do you want to tell us?

Dr K.D. HAMES: I am just assimilating his answer.

Mr R.H. COOK: Is the minister saying that the growth in the health budget of an average of about 8.2 per cent each year is down to accounting irregularities?

Dr K.D. HAMES: No. There are some each year that make it varied, but, generally, that rate has been about what our growth has been. Yes, this year our initial expenditure allocation for the year is about one per cent less. Of course, at the midyear review, which is coming up in about two months, we get refunded according to our actual activity—whatever comes through the door. Last year we got $85 million extra at the midyear review and that reflected the actual health demand coming through the door. I do not know whether we will need extra this year because emergency department demand has eased off marginally over the past three or four months. We will see how we go. It is a little different in health budgets compared to normal budgets. Everyone else gets an allocation for the year and we get an allocation that is adjusted according to demand management during the year. I think each year at midyear review we have had some extra funding, depending on the demand.

Mr P.B. WATSON: I refer to "Emergency Department Services" on page 133. In a recent question on notice I asked how many fly in, fly out specialists have been employed at Albany Hospital. I was told they are not employed by Albany Hospital, but 25 individual specialists, who are not residents in the great southern, were contracted. The costs for those were air fares, $110 000; accommodation, $20 000; and car hire, $40 000. The 25 specialists were contracted for 15 000 hours, but I was not told how much they cost. Can the minister tell me how much those 15 000 hours cost? Would it not be better to encourage people to be there full time rather than on a rotational system?

Dr K.D. HAMES: It is a good question, member, and it relates to what was in the media recently about the whole state. We fly specialists where we have to and carefully weigh up those options. Sure, it is much better for a specialist to be there full time, if we can get someone and if we need someone full time. We need to compare the difference in cost between when we might need someone there for only 10 to 20 weeks a year, with having someone there for the whole year. We weigh up those things all the time for the whole state. There are people available for relief work. There might be a surgeon down there who goes on leave or for professional development, which is another common reason for them moving away. We backfill their position to make sure places such as Albany get the service they expect. But our health department people do that within their budgets and make the best use of the money they have. That is a common feature. I am happy to pass the question onto the person responsible so he can explain how he works it out.

Mr P.B. WATSON: He will retire in Albany, so he wants to make the hospital look good!

Dr K.D. HAMES: Shane Matthews is acting country health director. Shane, do you want to have a crack?

Mr S. Matthews: Certainly. Our goal is to employ as many specialists and doctors on a salary basis under an enterprise bargaining agreement as we can. That means they commit to a five-year contract and to the longer term. That, of course, is not always possible, so we supplement that. We have a medical service agreement arrangement that will sign up locum doctors for a set period or specifically on a daily rate so that we have rosters et cetera covered on all occasions. We use agency staff to recruit some of those and, obviously, some of them come from far and wide, depending on the skill set we want for the particular position.

Mr P.B. WATSON: As the minister knows, Albany has a brand new hospital, and he is not like the Premier, who keeps throwing it in my face. The minister did a tremendous job; congratulations to all concerned, although there are a few issues there at the moment, but we will get to that later.

I notice that the department has been advertising for specialists to live in the region. A lot of the specialists have left Albany to go to Perth because the private and public hospital system is there and they do not have to work

weekends, whereas at the moment when specialists are in Albany, they are rostered on every second or third weekend. Is there any plan to offer incentives, maybe for younger surgeons or doctors to come to Albany?

[9.20 am]

Dr K.D. HAMES: They do get some country incentives.

Mr S. Matthews: Certainly, in certain locations around the state there are district allowances, which help. There is also a thing known as the homeownership subsidy scheme, which is an attraction for staff to come and sign up for a five-year contract to purchase a home. That scheme is currently under review by the Department of Housing; it has been around for about the last decade and has not kept pace with contemporary costs. Again, that scheme is currently under review and the Department of Housing will provide an alternative scheme by the end of this year. For the country, we see that as a very significant incentive—for not only doctors and nurses, but also staff across the board—to recruit staff and retain them for a longer term rather than what we are doing at the moment.

Dr K.D. HAMES: We expected a beautiful spot like Albany should not need too many subsidies because people are dying to go and live there. My chief of staff has just gone down there.

Mr P.B. WATSON: Only because of the local member!

Ms J.M. FREEMAN: The third dot point at page 132 states that in the 2013–14 year there will be an increase of "16 000 patients to stay and be treated". Can the minister confirm that the number of hospital separations, which I understand is patients to stay and be treated in WA hospitals, as outlined in the budget papers, has increased in the 12 months from March 2012 to March 2013 by 21 563, or 4.1 per cent, rather than what the minister is forecasting, which is 16 000? If the minister expects demand for hospital services to increase by 16 000 in the next 12 months, how does that equate to the fact that the evidence shows that it actually has increased by 21 563, or around four per cent versus the three per cent mark? How does the minister equate those two?

Dr K.D. HAMES: It is sort of the same answer that I gave to the previous question about money. Firstly, pressure has eased off, particularly in the last three to four months, in growth in our emergency departments, plus we have a midyear review. Our budget at the start of last year would have predicted a number that was probably more like the 16 000. Again, for last year through to the midyear review, with the activity-based funding that we introduced, it became clear that numbers were higher. We expect them to ease off. Some 16 000 is a reasonable estimate as to what we are likely to get, but if it turns out to be the same as last year, when we did have a surge in population as a result of the strength in the mining industry, that will get reviewed midyear, which is in fact only a couple of months away.

Ms J.M. FREEMAN: I am a bit confused. We come here and do the yearly budget, and we get the opportunity on behalf of the community to critically look at that, and what the minister is telling me is that the health department does it on a bit-by-bit basis. It comes in and goes, "Oh, we'll have a bit here and then in a few months' time, we'll be able to come back and have a bit more then." But we and the people will not get an opportunity to look at that and say whether the organisation is being managed appropriately. What the minister is telling me is that the organisation, in terms of patient inputs and costs, is currently being managed on a three-monthly basis.

Dr K.D. HAMES: No. The midyear review means six months, not three months.

Ms J.M. FREEMAN: Okay, but the minister has got it in three months because he has pushed the budget out.

Dr K.D. HAMES: Is the opposition supportive of activity-based funding or not, given that it was their federal government that insisted that all states —

Ms J.M. FREEMAN: We can get to activity-based funding and the fact that you are —

Dr K.D. HAMES: I am trying to answer.

The CHAIRMAN: Order, members!

Ms J.M. FREEMAN: The minister is telling me, "Don't worry about it; don't worry about it" —

The CHAIRMAN: No, member for Mirrabooka, allow the minister to answer please. Hansard cannot cope with several people talking at once.

Mr R.H. COOK: A point of order, Madam Chair, I thought that the minister actually asked us a question; he was inviting us to respond to his question.

The CHAIRMAN: If that is the case, it is just the same: Hansard cannot cope with three people talking at once. We will now return to the minister. Thank you.

Dr K.D. HAMES: Thank you. The management of activity-based funding is a critical issue across Australia. In fact, I copied it off the opposition's very good Minister for Health in South Australia, John Hill, who had it in before we did. We had started the process of bringing it when the national reform package resulted in an Australia-wide agreement to bring it in. The critical importance of activity-based funding as opposed to all other funding that all other government departments receive—which is on an annual basis—is that it allows scrutiny each year. The health department has to have some flexibility for growth in demand. If it did not have that, health services would have to wait a whole year and keep our services at less than what is reflected by the number of people walking through the door in terms of looking after them. No-one would desire that sort of system in place. It is not very much different. We expect that the requirement is for the government to manage according to the budget that we have, and predicted on the basis of the number of additional patients who come through the door. I expect, based on the demand we have seen over the last three to four months, that for that year the figure will be accurate and we will not need additional funding at the midyear review. I do not think we would need that.

But the midyear review is a document published by government that shows variations in funding for a whole range of things; it is not just variations in health. The previous government had midyear reviews for the full seven years it was in government, and it made adjustments to its budgets in the midyear review based on changes in circumstances—not on an activity basis because it did not have it—such as a change in demand in health, or the extra decisions by cabinet that allocated extra money during the year for all sorts of different programs. That comes in the midyear review that gets presented to the Parliament; people can see what those variations are. But I expect that the health department plans to and needs to work according to the figures that are in this budget. If they do change and if the surge in demand is greater than expected, we will deal with that through the years, as I am sure everyone would expect.

Ms J.M. FREEMAN: It does not seem to me to be an appropriate management of government funds when constantly the minister has said, "The previous government and this government". All the minister can do with his department and bureaucracy—which clearly shows they cannot manage their funds—is to guesstimate something that is more of a "hopetimate" because he is hoping to meet that target. The minister hopes that he will do the 16 000, then he comes back at a later date for something else. That is the difficulty I see in how the health budget seems to be managed by the government. The minister said that he will open a hospital at a certain time but then says, "Oh no, we can't do it then."

The CHAIRMAN: Member for Mirrabooka, are you getting to a question?

Ms J.M. FREEMAN: My question is: how can the minister base 16 000 on anything? Where is his evidence for that, because there is no evidence currently available that he will get 16 000, other than a hopeful aspect that it will reduce; where is the evidence?

Dr K.D. HAMES: That is clearly not true. The evidence is based on attendance figures over the last 12 months —

Ms J.M. FREEMAN: The last 12 months is —

The CHAIRMAN: Order, member!

Dr K.D. HAMES: — based on ABS growth figures and on a range of different parameters that guide the government in terms of what growth we are likely to expect in health. A range of growth parameters are followed by government—not only in health, I might add, but also in a whole range of different areas where growth is predicted. Education is a great example. I have never seen the indicators get exactly right the figures of growth in numbers in schools in the past.

The CHAIRMAN: Member for North West Central.

Mr R.H. COOK: Madam Chair, I have a follow-up question in relation to the point raised by the member for Mirrabooka.

The CHAIRMAN: I will go to the member for North West Central and will come back to you.

Mr V.A. CATANIA: I refer to page 136 and the school entry health assessment for preprimary schoolchildren. Is this additional funding on top of previous initiatives for children's health? Has it had an impact on waiting lists for children? Also, can the minister provide some details on additional funding and how it will actually benefit the children?

Dr K.D. HAMES: This $38 million is additional new funding over the four years of forward estimates. I am sure everyone will recall that it came as a result of an Education and Health Standing Committee inquiry that started, in fact, when we were in opposition. When we first started that inquiry, we were looking into the provision of health services to this state. The committee made recommendations in three areas: school nurses, child health nurses, and child health services—such as speech pathology, occupational therapy and the like . Early on in government we funded the first lot, which was just under $50 million in new funding for the services of speech pathologists and the like.

[9.30 am]

The second lot of funding was two years ago with an additional $55 million in new funding providing for the child health clinics. Those extra staff are now being put in place. At the time we could not fund the school nurses, which was the third component that we needed to do. Therefore, we made the commitment to do that in this budget, and hence the $38 million. To start off with this was going to be only school health nurses, but I was approached by Speech Pathology Australia which said that with the additional speech pathologists out in the community as a result of our first lot of funding, a lot of speech pathology issues were getting picked up in schools that otherwise might have been missed. Parents with children who have a speech impediment do not necessarily take them to see a speech pathologist unless the GP tells them to do so. There are 10 of those staff across the system—it is not a lot, so each one will have to cover a series of schools. The speech pathologists will talk to school health nurses, who might say, "Little Johnny in classroom 3 seems to have trouble." The speech pathologist can assess the child and either give advice to teachers and parents then and there or refer them to a speech therapist for proper management of their speech impediment. I think this is critically important.

Also, the school nurses there will make sure we have the first-up checks for students, make sure their vaccinations are up to date and deal with minor issues such as cuts and bruises that occur during the day in a normal school. It is a huge investment in extra services. If this $38 million is added to the previous two lots of around $50 million, that is a massive increase. In fact, it represents two per cent of our total budget in additional funding going into child health services.

Mr R.H. COOK: I noticed at the last election the minister promised $57.2 million for 155 school health nurses. This budget shows expenditure of just $38 million for the same number of nurses. I acknowledge that that has been revised to 145 school health nurses and 10 speech pathologists. How does the minister make up for the $20 million shortfall on that promise? Where will the $20 million be made up from? What services will be cut in order to fulfil that election promise?

Dr K.D. HAMES: Clearly no services will be cut because those services are not there yet.

Mr R.H. COOK: I mean services cut from elsewhere to make up that $20 million—where else in the budget?

Dr K.D. HAMES: We will be doing it within the funds that we have available to us; that is, the $38 million for that employment. It is partly related to the delay in the budget and therefore the delay in the timing for us to get this started. The start date for the program was pushed out until part way through this year. In the first place we have to recruit people. Therefore, the amount needed in the first year is significantly reduced, as opposed to if the budget had been done back in June and the program was started sooner. There has been a slight delay. A bit of extra work was done over the actual cost per person of putting the program in place, and some of the original cost estimates per teacher across the system—some will be city and some will be country and some will be speech therapists—has changed slightly. It also has to do with the timing of appointing people. In the fourth year, there was always the final contingent to get us up to 120 or 130 in three years and then up to 155 in the fourth year. That will be later in the financial year and some of those costs will go into next year's budget—the year's budget that we do not have yet. Some of that $20 million will be pushed out, but we will be employing those people part way through the final year of the four-year forward estimates. They will not have to be paid wages for a whole year.

Dr G.G. JACOBS: Has the minister worked out the distribution of the school health nurses and speech pathologists; where they will go? The minister did mention a metro–regional split, and could he provide that by way of supplementary information?

Dr K.D. HAMES: I do not think that it has been finalised until we actually do the appointments, but I think we have a rough idea. Mark Morrissey might have the answer.

Mr M. Morrissey: We are currently working on that formula in conversation with the Department of Education because many of these nurses will be located in schools. We are fairly close to having that information ready to be made available to the minister.

Dr K.D. HAMES: I think the answer is that I cannot provide a supplementary because I do not have it yet, but I am happy to provide that information to the member once that decision has been made. Remember, it still has all election commitments, and the individual proposals in the budget still have to come before cabinet for final approval of how the funding is spent, the distribution, the numbers and so on. I need an opportunity to look at the distribution and make sure that I am happy with the country–city split, and to make sure that we are getting plenty of people out in the bush and not all in the city.

Ms J.M. FREEMAN: I have a school nurse set up at Westminster Primary and it is working really well. I just thought that I would tell the minister that. There is also a school nurse at Koondoola Primary School and Parkwood Primary School as part of the integrated services centre, and that is also with a psychologist from the Department of Health. Last year at estimates, the minister said he was going to enter into a four-year agreement with the Edmund Rice Centre over the delivery of that service to those two schools. I have raised this with the minister in the house. I understand that there has been only a one-year payment so far and there has been no four-year contract entered into. I wonder when that four-year contract will be determined, fulfilled and delivered so that there is certainty for the integrated services centres at Koondoola and Parkwood Primary Schools?

Dr K.D. HAMES: That is an excellent question and I am hoping that someone here will have the answer.

Prof. B. Stokes: I do not. We will take it on notice.

Dr K.D. HAMES: I think that it is a good question, and I am keen to see it happen.

Ms J.M. FREEMAN: Certainly that is what the minister said at last year's estimates, when he announced to me that a four-year contract was going to be entered into. That contract has not been entered into. It gets a bit dull raising it each time.

Dr K.D. HAMES: That is a good lesson for everybody sitting behind me that when I say something in this house I mean it. Whoever it was who did not progress it last time needs to provide me with a supplementary answer, and I am happy to have that as a supplementary answer.

The CHAIRMAN: Can the minister just define what he will provide.

Dr K.D. HAMES: We are going to do a supplementary answer on the issue of four-year contracts for the integrated service centres at Koondoola and Parkwood Primary Schools.

[*Supplementary Information No A23*.]

[9.40 am]

Dr G.G. JACOBS: I refer to the first dot point on page 133 that refers to the cost of delivering services and benchmarking—and congratulations for adopting activity-based funding as they are figures that cannot be fudged as it is activity based. My question is: I note that emergency department services have significant growth; in fact, last year there were 935 000 presentations at emergency departments. Can the minister provide an update on the impact of the four-hour rule and the report on the visit to Western Australia by UK specialists to advise on that four-hour rule and how we handle patients presenting to emergency departments?

Dr K.D. HAMES: There are two parts to that question. One is —

Mr R.H. COOK: Is that question on emergency departments or activity-based funding?

Dr K.D. HAMES: I do not know exactly.

Dr G.G. JACOBS: There was a message there that we cannot fudge if we work on an activity base.

The CHAIRMAN: Order!

Dr K.D. HAMES: There are two components to the question. One is the review of the four-hour rule and how that works. As we know, the acting director general, Professor Bryant Stokes, who is sitting beside me, did a review of that and reported back on how it was working. That was done in 2011. He also provided some recommendations for changes.

Just recently, a team from the United Kingdom came here and went through our three tertiary hospitals. I have to say that that was extremely valuable. The team identified some areas of management that need to change to better meet the four-hour rule target, or NEAT as it is now known—the national emergency access target. We are supposed to be at 76 per cent and we are at 76 per cent, but the next target will prove to be more difficult to reach because of the pressures on our hospitals. We are leading the nation, but to continue to do so, we need to improve.

Mr R.H. COOK: That is not true.

Dr K.D. HAMES: It is true; in fact, it is in the latest statistical report put out on my website comparing hospitals.

Mr R.H. COOK: It showed that WA emergency departments were not improving and others were.

Dr K.D. HAMES: Madam Chair, I am trying to answer.

The CHAIRMAN: Order! Can the minister finish his answer, please.

Dr K.D. HAMES: The member can ask that as another question if he likes.

We are going exceptionally well in our four-hour rule work, but further change is needed. The UK team went through the statistics for every hospital in terms of presentation, case mix, admission rates, distribution throughout the hospital, discharge plans and discharge rates. The team members have statistics coming out of their ears, let me tell members! They are putting it all together in a package and giving it back to us with recommendations. Unless there is a very good reason—I cannot imagine what that would be at this stage—I intend to make that a public document. Then we will look to implement those recommendations, and I think that there are some things we can do that will make a significant difference within our emergency departments. As I said, presentations have flattened off a little just recently, but, even so, our hospitals are under enormous pressure and I think they will remain so until we open the additional beds at Fiona Stanley Hospital in 2014 and at Midland in 2015.

Mr R.H. COOK: Can the minister please detail the costs associated with bringing out the experts from the UK?

Dr K.D. HAMES: I am happy to; there is no reason not to. It is funded from something like a trust fund that is called the King's Fund. There is an arrangement between us and the UK government that is for research and the support of doctors doing training. All we had to pay for was their airfares and accommodation. They have come out of their own volition and are paid by the National Health Service, so they still get paid but they are allowed to do professional development. Their advice is that although this arrangement is of great benefit to us, it is of benefit to them as well. They get to come out and see how our system works and what we do. There may well be things that we do better than they do that they can take back to the UK.

Soon after we were re-elected, I went over there to reinvigorate our four-hour rule, which was lagging a bit, and to make sure that the things they do in the UK are of value, because the NHS as a whole is not a great system, in my view, particularly its management through general practitioner services. However, its management within the hospitals is very good. Despite this talk of the four-hour rule being abandoned, it is very much not the case. The NHS has just had a directive from the government that it can reduce its target from 98 per cent to 95 per cent, but still that is what almost all its hospitals manage to achieve and that makes an enormous difference. We wanted to see what things we need to change, and they found a number of things that we need to do to ensure we keep on track. In the UK, clinicians manage their own individual hospitals. When other hospitals within the UK system do not achieve the 95 per cent target, this team is invited to go out to those hospitals and go through the system, as it did here, and give them advice about what they can do to fix it. I have to say that they are called dysfunctional hospitals when they are at 85 per cent, let alone the 76 per cent that we are at now.

The CHAIRMAN: Member for Albany.

Mr R.H. COOK: Madam Chair, I have some further questions around the issues of EDs, particularly the national emergency access target program. I am happy to ask about those issues as further questions, or would you prefer it to be separate?

The CHAIRMAN: If we are talking about emergency departments, you might as well ask a further question, member for Kwinana.

Mr R.H. COOK: Thank you, Madam Chair. Minister, I —

Dr K.D. HAMES: We would think he was shadow Minister for Health, would we not?

Mr P.B. WATSON: Yes! Just bump me—go on.

Mr R.H. COOK: I would never try that, member for Albany!

Based on the previous 12 months, emergency department presentations increased by 4.1 per cent, or 39 268, in the 12 months to March. The minister has budgeted for growth of just 25 000 presentations and he said that there is some levelling off. However, that is roughly a growth rate reduction of about 64 per cent, which is a drastic reduction in the growth of demand for EDs. Can the minister explain why he plumped for a number of 25 000 or is that number plucked out of the air like the 16 000 for the hospital separations?

Dr K.D. HAMES: Madam Chair, once again I am forced to deny the content of the question that is put to me about numbers "plucked out of the air". Clearly, that is not true. Clearly, it is based on significant work done around figures, as is the whole clinical services framework, which is based on growth figures, and a lot of the work done by Treasury.

Mr R.H. COOK: Growth figures that were shown to be absolutely flawed.

Dr K.D. HAMES: There is an enormous number of person hours that get—did the member see how well I did that?

Ms J.M. FREEMAN: Thank you, minister! "Staff hours" is good, though, if the minister wants to do it that way.

Dr K.D. HAMES: All right; that is better. An enormous number of person hours go into working out what the actual growth in demand is likely to be. As I said, we have had the benefit of this formula. When we first opened Joondalup, for example, growth was at 18 per cent and that settled down to 11 per cent. But I was just up there yesterday and they showed me that their growth in ED presentations in the year to date is only two per cent. The member was talking about a drastic reduction in growth —

Mr R.H. COOK: It is 64 per cent less.

Dr K.D. HAMES: We do not work on things like that; saying it is going to be 100 per cent growth next year and this year is only 50 per cent growth, so it is a drastic reduction. Fifty per cent growth is drastic growth and so is 25 000 presentations. That is still very strong growth; it is stronger growth than any other state or territory in Australia.

Mr R.H. COOK: So why does the minister expect that growth —

The CHAIRMAN: Is that a further question?

Mr R.H. COOK: Yes.

The CHAIRMAN: It is the last one.

Mr R.H. COOK: Thank you, Madam Chair. The point of my question is that the minister said that presentations will grow by just 25 000 over the next 12 months. Presentations in the previous 12 months grew by almost 40 000, so why does the minister expect that growth to drop off so significantly?

Dr K.D. HAMES: I do not think the member listened to my answer, so I will exaggerate even more to make it clearer. If we predicted 200 per cent growth in the previous year and then say that the year after it will be only 100 per cent so there is a massive reduction, the reality is that 100 per cent growth is still a lot of growth—and 25 000 is still a lot of growth. Just because the member does not think that it will be as much as in the previous year when it was dramatic, does not mean that it is still not significant growth.

Mr P.B. WATSON: I refer to the "Patient Assisted Transport Scheme" line item on page 130. Can the minister provide details on the 2016–17 allocation of $10.5 million? Why has it been held off until 2016–17? Can the minister please provide the current funding and eligibility criteria for the patient assisted travel scheme?

[9.50 am]

Dr K.D. HAMES: That is a lot of detail that is being asked.

Mr P.B. WATSON: Okay, I will ask the first one.

Dr K.D. HAMES: It is all right, I am happy to try to answer. When we were in opposition in 2008 there was a Senate review of PATS services across Australia. In opposition we committed to implementing the recommendations of that review; the member for Albany's party did not. In fact no other state in Australia did. We are now the envy of every other state in Australia. We committed to that in opposition. It contained a lot of additional funding, particularly funding for cancer patients, which would have benefited the member's electorate. I forget the actual number of hours, but I think patients had to be 16 hours' drive away to be eligible for a flight. We changed that to four hours to make sure places like Albany, Kalgoorlie and Geraldton would be covered by that allowance. Cancer patients were then able to get PATS for flights to Perth. We also changed the rules on carers so that it was almost automatic that someone with cancer who needed a carer could have one come with them to Perth.

Mr P.B. WATSON: I am aware of all of this. Can the minister just tell me what the $10.5 million is for?

Dr K.D. HAMES: This is a really good answer on PATS. I like the total answer, if you do not mind, Madam Chair.

Mr P.B. WATSON: Just hand it to me.

The CHAIRMAN: Order, member!

Dr K.D. HAMES: I will need to hand the member some stuff but not all of it. Those additions therefore were put in place. There was a silly situation previously in which cancer patients with an accommodation allowance, who came to Perth and were then admitted to hospital because their condition got worse, had their accommodation allowance for the carer taken away, leaving them with no accommodation allowance. We changed that so that they could still get the allowance. We increased the rate of the petrol allowance. Remember that PATS is supposed to be a subsidy, not a full replacement of cost. We put in place a mechanism to adjust the allowance for changes to the cost of petrol. Having committed to that funding in opposition, we then got into government and put those changes in place. There has been a significant increase in budget requirements and demand.

Mr P.B. WATSON: I appreciate that. Can the minister answer my question?

Dr K.D. HAMES: The extra budget we put in place did not cover the cost, and the budget requirement for extra PATS funding has grown exponentially every year. I will hand over to Wayne, if it is okay with you, Madam Chair, who will be able to give us some more detailed figures around what is in the budget for PATS.

Mr R.W. Salvage: The simple explanation is that it is a continuation of funding that has been awarded in previous budget rounds. I refer the member to the 2009–10 budget papers at page 162 where there is an allocation for the patient assisted travel scheme that ended in 2012–13.

Mr P.B. WATSON: I do not have it with me today.

Mr R.W. Salvage: In the 2010–11 budget papers at page 179 there is a continuation of that funding at $9.741 million into 2013–14, which is obviously the current budget year, and we need to make sure that that funding is available going forward. The funding that the member sees in the budget papers recognises the need to populate, essentially, that funding in the out years.

Mr P.B. WATSON: So that is for 2013–14?

The CHAIRMAN: Is that a further question, member for Albany?

Mr P.B. WATSON: Yes. That is for 2013–14 and the next lot is 2016–17. Where is the amount for 2015–16?

Dr K.D. HAMES: While Wayne is looking for this —

Mr P.B. WATSON: While that is happening, minister —

The CHAIRMAN: Minister.

Dr K.D. HAMES: With you in the chair, Madam Chair, I think I had better make the point that royalties for regions funding provided that additional amount of funding.

The CHAIRMAN: Thank you, minister. I greatly appreciate that.

Mr R.H. COOK: Do not stand for it, Madam Chair! Interject!

The CHAIRMAN: I was tempted!

Ms J.M. FREEMAN: Can I have a question?

Mr P.B. WATSON: I find that offensive where the Chair is promoting a fund of a political party from the chair. I find that very offensive!

The CHAIRMAN: I did not promote it at all, member for Albany; it was the minister.

Mr P.B. WATSON: I will be passing that onto the Speaker! Can the minister please provide details of the current funding and the eligibility criteria for PATS, please? Minister, one of the main concerns —

Dr K.D. HAMES: The eligibility criteria are simple to provide, are they not? Are they not just available on the website?

Dr G.G. JACOBS: Yes.

Mr P.B. WATSON: I am not speaking to you, doctor! I was speaking with that doctor.

Ms J.M. FREEMAN: If I could just ask —

The CHAIRMAN: No; we have doubled up here at the moment because Mr Salvage is still looking for the 2015–16 figures.

Mr P.B. WATSON: That is why I am asking.

The CHAIRMAN: Now the minister is talking about the criteria, so, member for Mirrabooka, please do not complicate the situation.

Mr P.B. WATSON: Could I just ask the minister a further question?

Dr K.D. HAMES: We just have to finish that answer.

Mr P.B. WATSON: Has the criteria changed recently? That is all I want to know.

Dr K.D. HAMES: No. We certainly have not and I certainly have not changed anything and I am not aware of any change. But we need to provide supplementary information on this.

The CHAIRMAN: Okay, let us do that then.

Dr K.D. HAMES: We cannot find the 2015–16 budget funding. We will provide the budget funding across the six years. We will provide the two previous years plus the current four years of forward estimates.

The CHAIRMAN: For PATS?

Dr K.D. HAMES: Yes, of PATS funding.

The CHAIRMAN: Okay, the minister has sufficient information. Does the member for Albany want to add to that?

Mr P.B. WATSON: Yes, I have a further question. We have received reports that cuts being made to PATS include a limit on the number of times a patient can draw on PATS for paid flights. Are those reports correct?

The CHAIRMAN: I think we will just deal with this one first, which is the budget as we discussed.

[*Supplementary Information No A24.*]

The CHAIRMAN: Did the member for Albany have a further supplementary question?

Mr P.B. WATSON: I have one further supplementary question.

Dr K.D. HAMES: The answer to that is that we are not aware of any change that the member talks about.

Mr P.B. WATSON: The main concern of constituents in regional areas is the cost of accommodation in Perth. I know, from when I first got into this job, that some of my constituents got accommodation for $80 a night in Perth; now they are paying between $250 and $300 a night. Has the government taken that into account in the latest funding?

Dr K.D. HAMES: When we came to government the amount of the allowance had been the same for years. There had been no recognition of increased accommodation costs and it was very hard then to find accommodation. We increased the funding. It was not by a huge amount, but remember that it was established as a subsidy to assist people and was never meant to cover the full cost of accommodation. The subsidy depends on where people stay. There is an amount to stay with friends and relatives and an amount to stay in accommodation. As the member knows, charity groups and specific support groups such as the Leukaemia Foundation provide accommodation

Mr P.B. WATSON: A lot of seniors in my electorate cannot get it.

The CHAIRMAN: Order!

Dr K.D. HAMES: I understand it is difficult, but the budget has already increased enormously, as the member will see when he gets those figures, and we do not have any more capacity to increase that funding. We are looking at how we can provide more accommodation in the city at that lower cost and we are working on that now.

The CHAIRMAN: Thank you. We move to the member for Balcatta.

Ms J.M. FREEMAN: Can I just have a further question to that, because I think it is very important.

The CHAIRMAN: Member for Balcatta.

Ms J.M. FREEMAN: Can I just have a further question to that because it actually engages with the aspect of the further accommodation? Minister, you would have read recently —

Dr K.D. HAMES: The Chair has not said yes yet.

The CHAIRMAN: No, I have not, and I would like to go to the member for Balcatta, thank you, who has waited for some time. We will come back to you, member for Mirrabooka.

Ms J.M. FREEMAN: It is actually about —

The CHAIRMAN: I will come back to you, member for Mirrabooka. I am going to the member for Balcatta.

Mr C.D. HATTON: I refer to "Joondalup Health Campus—Development Stage 1" on page 148 under "Works in Progress". I understand that the minister recently opened new beds in the private hospital at Joondalup Health Campus. Can the minister advise what benefit the opening of these beds has been for the public health system, particularly for that northern region that is now such a largely populated area?

Mr R.H. COOK: Why does the member not just read the minister's brief ministerial statement he gave in Parliament recently, because he has answered your question?

Mr C.D. HATTON: I did. I need clarification.

Dr K.D. HAMES: It is an excellent question because I can give some updated information. I did a tour yesterday of Joondalup Health Campus and went through some of those figures we talked about. One of the critical problems at Joondalup at the moment is a lack of mental health beds. There were a significant number of breach patients—between 15 and 20 patients—in the emergency department at that time, and of that number 11 were psychiatric patients waiting for a bed. There is insufficient space in Joondalup hospital to cope with that number of psychiatric patients. One matter we discussed was the significant increase in funding going to Joondalup Health Campus to open the additional 25 or 26 beds that I referred to in the brief ministerial statement. The issue is how the hospital uses those beds. The hospital is looking at whether it can significantly expand the mental health unit or open a second mental health unit to take the pressure off the emergency department and to provide accommodation for those patients who often otherwise are totally managed through the emergency department.

[10.00 am]

There have been cases when they have been there for two to three days being managed in the emergency department with psychiatric staff coming down to look after them. That is totally unacceptable from an emergency department management point of view. Work is being done on new beds now with an old area being renovated and it will be ready in six weeks. Right now the question of whether the best management of those additional beds is to have those extra wards is being looked at. An acute medical unit is needed, which is not there at present, to deal with four-hour rule issues, because there is a very strong desire to improve the four-hour rule performance. They are working with a United Kingdom team to get advice. Some people will probably be sent to the UK to look at how things work better over there, as I did, and to perhaps try to bring some people back to assist them at that hospital. An acute medical unit is needed, but additional beds are not necessarily needed within a hospital to create an acute medical unit, because, generally, patients stay there for up to 48 hours. That means that the wards are needed less, because a lot of patients will be discharged home from the acute medical unit. We think that within the confines of the additional funding provided they will be held to address that very important problem. It just shows that there is a massive demand for services for patients with mental health issues. They are not all people with schizophrenia, for example, with the need for long-term wraparound services. Some people, through family circumstances, for example, might have a period of acute depression that might affect them for six months or a year or two years of their lives and then they are fine again. However, there needs to be somewhere for them to be and currently there is not sufficient space in our system for all those mental health patients.

Dr G.G. JACOBS: In relation to what the minister has just said, I note his comments regarding the treatment of acutely disturbed people in an accident and emergency department. We have a model from Brisbane that works with a psychiatric assessment unit. Is there any ability to create a psychiatric assessment unit at Joondalup Health Campus for these people where they are assessed separately from the people having heart attacks and broken bones? This would deal with those disturbed patients, who have an enormous impact on the traditional accident and emergency departments.

Dr K.D. HAMES: I have not seen the Brisbane model and as the member knows I am not the Minister for Mental Health, so I am not across that system. There may be some advisers who have that knowledge. It is critically important and we need to find a different way, frankly. I am totally unsatisfied with the way we deal with the issue at present. Sir Charles Gairdner Hospital is another good example of this problem. When I front up to the emergency department at Sir Charles Gairdner Hospital, again, I find large numbers of patients. Quite a few of those are form patients who are waiting for beds at Graylands Hospital. There are issues to do with transport. The police have within their legislation up to 72 hours to transfer those patients across, and so

sometimes they will sit for that whole time in our emergency departments, which is a totally inappropriate place for them. There are other patients coming in. Often the mental health patients want to have a smoke and they cannot. They have to have a security person sitting there with them the whole time, so they do not do anything. At Sir Charles Gairdner Hospital we are now creating an eight-bed offset to the ED, which will cost us about $500 000. That will be a place those patients can go to while they are either waiting for admission to the hospital or transfer to a formed place. We are also looking at an alternative method of transport so we do not have to use the police. The Minister for Mental Health has some funding that will allow her people especially allocated for the transport of patients with psychiatric illnesses. That will put more pressure on Graylands, but it will take some of the pressure off our emergency departments. Frankly, we need to find a better system.

Ms J.M. FREEMAN: Regarding mental health services and the role of hospitals, the minister would be aware that Ishar Multicultural Women's Health Service runs an outpatient service, almost a visiting service, for women with prenatal and postnatal mental health issues. That program has no certainty of funding over the long term. I have written to the mental health minister and told her that funding finishes in December and she is looking at that. Given the importance of preventing women with mental health issues coming to the baby–mother unit at King Edward Memorial Hospital, is there an opportunity for the Department of Health to ensure that that vital service continues? It is less than $1 million, I think.

Dr K.D. HAMES: I am not sure where that funding comes from, but I assume it most likely comes out of the health department budget, which has funding for non-government organisation services. It is proposed to continue all of the funding for that organisation.

Ms J.M. FREEMAN: This is separate funding that came from the Department of Health originally, and the mental health budget picked it up.

Dr K.D. HAMES: If it comes out of the Minister for Mental Health's budget, I have no say in it. If it is out of my budget, it will be continued.

Ms J.M. FREEMAN: I understand that; I am asking the minister to look at the funding because it came out of his budget originally and shifted to mental health. It is a vital service to be delivered to those areas.

Dr K.D. HAMES: I am advised that the Minister for Mental Health is aware of this issue and she is trying to sort it out.

Dr G.G. JACOBS: I have a further question on the handling of acutely disturbed patients presenting at accident and emergency departments. What arrangements have been made at Fiona Stanley Hospital to cope with this issue?

Dr K.D. HAMES: That is a good question. I will hand over to Dr Russell-Weisz.

Dr D. Russell-Weisz: There is the 30-bed unit at Fiona Stanley Hospital that is already completed. It has 22 mental health beds to support the emergency department and an eight-bed mother–baby unit—so it expands the mother–baby provision in the whole state quite substantially. There will be a mother–baby unit both north and south of the river. The 22 non-mother–baby unit mental health beds are there to support the emergency department, and obviously there will be close liaison between that 22-bed unit and the larger Alma Street unit in Fremantle.

Dr K.D. HAMES: Just before we move on, a question was asked by the member for Albany that we had listed as being answered by way of supplementary information. We probably still need to supply that, but we have found the answer. Therefore, with Madam Chair's indulgence, I will ask Wayne Salvage to provide it.

The CHAIRMAN: Certainly. Why does the minister not go ahead and we will find the supplementary information number and remove it from the list or do something tricky? We will get back to the minister on that.

Dr K.D. HAMES: We will still provide it in writing.

Mr R.H. COOK: The minister has offered to provide the answer by way of supplementary information. Why do we not stick to that and get on with it?

Mr P.B. WATSON: I would prefer it in writing; I have a bad memory.

The CHAIRMAN: Fair go!

Dr K.D. HAMES: All right; we will move on.

Ms J.M. FREEMAN: Page 133 of the *Budget Statements* states that the construction of Fiona Stanley Hospital "brings unprecedented opportunities"—yes, an opportunity to delay from April 2014 to October 2014. I refer to

the commentary that reports that the health budget has no estimates for the mitigating costs to be charged by Serco for clinical reconfigurations and the delay at Fiona Stanley Hospital. What is the order of magnitude of exposure associated with the dispute or discussions with Serco, and does the minister concede that the privatisation policy with Serco has the potential to expose taxpayers to millions of dollars in damages?

[10.10 am]

Dr K.D. HAMES: I cannot answer the first part of the question because it is still part of current negotiations, so it is not appropriate for me to speculate on potential costs. The reality, of course, is that the contract had a component that allowed for negotiations around delays in start-up time, and that is what we are doing. No, I do not accept the member's final comment.

Mr R.H. COOK: The minister is telling us that, as a result of the Serco contract, taxpayers are now exposed to an open-ended negotiation around the delays and the reconfiguration of the clinical framework for this hospital and the minister does not know the order of magnitude of that exposure.

Dr K.D. HAMES: I think I have said publicly on a number of occasions that until we finalise those negotiations, we do not know what the exact amount will be, but it is all contained within the requirements of the contract. There is a range of reasons why the contract may have been delayed. Quite properly, there is a clause that requires mitigation by Serco if the hospital is not ready to open on time. For example, those delays might have been construction delays. As it turns out, that is not the case, but it could have been. If the construction company had been delayed in completing the construction, we would have needed to delay the start, so we had a mitigation clause under which Serco could not employ the full complement of staff it would have needed if the hospital had opened in April. We are now going through the process of negotiating that amount. Of course, if the hospital were to open on that date in April, we would be paying that full amount now. Obviously, that is not the case and it needs to be delayed. The reason for the delay is around the complexity of the information technology systems that need to be put in place for one of the most modern hospitals in the world. A six-month delay is not a great deal of time when we consider that under the previous government, there was a four-year delay in the start of construction of the hospital. I would have died to have those beds available now within our system; that would have helped us mitigate some of the pressure issues due to the growing population.

Mr R.H. COOK: What is the cost to the state of having a $1.6 billion—in some circles I hear $3 billion—asset sitting around doing nothing?

Dr K.D. HAMES: Where is the $3 billion asset?

Mr R.H. COOK: There were suggestions in some media. Let us say that there is a $1.6 billion asset sitting around doing nothing. What are the depreciation costs associated with that and what are the maintenance costs for that building asset that is just sitting idle?

Dr K.D. HAMES: The hospital always required a period of time for construction, a period of time for installation of equipment and services, a period of time for training and establishing services within the hospital, and an opening time. Originally, the opening time was 2014, not April 2014. The original opening time put forward by our government in the early stages of construction was 2014. As we progressed in developing the contracts and doing all the work on the construction of the hospital, that was narrowed down by the health staff to April 2014. The subsequent work has shown that it will not open until October 2014. That is the nature of construction and development. We need only look at the projects that were developed under the previous government to see that Perth Arena is an excellent example of something that was significantly delayed at significant cost.

Mr R.H. COOK: I have a point of order, Madam Chair. I note your comments at the beginning of the session whereby you asked the questioners and the minister to be succinct. I asked the minister a very clear question: what is the cost brought to book as a result of a $1.6 billion asset sitting idle? It is a simple question.

Dr K.D. HAMES: I will hand over to the acting director general to answer that component of the question.

Prof. B. Stokes: This process is still in discussion. It is part of the issue associated with discussions with Serco, but also, of course, an important issue is that any structure requires maintenance, even when it is finished. In answer to the question the member asked, the cost is not known.

Mr R.H. COOK: The minister must have at least a depreciation value. When an asset that big is acquired, it must be depreciated over the life of the asset, so there must be some cost associated with that. We will come back to the question of the Serco negotiations.

Dr K.D. HAMES: There is a depreciation cost for every building the Department of Health owns.

Mr R.H. COOK: But most of those are actually functional, rather than, in this case, dysfunctional.

Dr K.D. HAMES: I will seek advice. I am told that there is such a depreciation figure, but we do not have it here with us, so we will provide that as supplementary information. Does the member want it for all our hospitals across the system? I am happy to provide that as well.

Mr R.H. COOK: No, only the perfect ones that do not have any patients, minister.

Dr K.D. HAMES: That will be Midland hospital. Does depreciation start from the time it is built?

Mr R.H. COOK: No, there is no asset there. Does the minister not understand basic accounting?

Dr K.D. HAMES: No, not really!

[*Supplementary Information No A25.*]

Mr R.H. COOK: I have further questions on the issues raised by the member for Mirrabooka. I understand that the minister cannot reveal the amount that he will settle with Serco because that is under negotiation. How has Serco opened the batting? What does it think is the amount in dispute for the mitigation costs associated with the contract?

Dr K.D. HAMES: It may be that I do not have such a grasp of accounting as the member, but clearly he does not have a grasp of confidentiality in negotiating contracts. There is no way that I will reveal any of the details of the negotiations currently being undertaken with Serco.

Mr R.H. COOK: Has it provided the minister with a number?

Dr K.D. HAMES: The answer is that I will not make any comments, and nor should I.

Mr R.H. COOK: This is taxpayers' money.

Dr K.D. HAMES: Of course it is, and we will look after it very well.

Mr R.H. COOK: This is taxpayers' money that the minister has hidden inside a privatisation contract. These are the consequences of the minister's privatisation policies.

Mr V.A. CATANIA: I have a point of order. The member for Kwinana has asked a question and the minister has answered it, but the member for Kwinana is having a debate about it.

The CHAIRMAN: Thank you, member. I am perfectly capable of stopping that. It is not a point of order. Would the member for Kwinana please not interject across the chamber without being given the call for a further question.

Mr R.H. COOK: Is the minister aware that Serco is under investigation by the serious fraud squad in the United Kingdom after it was revealed that Serco and G4S overcharged the United Kingdom government by up to £50 million for contracts with that government? What extra precautionary measures is the minister taking, given the current contract he has with Serco?

Dr K.D. HAMES: Yes, I am aware that that occurred last year. Frankly, I do not think it is relevant to the budget.

Mr R.H. COOK: The minister is in negotiation for a serious amount —

The CHAIRMAN: Does the member have a further question, but not on this issue because the minister says that it is not relevant to the budget. If you have a further question, go ahead.

Mr R.H. COOK: When will the minister complete the negotiations with Serco and when will the taxpayers of Western Australia know how much money has been wasted through the delays to Fiona Stanley Hospital?

Dr K.D. HAMES: I will hand over to Dr Russell-Weisz, who is involved in the negotiations.

Dr D. Russell-Weisz: We do not have a definitive time for those negotiations to cease, but we are in negotiations with Serco at the moment. I imagine that we will know more within the next two months, and that is the time frame that we are working to at the moment.

Mr V.A. CATANIA: I refer to the line item for the Southern Inland Health Initiative on page 149 of the budget papers, which initiative is funded by royalties for regions. The estimated total cost of telehealth is $5.5 million but there is $1.45 million for this financial year. Can the minister outline the initiatives that will be put in place for telehealth, because it seems to be working quite well in regional WA?

[10.20 am]

Dr K.D. HAMES: One of my staff has an answer to this, but I can say that there are different components to telehealth. There was a significant amount of funding in the southern inland health package. There is additional funding in the north west health initiative, and there is additional and specific funding for the goldfields region to improve telehealth. It will make an enormous difference to be able to roll out those increased telehealth services across the state. For the specific answer, through Bryant, we will defer to Shane Matthews from the WA Country Health Service.

Mr S. Matthews: In excess of 10 000 occasions of service will be delivered through telehealth in 2013. That number is growing at approximately 40 per cent per annum. One of the two most mature telehealth services in WA is the emergency telehealth system that was set up by the WA Country Health Service in August last year. To the end of July, 2 863 emergency telehealth consults were delivered over the previous 12 months. That is available in numerous wheatbelt towns as a backup to local services, but also now currently available in Fitzroy Crossing and Halls Creek. There is a pilot for the Geraldton emergency department as a backup for emergencies. The other most mature telehealth service is the plastic surgery telehealth service coming out of Royal Perth Hospital. It has had strong support over many years. In relation to telehealth, we have been talking with the Ontario Telemedicine Network. We are currently looking at a scoping project. It is likely we will create a non-government organisation that will actually be the receptacle for private and government telehealth services across the state. We think that will have a dramatic increase as well.

As the minister mentioned, there is funding through the goldfields emergency telehealth as part of the government's election commitment. There is also telehealth funding in the north west health initiative. WACHS is currently looking at the consolidation and expansion of the emergency telehealth service into what we are calling at the moment a "virtual emergency telehealth service" that will see funding from each of those programs pooled into one service to ultimately supply the entire state.

Mr V.A. CATANIA: With the redevelopment of all the hospitals occurring in regional WA, will it be an option for telehealth to be put into these hospitals or is it more on a private practice basis?

Dr K.D. HAMES: There are two components to the answer. One is the vision that we had particularly for the southern inland health package. Because we cannot get enough general practitioners to service all of the smaller towns throughout the wheatbelt, for example, Merredin or Northam could be a central place to provide doctors. We would support and help to recruit doctors. They would do outreach services to the smaller country towns that could not get a doctor, maybe with the assistance of a nurse practitioner. A little country town, for example, might have a nurse practitioner working there and consulting with patients three to four days a week, and two or three days a week one of the doctors might conduct a clinic as well. To do that, there has to be really good telehealth links. For example, the nurse practitioner could see someone that she perhaps could not treat on her own, linking into the hub—people do not like "hub and spoke"; I am not sure exactly why—such as Merredin, and getting advice from doctors in Merredin. Consecutively, they could link into Royal Perth Hospital or Sir Charles Gairdner Hospital for more serious advice about higher level things. It is about having that network.

We are talking about how the Ontario model works. That is run by a non-government, not-for-profit organisation. Queensland has the highest number of telehealth services in Australia; it does about 20 000 services per year. In Ontario, for the same population and for a region the same size as Western Australia, there are 100 000 uses per year. In fact, I planned to look at that until the state budget was put off and we were doing budget stuff. A very good Northern Territory model has been put in place. We need to look at the Ontario and Northern Territory models. I suggested to the Chair of the Education and Health Standing Committee that since I cannot go, it would be a great task for that committee to look at these things. It could assess how we can maximise the significant funds we are putting into telehealth in this state.

Mr R.H. COOK: I refer to page 130 of the first volume of budget paper No 2. The minister promised during the election campaign that he would commit an additional $30 million over four years towards health and medical research. The minister has now comprehensively broken that promise, with the budget papers revealing only $12 million in new money. How will the minister make up the shortfall of $18 million, or is this a blatant broken promise?

Dr K.D. HAMES: I have clearly not broken the promise. The promise was to provide an additional $30 million for research. That is exactly what we are doing. That $30 million is additional for research; $12 million was provided through government money. In doing that, we are providing additional funding of $6 million this current financial year for research; $8 million the following year; $8 million the year after that; and $8 million the year after that. That adds up to $30 million. That is an extra $6 million, $4 million, $4 million and $4 million above what is in the budget. The budget has nothing this year; $4 million, $4 million and $4 million. It will become $6 million, $8 million, $8 million and $8 million. To provide that, it requires $6 million additional

funding this year and $4 million for the subsequent three years. We have identified money within HIN—contracts worth probably just under $100 million a year.

Ms J.M. FREEMAN: Sorry, what is HIN?

Dr K.D. HAMES: It is health information network.

Some of those contracts are coming to a close. We think that more work can be done in-house rather than contracted out to sometimes extremely expensive consultants. I have decided that that money is far better spent doing significant work in research than it is staying in HIN. We will set up a future fund that allows the private sector to make donations to it as well and for them to be tax deductible. An independent committee will provide governance over the spending of that money and other funding. I think we announced last year an additional $5 million. Some of that went towards Alzheimer's research, some went to muscular dystrophy research and a range of other areas, and some went to the stuff we did with the Telethon Institute for Child Health Research. For our $1 million, Telethon provided an additional $2 million in this current year for paediatric research. We will feed all those funding amounts through that future fund. An independent committee will assess applications and distribute the funding, recognising of course that there is always some research to which the government needs to provide priority loading.

Mr R.H. COOK: Can the minister point out where in the budget extra funding is available for future health, particularly in relation to the cuts to HIN?

Dr K.D. HAMES: That is in the total budget allocation to health. Within the global health budget is an internal allocation to HIN. The budget does not contain all the lower-end details. It will be in areas that are under the main health component of the budget.

Mr R.H. COOK: Given that there is only $12 million in the line item "Future Health – Health and Medical Research"—which is what is detailed in the budget—how can we have any confidence that that money has actually been provided? Are we supposed to just rely on the vibe of the budget?

Dr K.D. HAMES: Which page?

Mr R.H. COOK: It is on page 130, minister.

[10.30 am]

Dr K.D. HAMES: I refer the member to the third dot point on page 137, where it quite clearly says that a further $18 million for health and medical research is to be reprioritised from within the budget, bringing the total to $30 million. The member can take confidence in this because it is in the budget papers.

Mr R.H. COOK: But it is not. The allocation under future health is $12 million. I understand that there is a bit of commentary around reprioritisations. For a member of the public, that is interesting commentary but it is not an allocation to future health.

Dr K.D. HAMES: The budget documents often contain additional funding for some areas that is extra appropriation. We had that discussion before about the patient assisted travel scheme funding. The funding that was previously there for PATS was baseline funding. The funding will be provided, and the member will know that when we allocate $6 million to that committee for this financial year in the very near future.

Mr R.H. COOK: Why is it not in the budget?

Dr K.D. HAMES: It is in the budget.

Mr R.H. COOK: It is not. Under "2013–14" there is nothing.

Dr K.D. HAMES: I have given my answer.

Mr P.B. WATSON: I refer the minister to page 139 and the proportion of target population who receive home and community care services. Given the ageing population, can the minister explain why the number of people in the target population receiving HACC services is anticipated to fall?

Dr K.D. HAMES: I do not understand the question. I am on page 139. I ask the member to take me to the line that he is talking about.

Mr P.B. WATSON: It is at the bottom of the page—"Rate per 1,000 target population who receive Home and Community Care". The 2011–12 actual is 378 per thousand and the 2013–14 budget target is 361 per thousand.

Dr K.D. HAMES: I am afraid we will need to provide supplementary information.

The CHAIRMAN: Is the minister saying he will provide supplementary information?

Dr K.D. HAMES: Looking at those figures, we can see that the estimated actual for this year is 363. HACC services are provided jointly between the state and the commonwealth, and we provide them according to demand. The rate was 378 in 2011–12. The question should be: why did it go from 378 in 2011–12 down to 363 in 2012–13? I do not know why but it did. It has already done that.

Mr P.B. WATSON: It is going down a little bit more next year. It is gradually declining.

Dr K.D. HAMES: I do not know why. We will provide that as supplementary information.

The CHAIRMAN: Can I confirm what supplementary information the minister will provide?

Dr K.D. HAMES: I will provide the reason for the reduction from the estimated actual of 363 per 1 000 population in 2012–13 to 361 in 2013–14.

Mr P.B. WATSON: I really want to know the rate for the previous years.

Dr K.D. HAMES: The member would have noticed the budget in 2012–13. He did not ask me that last year. He should have asked me then so I could find out why. It was a 50-person reduction. We just provide the service, but we will get the answer for the member.

[*Supplementary Information No A26.*]

Mr C.D. HATTON: I refer to page 133 and the emergency department services' ambulance surge capacity unit. Although there has already been some discussion, can the minister please advise what strategies have been put in place to alleviate the pressure on emergency departments and, in particular, details about the trial unit at Hollywood Private Hospital?

Dr K.D. HAMES: The trial unit at Hollywood hospital was initiated by St John Ambulance but supported by the Department of Health to provide an alternative to significant problems we are having with numbers in our emergency departments, specifically, ambulance ramping, which was the worst ambulance ramping we have had. As I said before, I would have loved to have Fiona Stanley Hospital ready four years prior to its opening because demand, particularly with the surge in population in Western Australia, continued to grow and put pressure on our emergency departments. Frankly, without the four-hour rule in place we never would have coped years ago. That initiative was set up to give immediate treatment to mostly category 4 and 5 patients, with some category 3 patients that would otherwise have been ramped at a hospital. It was set up with a general practitioner, nursing support staff and paramedic support staff so that they could treat those patients and take off some of the pressure, and it has worked very well, although we have continued to have ramping. In the first instance, it stayed high when not all hospitals were involved in it but once we added the full suite of hospitals, we saw a reduction in ramping, although it was still at unacceptable levels. Those hospitals have been using Hollywood hospital but they have been told that the time for that is up in October, and that after that we have to find an alternative. My wish—that is the point of getting doctors out from the UK—is that we can significantly improve the four-hour rule. When we improve the four-hour rule, we will get rid of that ramping at the front door because we will get a much better flow of patients through the system. In the meantime, we need to keep that going to help keep the pressure off our hospitals.

The figures that St John Ambulance has put out show that a significant number—probably at least a quarter of those patients—are admitted to a private hospital. Although they have come by ambulance and would otherwise have been at our public hospitals, they have been admitted to a private hospital. A small number go home. They go to a private hospital to get assessed by the doctor who is looking after them, and realise that they are not as bad as they thought, the problem settles and they go home. The others are then sent home within 24 hours of their arrival, so they do not stay overnight. In the evening they are then referred to the hospitals in a more planned manner so that, depending on what is happening in the hospital and what the demand is in the hospital, it smooths that out. I have just been advised that 20 per cent of the patients go home, which is a significant number. Having those patients assessed takes the pressure off the hospitals. On some occasions the ambulance has gone to those patients assessed by the doctor and he sends them straight off to hospital because he feels that they need more acute care. St John Ambulance is looking at alternative locations to provide the service post-October. Frankly, I think we need to keep supporting that service until we get to the stage at which our hospitals do not need it any more. It is certainly not the preferred option but, sadly, it is very difficult to find alternative options. We looked at space at the front end of Royal Perth Hospital for where these patients could stay. We did a small trial there but it quickly failed because the space was not adequate. We do not have empty, unused areas in our hospitals that could be used for this purpose, so the only way to do that is to provide it off-site.

[10.40 am]

Mr R.H. COOK: I noticed that the minister raised the issue of the four-hour rule and the deteriorating performance of our emergency departments to meet that rule—in fact there has been a reduction by almost four per cent. Can the minister explain why there is such a drastic drop in commonwealth funding from $21.7 million to $4.6 million towards EDs, and the implications of that drop?

Dr K.D. HAMES: Mr Salvage will need to answer that, but before he does, I can say that in terms of the deteriorating position it is interesting to note what has happened in the United Kingdom. All its hospitals were running at 98 per cent and the government then changed its target to 95 per cent. The hospitals that were running at 98 per cent were quite angry about it because they said that as soon as the government announced the reduction, there was a drop-off in performance in just about every hospital in the system. We hit our target of 85 per cent, and at the same time we had targets of 75 per cent under the National Emergency Access Target program, but then not for a while; and almost to that day the performance of hospitals dropped away because they were not under such pressure and it was easier to sit back, relax and take it easy. In terms of the specific commonwealth funding that is provided, we need a page number in the *Budget Statements*.

Mr R.H. COOK: That commentary occurs on page 143 under the fourth service "Emergency Department".

The CHAIRMAN: It is also a continuation of the previous question.

Mr R.H. COOK: That is correct.

Dr K.D. HAMES: Where is the commonwealth funding?

Mr R.H. COOK: The minister will notice it under the heading "Explanation of Significant Movements", which in that context is across the services. The commonwealth funding has dropped significantly, as the minister can see, from $21.72 million to $4.6 million.

Dr K.D. HAMES: We do have that answer. I defer to Mr Salvage.

Mr R.W. Salvage: That represents the tailing off of funding received from the commonwealth under the National Partnership Agreement on Improving Public Hospitals, which was a time-defined commonwealth funding stream announced a couple of budgets ago. That provided dedicated funding for elective surgery and emergency departments and has been applied to do service redesign work and the like, but it was always a time-defined funding stream. Under the National Health Reform Agreement, there is a commitment on the part of the commonwealth and all states and territories to review the way in which the funding under that agreement has been applied across the four years of its duration. That agreement ends in 2013–14, and there is a decision point in December 2013 as to whether the commonwealth will commit ongoing funding to that program into 2014–15 and beyond. Until we have an announcement of that decision, we can put in the budget papers only the numbers that are representative of what the commonwealth is providing to the state.

Mr R.H. COOK: Does that money include the moneys that the department would have received if it had met its targets under the NEAT program?

Mr R.W. Salvage: Yes. In terms of the total package of funding under that agreement, which came to $351 million—it is referred to in earlier budget papers if the member would like me to reference that—there was a component for reward funding for performance in emergency departments and elective surgery delivery, and obviously that is contingent upon the department meeting the targets under the agreement.

Dr K.D. HAMES: We have met the targets for NEAT and received the full component of the NEAT funding, so we got the full reward payment.

Mr R.H. COOK: What will be the reward payment if we meet the funding by the December quarter?

Dr K.D. HAMES: I think Mr Salvage just said that those figures and final payments of money will be decided in December. It is not yet finalised.

Mr R.H. COOK: Are they represented in the $4.6 million?

Dr K.D. HAMES: They will not be—no. That is the tail-off of the existing funding that was provided.

Mr R.H. COOK: Can I be clear on this? Is the minister saying that the payments that are detailed in 2012–13 and 2013–14 are not any of the reward moneys for meeting targets?

Dr K.D. HAMES: The answer was that they contained the reward moneys within them. It is not as though massive amounts were available altogether. Some money was available for use within the system, and, as we heard earlier, although there is a year to go, that is not in the out years. That funding finishes in 2013–14. That final method of payment, and how that will work, was not decided by the commonwealth, but there were reward

payments for hitting the targets that we hit before. Part of the money expended included that reward funding. I must clarify that answer through Mr Salvage, as I might not have it got it exactly right.

Mr R.W. Salvage: For reward payments under the national partnership agreement to be consistent with the way the state approaches these across other arrangements with the commonwealth, the money will not be allocated to the Department of Health until it is earned. Therefore, the numbers that the member sees here will be net of the reward funding until it is confirmed. Of that $351 million I referred to earlier, there is approximately $20 million each in reward funding for both elective surgery and emergency department performance.

Mr R.H. COOK: Can the $4.6 million be characterised as clinical redesign minor works?

Mr R.W. Salvage: That is correct. When we received the commonwealth money, there was a process of engagement with area health services about what they needed to do to improve their emergency department performance. Solutions were agreed to, and the commonwealth money was applied to meet those solution requirements.

Mr R.H. COOK: Will we meet our NEAT targets by the December quarter?

Dr K.D. HAMES: The target is 81 per cent by December, and with the way we are going, it looks like we will not meet it—but no other state is anywhere near doing that; in fact, they are miles behind us. Hence, our negotiations and discussions with the commonwealth about that reward payment and how it operates. There are similar things in elective surgery and ED access targets. We need to significantly lift our game. I am pushing hard for us to meet that 81 per cent by December, but it is supposed to be averaged over the preceding period, and not that that is the target and we hit it. I hope to convince the commonwealth that that should be the method we use, as we would then be the only state that gets the money. I think the commonwealth will recognise the difficulties in achieving that across Australia and provide those funds to help stimulate our being able to get there. As I said, it is proving very difficult. Some hospitals are going very well. Our children's hospital is working at about 95 per cent, but others—Joondalup and Sir Charles Gairdner Hospitals are good examples—are going backwards at the moment.

Mr R.H. COOK: The contrast with the other states that I alluded to earlier is that other states are improving and our state is not.

Dr K.D. HAMES: Sure, but they are improving from a very low base, and a lot of their percentages are way behind ours. Their growth rates have been far less than ours. We have had a population boost, with people coming into Western Australia from other states, and our ED demand has gone up on average by more than six per cent. It has been very difficult in that respect. The health system is always a challenge, as the member will hope to find out in future.

[10.50 am]

Ms J.M. FREEMAN: I refer to page 189 of budget paper No 3, and I note that $10 million has been taken from Royal Perth Hospital redevelopment stage 1 in 2013–14 and another $108 million in 2016–17. Does the minister now concede that he broke his promise to redevelop Royal Perth Hospital, given that he promised it in the 2008 election and then said it was a second-term commitment, when the budget papers now reveal that he will not deliver on that promise this term? When will he deliver on the Royal Perth Hospital redevelopment for the people in the area? I note that in the budget papers there are allocations for Royal Perth Hospital stage 1 of $4 million for both 2013–14 and 2014–15; $9 million for 2015–16; and $50 million for 2015–16. I am rather confused. Does that mean the amount for 2013–14 was $14 million, but now it is only $4 million?

The CHAIRMAN: There are a number of questions there. Did you get all that, minister?

Ms J.M. FREEMAN: He gets the vibe!

Mr R.H. COOK: It is the health budget, Madam Chair; we can talk about things that are not in there because, apparently, they sometimes are.

The CHAIRMAN: Thank you for those comments, member.

Ms J.M. FREEMAN: Anyway, the minister broke his promise, so what will he do for the people who use Royal Perth Hospital?

Dr K.D. HAMES: The answer is no; I did not break the promise.

Ms J.M. FREEMAN: Yes, you did.

Dr K.D. HAMES: We promised to retain Royal Perth Hospital as a tertiary hospital, which we have done, as was our commitment in the election. We are also looking to redevelop it. We made it very clear through the first term of government that that was not a first-year commitment; it was a second-year commitment. Given we are now only six months into our second term of government, I cannot see how members opposite can say we have broken our promise when we have three and a half years left.

Ms J.M. FREEMAN: Given that —

Mr R.H. COOK: The budget papers show it.

The CHAIRMAN: Member!

Dr K.D. HAMES: It was a long question and will require a long answer in response. We are committed to do that redevelopment of the hospital. My preferred option was to do a new west wing and a new emergency department. When we came to government we had to spend $2 billion on Fiona Stanley Hospital and $1.2 billion on the children's hospital. The Labor government had left only $200 million in the budget for it and we had to find another billion dollars. We also had to build Midland hospital, for which there was only half the money we needed and so on.

Mr R.H. COOK: The commonwealth gave you half the money.

Dr K.D. HAMES: It was not financially possible for us to do that because it would have been another $500 million or $600 million minimum at the time—perhaps more like $1 billion now—to build that additional west wing. Remember that we are downsizing that hospital to only in the order of 450 beds, so we do not need the whole hospital. The advice we had was that the structure of that building is still of a very high quality, so the proposal is to totally clean out and renovate the inside of that H-shaped A block. As a result of the opening of Fiona Stanley, there will be a significant reduction in staffing, so a lot of staff and services will move out of Royal Perth Hospital to Fiona Stanley. We cannot do that while the hospital is full of all its current patients; we have to wait until after the transfer of patients to create the space, when we will do internal renovations. We have just referred it to our major works component, so that the task force that looks after major works, such as Fiona Stanley and the children's hospital, has now taken over responsibility for the management of that redevelopment. In the near future the task force will start getting together a business case to prove up the exact changes that will be put in place and the cost of those. We still have $50 million in those out years to start that construction. It means that it has probably been pushed back slightly because of the Fiona Stanley Hospital changes, but we will work on that once we get the business case prepared.

In my view, the best way to do it is to do the block of, I think, seven storeys adjacent to Wellington Street, move all the patients to the church side and do a complete redevelopment of that side, which could be done reasonably quickly. The $50 million may well cover completely renovating the ward side of it. The outer section was largely going to be administration, so total costing and timing need to be done for that because it will happen after the patients move from the church side of the H block to the Wellington Street side of it.

Ms J.M. FREEMAN: Is the minister managing the health budget on his hopes and aspirations or on what he knows he can deliver? He cannot deliver a promise on the basis of taking out $108 million.

Dr K.D. HAMES: I was going to say that members of the opposition know the importance of getting business cases prior to allocating funds for construction, but then I remembered that they do not know that. We saw that with the Perth Arena project and with most of the others—for example, the Fiona Stanley Hospital that started with a budget of $600 million and worked its way up over about four years —

Ms J.M. FREEMAN: At least we left money for it and not a deficit.

Dr K.D. HAMES: — until it finally got a business case.

Mr R.H. COOK: We paid for it.

Ms J.M. FREEMAN: Then we paid for it.

Dr K.D. HAMES: Members are not supposed to interject.

The Labor government did not have the full amount of money there, anyway. If the money had been put into debt levels, there would have been less debt and greater capacity to borrow. It made no difference where the money was put.

Mr P.B. WATSON: Not like the futures fund.

The CHAIRMAN: Members!

Dr K.D. HAMES: It is like putting it in one bank versus another. I have drifted off the topic.

Ms J.M. FREEMAN: The question was —

The CHAIRMAN: Can members please not interject over the top of each other. Hansard has indicated they are having difficulty keeping records. It is really important. Have you finished, minister?

Dr K.D. HAMES: I do not think so; I will see whether more comes to me.

My point is that we must have a business case before making those final decisions. We have three and a half years of government left. This budget takes some funding out to cope with overall funding levels in those out years because the project may need to be put back 12 months as a result of what has happened with Fiona Stanley Hospital. We have to deal with the reality of the circumstances.

Ms J.M. FREEMAN: Given the minister promised this before he was elected in 2008 and then said it would be delivered as a second-term commitment, would he not have done a business case in the first term so he could have it ready to go in this second term, or is he just fudging and managing the health budget on hopes and aspirations while taking out $108 million and being unable to deliver what he promised people?

Dr K.D. HAMES: We are six months into a four-year term of government. The public will be able to judge in four years whether we have met the election commitment.

Ms J.M. FREEMAN: The significant reduction in staff —

Dr K.D. HAMES: I do not think you have been given the question yet.

The CHAIRMAN: One further question.

Mr R.H. COOK: The minister said that the limitations on his capacity to deliver on election promises were as a result of his now having to take account of the construction costs associated with Midland, Fiona Stanley and other hospital developments.

Dr K.D. HAMES: I do not recall saying that; say it again so I can be clear.

Mr R.H. COOK: The minister said the delays in developing Royal Perth Hospital in an overall budgetary sense were because he has to take account of the costs associated with the Midland hospital construction, the Fiona Stanley Hospital construction and other associated costs.

Dr K.D. HAMES: I do not think I said that. We can refer to *Hansard* later.

Mr R.H. COOK: My question is: is the minister saying, therefore, that his promise to redevelop Royal Perth Hospital was not fully costed and fully funded when he made that commitment at the election?

[11.00 am]

Dr K.D. HAMES: The member is incorrectly referring to words that I said. I said that when we were in opposition, we said we would retain Royal Perth Hospital as a tertiary hospital, and my preferred option at that time, from opposition, was to build a new west wing for Royal Perth. However, when we got to government, we found that the Labor government had not budgeted for the children's hospital, it had not fully budgeted for Fiona Stanley Hospital and it had not fully budgeted for Midland hospital.

Mr R.H. COOK: When was that, minister?

Dr K.D. HAMES: The constraints on —

Mr R.H. COOK: In 2000 and when?

Dr K.D. HAMES: The constraints on that —

Mr R.H. COOK: How many years ago?

Dr K.D. HAMES: Madam Chair, I think the member is acting contrary to your advice.

The CHAIRMAN: Member, I will warn you again: do not yell across the chamber.

Dr K.D. HAMES: He was not yelling. He was just interjecting.

The CHAIRMAN: Member for Albany! Minister, would you like to complete your response?

Dr K.D. HAMES: I would love to!

The CHAIRMAN: Thank you.

Dr K.D. HAMES: I forget what the member said.

The CHAIRMAN: Fine. Shall we move on?

Dr K.D. HAMES: Sure.

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

Mr R.H. COOK: We are not talking about the minister's problems associated with when he was elected in 2008. Throughout his term of government from 2008 to 2013, he repeated the promise that he would redevelop the hospital in his second term.

Dr K.D. HAMES: Yes.

Mr R.H. COOK: The minister is now saying that he cannot afford to do that because of financial constraints.

Dr K.D. HAMES: Again, the member is wrong, and I made that clear in my previous answer.

Mr R.H. COOK: So why is the minister delaying it?

Dr K.D. HAMES: The member was using an answer to a question relating to why we did not do it in our first term of government and extrapolating that to say that that is what I said for our second term of government. That is not what I said. He really needs to read —

Mr R.H. COOK: Why is the minister not doing it in this term?

The CHAIRMAN: Member for Kwinana!

Dr K.D. HAMES: We promised to do it within this second term of government. We have three and a half years to go for our second term of government. The member can make the judgement at the election time in three and a half years to determine whether or not I have met my election commitments.

The CHAIRMAN: The member for Eyre.

Mr R.H. COOK: More lies. Liberal lies—that's all it is!

Dr K.D. HAMES: Madam Chair, I do not think that is an appropriate term to use in this house.

The CHAIRMAN: The member was speaking over the top of me. If you feel that it should be withdrawn —

Mr R.H. COOK: I do not, Madam Chair.

The CHAIRMAN: I am sorry; I did not hear what the member said, but please keep your decorum in this estimates committee and then we can achieve a lot more.

Dr G.G. JACOBS: My question relates to page 149, under the heading "Works in Progress", and the minister's good management of his aspirations for Midland and the Midland Public Hospital. I refer to the Midland Public Hospital development stage 1, which is a $360 million project. The government has spent $92 946 000 this year. Can the minister outline how the construction is going? I believe we are a year into it; the project celebrated its first year of construction. Will the construction be on time and on budget?

Dr K.D. HAMES: The Midland Public Hospital is going really well. We were down there just recently to celebrate the project's first year of construction, and I think it was 30 per cent completed; it is going up amazingly well. One whole section of the building on the site away from Midland town is now at its full height, and the other building section is up about halfway. Associated with that project is the need for some roadworks to make sure that there is good access. At the Lloyd Street crossing, an overpass at that railway line is needed. That will start in the near future. Of course, some services will be provided by the private sector adjacent to that hospital. We will be going out in the near future for expressions of interest for that to be done. The hospital itself, as members know, will be a huge boost to the region and will take over from the Swan District Hospital. While it has provided a great service to that community, it is well past its use-by date.

Mr R.H. COOK: In relation to that line item, does that include funding for the construction of the alternative clinic that the minister has undertaken to run next to that hospital?

Dr K.D. HAMES: The government will not be running the alternative clinic. We will be going for expressions of interest from the private sector to run a day surgery centre there. I have said that publicly before. We will be funding some services within it; that is, services that Sir John of God is not able to provide will be funded —

Mr R.H. COOK: Or will not even refer patients to —

The CHAIRMAN: Order, member! Allow the minister to complete his answer.

Dr K.D. HAMES: There is not a great number of patients; I forget the exact number.

Mr R.H. COOK: So it does not matter then!

Dr K.D. HAMES: About 100 patients a year are the number who will not be able to be looked after. Alternatively, they can go to Kalamunda Hospital if they wish; there is the opportunity to provide all those services at Kalamunda Hospital. But in keeping with the commitment that we made before the election, a piece of land at the east end of that site can be used to provide not just the services that we are talking about, but significant additional services. There is a need for a day surgery centre in that region to provide a whole range of other services, some of which, such as endoscopies, government will need to have done in a clinic like that. Also, general practitioners will be able to undertake minor day surgery there. It is a great opportunity for the government to provide additional services to the region, covering the things that will not be provided by St John of God. As I said, it is a very small percentage of the total number of services that are currently being provided at Swan District Hospital, but this gives the government an opportunity to expand that significantly by allowing a private provider to put facilities on there that will cater for a whole range of other services as well.

Mr R.H. COOK: A further question, Madam Chair.

The CHAIRMAN: A further question—the last one.

Mr R.H. COOK: I begin by making the observation to the minister that the government calls it universal health care for a reason. But I ask the minister to set out what moneys have been set aside in the forward estimates to establish the new medical school, given his commitment to deliver the medical school at that site by 2020. If the government is supporting the new medical school, what representations has the minister made to the federal government to promote its funding?

Dr K.D. HAMES: I am very much in favour of a new medical school in this state. There was one other organisation that is strongly opposed to it, and the Australian Medical Association —

Mr R.H. COOK: Of which the minister is a member!

Dr K.D. HAMES: The AMA has spoken publicly on frequent occasions opposing the school. I am a strong believer in its value. It is not in our budget. Money has been committed; it is either in the Premier's budget or the Minister for Education's budget because it is an education facility that is proposed, not a health facility. We do not fund medical schools or medical training through the health budget. But it is something I strongly favour. We have a significant shortage of GPs in this state. The national average of GPs is something like 7.5 GPs per 10 000 head of population. The national average, when one looks at each state, shows that most of the other states are around that figure. Western Australia is at 6.5 GPs per head of population. If someone was to do the sums on a city population of 1.6 million, it means that we are in the order of 300 GPs short in the metropolitan area, and 100-and-something in the country. Having an additional medical school would be fantastic, particularly as the other two now have postgraduate programs. Medical students must complete seven years of study—unlike the six years that I did. Students need to complete a three-year or four-year degree—whatever the degree is that they want to do, but it is a minimum of a three-year degree—and then four years of medicine following that. The alternative proposal for the new medical school is a five-year program, similar to one in Canada that has proved very successful. In my view, the type of training students will undertake is far better suited for people who want to be GPs—namely, a lot of hands-on training with other service providers such as physiotherapists, occupational therapists and the like to give a much more hands-on experience for those doctors doing their training. The school would be a great boon to GP numbers in this state.

The criticism comes around the ability for training and the space within our hospital system for training; that is why the AMA is saying it is opposing it. In my view, we are significantly increasing bed numbers throughout the state, particularly with the Midland Health Campus, which is virtually double the size of Swan District Hospital, and with Fiona Stanley Hospital, which adds an extra 200 beds to that system. I think there are far better opportunities for using our new country hospitals, such as Albany; Busselton, which is under construction; Karratha, which will start in the near future; and the expansions at Geraldton. So there are opportunities for that training to occur in other areas.

[11.10 am]

Mr R.H. COOK: I have a point of order. I asked the minister what representations he had made to the federal government to support it, not his sort of cheering from the sidelines.

The CHAIRMAN: I ask the minister to get to that in his answer to the question.

Dr K.D. HAMES: I make the point that it is the member's question but my answer; therefore, I give my answer in the way I think best.

Mr R.H. COOK: No, the minister is under instructions from the Chairman to be concise in his responses.

Dr K.D. HAMES: I thought it was a very concise answer compared with what I could have said as an alternative answer.

In terms of my representations, I have had frequent conversations with federal government ministers, particularly Tanya Plibersek and, I think, Nicola Roxon before her, asking them to support the project. I have also written to the federal minister, supporting that medical centre, and we have had discussions with the potential alternative government. I have had conversations with both Peter Dutton and the guy who assists him, Andrew Laming, who is a specialist and a member from Brisbane. I had a detailed discussion with Andrew Laming to promote the need for an additional medical school in Western Australia. Is that a good answer?

Ms J.M. FREEMAN: We got bored halfway through.

Mr P.B. WATSON: We went to sleep halfway through.

I refer to "Government Initiatives and Budget Priorities" on page 130, and specifically the line item "Expansion of Renal Dialysis Service".

Dr K.D. HAMES: Which one, because we have a few renal dialysis —

Mr P.B. WATSON: I am just using that line item to get in to talk about dialysis at Albany Hospital. The minister can take any one of those! My constituents have a real issue about the fact that the people who cannot get into the dialysis service in Albany have to go to Perth and, therefore, their whole family has to go to Perth. This especially affects our seniors. I asked a question on notice about this issue. To the question, "How many patients are on the waitlist", I received the answer, "Nil." I asked: what is the average time spent on the waitlist prior to treatment? The answer was —

> Data on waitlist time prior to being accepted at Albany Health Campus is not kept.

To me, that answer means that these people have put their names down, but they are not on a list. Therefore, they have to go to Perth and there is no chance in the future that they will get the service in Albany. Why have a waiting list when data on the waitlist time prior to being accepted is not kept? That confuses me and it confuses my constituents.

Dr K.D. HAMES: Madam Chair, I will need to get Shane to answer that question. It is to do with renal dialysis, and there are specific things about the waiting times for the hospitals. In terms of the broader question of renal dialysis—since the member used a broad number to ask the question, I presume I can use that same broad number to give the answer—we have provided significantly increased funding for renal dialysis across the state —

Mr P.B. WATSON: I realise that and I am not having a crack at that. All I am saying is —

Dr K.D. HAMES: I am about to get the member's answer for him; I know what he asked.

Mr P.B. WATSON: I just wanted to cut short that long answer!

Dr K.D. HAMES: I am sure the member did!

The CHAIRMAN: Minister, complete your answer.

Dr K.D. HAMES: I refer the question to Shane Matthews.

Mr S. Matthews: I do not have a specific answer to that question, but that person assumedly is receiving dialysis in the metropolitan area and is waiting to return to Albany. So, the fact that there is no waiting list does not gel with me and make sense, so we will need to understand that better.

Dr K.D. HAMES: I do not exactly understand the answer, I have to say.

Mr P.B. WATSON: I do not either.

Dr K.D. HAMES: If someone is waiting to be treated in Albany, surely they would be on the waiting list for Albany while they are being treated in Perth; is that not correct? I am asking questions of my own staff now!

Mr S. Matthews: That is why I do not understand why we said that there is no waitlist if that is the case.

Mr P.B. WATSON: The answer, in part, stated —

> At this time, there are no patients on a waitlist.

The answer also stated —

> Data on waitlist time prior to being accepted at Albany Health Campus is not kept.

Therefore, the answer is that if people put their name down, the department does not keep a list until they have been accepted. How can they be accepted if they are not on a list?

Dr K.D. HAMES: I do not understand the answer. I understand the question but not the answer, so we will have to provide that answer as supplementary information.

The CHAIRMAN: Minister, can you just define what will be provided?

Dr K.D. HAMES: The answer is around waiting lists for patients requiring renal dialysis in Albany —

Mr P.B. WATSON: Minister, could we say that there are some who are receiving treatment in Perth at the moment?

Dr K.D. HAMES: Yes. We will review the answer previously provided on notice to the member for Albany and clarify the issue of patients who are not on the Albany waiting list who may be getting treatment in Perth.

[*Supplementary Information No A27.*]

Mr D.A. TEMPLEMAN: I refer to the line item "Peel Health Campus — Development Stage 1" in the table of works in progress on page 149. There is a figure of just over $1 million and I ask what that involves. Does anything in the budget include moneys for the expansion of the Peel Health Campus car park? As the minister is probably well aware, the car park is basically in an overflow situation every single day.

Dr K.D. HAMES: It is a big car park, but it is just not big enough.

Mr D.A. TEMPLEMAN: In that allocation or any other allocation in the budget, are any moneys set aside for increased car parking at Peel Health Campus?

Dr K.D. HAMES: I refer that question to Ian Smith and then Wayne Salvage.

Mr I. Smith: Those funds are over 2013–14. We are currently commissioning a site audit that will consider all things that are fit for purpose, so it is not excluded or included in that process. That will be something we can ensure that we consider through this audit, which is happening now and will be completed by the end of this month.

Dr K.D. HAMES: Can I say to you that parking is a critical issue down there. I have raised it with the new managers of that site. As a local member, I am getting numerous complaints about people being unable to find parking and then of course the council gets them when they park on the verge. So, that problem really needs to be addressed. Mr Salvage does not have a further answer on that.

Mr D.A. TEMPLEMAN: Can the minister clarify that there is no money in the budget for the expansion of car parking?

Dr K.D. HAMES: I thought you said you could use that.

Mr I. Smith: The $1 064 000 is not ring-fenced. I cannot clarify at the moment whether car parking is or is not in the fit-for-purpose audit because we have not finished that audit.

Dr K.D. HAMES: What he is saying, from my point of view, is that some funding is not specifically allocated, so there is an opportunity to use that on car parking. An audit of works is underway at the moment. That amount of money is available to do whatever works are designated for it.

Mr V.A. CATANIA: Staying on page 149, I refer to the Southern Inland Health Initiative and the line item about the integrated district health campus, which has $147 million of royalties for regions funds. Can the minister please advise where the integrated campus will be located and what benefit it will bring to regional communities? Also, can the minister provide a general update on SIHI; what is happening with that? The reports I am getting are that the Southern Inland Health Initiative is working extremely well.

Dr K.D. HAMES: The Southern Inland Health Initiative has been working very well and it is bringing a huge number of increased services to people in the regions. The member asked where the campus will be located, but it is not a campus; it is campuses, and that is funding for work on all those. I presume Shane Matthews has a further answer to the member's question.

[11.20 am]

Mr S. Matthews: The $147.7 million is for —

Dr K.D. HAMES: It is $147.1 million.

Mr S. Matthews: Functional regional project definition plans will be developed in the latter part of this year for Narrogin and Katanning. In the early part of next year they will be developed for redevelopment works in Northam, Merredin, Collie and Manjimup.

Dr K.D. HAMES: Can I just clarify some of what has been said because the member seemed to think that some places would get totally redone hospitals earlier, which is not what is planned under the southern inland health package. A lot of the package is about funding to support services, getting extra doctors working in the system, telehealth and so on. But there is a component of funding—$147.1 million—that is designed to do improvements to hospital infrastructure to make sure that it better suits the services that are being provided. Across the forward estimates it can be seen that there is not enough funding in any year to build a new campus; it is for upgrading existing campuses and providing a better health service.

In the first year there was a lot of consultation and discussion across the regions about which hospitals needed to be done first and what upgrades were required as a part of that. The same is happening with the northern initiative, of which the member is aware. We will progress over the next three years to do that work. Most of the work will be done next year and the year after. There are a couple of projects we want to get on and start, and each year a number of them will be completed.

Mr V.A. CATANIA: Can the minister give an explanation on SIHI? It is not just rebuilding hospitals; it has touched places in my electorate, such as Mt Magnet, and provided extra nurses. Can the minister elaborate on how it is about not just building infrastructure, but providing the services we need?

Dr K.D. HAMES: I might go to the former country health manager because he developed the full Southern Inland Health Initiative package when he was doing country health and knows it intimately. I will ask Mr Smith to do a summary of how the SIHI works and what it provides.

Mr I. Smith: We split SIHI into several streams, with the key focus being how to stop the haemorrhaging of GPs from the country. Through the incentive package, we worked with the local GPs, the private GPs, and this has been extremely successful. Unfortunately, I do not have the very latest figures of how the GP numbers have improved but SIHI has made sure that we have a sustainability of service that is well backed up by the telehealth service. From an earlier question, it is interesting that when we started this process, we thought there would be some resistance from the local GPs to fully utilise telehealth, but they have embraced it extremely well because of the increased comfort and confidence it gives them to deal with the full range of accident and emergency cases that come through the door. That has stabilised the medical workforce in the southern area.

The second component was to look at innovation around creating primary health care demonstration sites. That is a process whereby we involve the local government to express an interest about whether it wants a different model of care in its community; and we are working with a couple of communities very closely there. But that is predominantly around a capital building program as we reconfigure services.

We also created a stream through which we were trying to have not only GPs but also a much more comprehensive primary health care service with other service providers in the town to ensure that the aged-care nurse or nurse practitioner looking at ambulatory rather than acute care services could all work in partnership and minimise the amount of travel and inconvenience to patients. This has occurred predominantly around the larger sites of Merredin and Katanning and is initially a concept-proving process.

The final stream is the capital works that was described earlier. We are trying to get a very strong—I do not want to use the words “hubs and spokes”—process whereby the smaller sites are much better supported by the district sites and the facilities are being built to enhance primary health care and support the larger community.

Ms J.M. FREEMAN: I want to look at Osborne Park Hospital, listed under the asset investment program review on page 189 of budget paper No 3. I note that the redevelopment of Osborne Park Hospital will cease with a reduction in funding of $0.4 million in 2015–16 and $16.8 million in 2016–17 and that the current funding of $1.5 million in 2013–14 and $1.9 million in 2014–15 listed on page 151 of budget paper No 2 is related to additional parking facilities. The member for Mandurah might find it interesting that a whole line item is for additional parking facilities. Can the minister confirm that the redevelopment of Osborne Park Hospital has now been cancelled? Can the minister also confirm that this funding was for the redevelopment of a 50-bed mental health service? Can the minister confirm that this mental health service reconfiguration was to take place to create extra capacity at Graylands Hospital, and that this impacts Graylands Hospital’s modernisation and capacity?

Dr K.D. HAMES: I can answer only a component of that question. The issues to do with Graylands Hospital and the need for the mental health service at Osborne Park Hospital are clearly for the Minister for Mental Health. I understand from conversations with the minister that she has an alternative model for the provision of

mental health services. During the budget process, there was a requirement for a reduction in capital works projects across the system, including in health, and the redevelopment of Osborne Park Hospital was taken out, given that the minister said that there were other ways she wanted to provide those additional mental health services.

Can I say to the member, who is from that area and obviously has strong personal and family links to that hospital, as I am aware, that we need to look in the not-too-distant future at the redevelopment of that total hospital site. It is not big enough and, as she knows, it has been there a long time and is getting pretty old. We will need to look to the future at what we do with that site as a major project, not just one providing additional mental health beds.

Mr R.H. COOK: For the Chair's benefit, this issue has come up in every estimates since 2009—since the minister has been the Minister for Health. Osborne Park Hospital and Graylands Hospital have been discussed every time that it has come up. I note in the budget this year that the planning that went into the Graylands Hospital redevelopment has now been completed, yet there is nothing in the forward estimates about the redevelopment. The reason why this is further to that point is that in the past the minister has clearly explained that the redevelopment, or the retirement, of the Victorian, and quite frankly disgraceful, conditions at Graylands Hospital is contingent upon the creation of extra capacity at Osborne Park Hospital. In May 2012 the minister confirmed that the redevelopment was for an extra 50 mental health beds that would then create capacity at Graylands Hospital. Can the minister confirm whether, now that the government is no longer going to redevelop Osborne Park Hospital, Graylands is now off the list as well?

[11.30 am]

Dr K.D. HAMES: I have no knowledge of what is happening with Graylands. The member would need to ask the Minister for Mental Health.

Mr R.H. COOK: It is in this minister's budget.

Dr K.D. HAMES: All I know is that the minister has alternative plans in mind and this money has been withdrawn from my budget for the construction of those services at Osborne Park Hospital.

Mr R.H. COOK: Madam Chair —

The CHAIRMAN: Is this a further question?

Mr R.H. COOK: It is, Madam Chair, because after we have completed division 9, we will have an opportunity to quiz the Minister for Mental Health. The Minister for Mental Health's representative will not answer our questions because he will say that the question belongs to division 9. This is the issue we confronted last year in estimates. The minister is deliberately trying to avoid answering the question. It is in his budget; it is his budget line item, Madam Chair, so he should be answering it.

The CHAIRMAN: Can the member identify the line item?

Dr K.D. HAMES: Madam Chair, the only thing that is in the line item to which the member refers is the Osborne Park Hospital reconfiguration, and I can confirm that money for that has been withdrawn. Graylands Hospital does not form part of my budget.

Ms J.M. FREEMAN: The minister says that money has been withdrawn, but in answer to a previous question the minister talked about funding for scientific research work having been reallocated. On this fourth point does the $6.8 million for Osborne Park Hospital just go back into central revenue funding, or does it go back into general health department funding for redistribution to other areas?

Dr K.D. HAMES: We have a four-year budget before us, but clearly in health planning we plan for periods outside those four years. The funding for Osborne Park Hospital in that year has been pushed back. It is not in the budget because we are not budgeting for that year, but it is planned to be in the budget for the 2017–18 financial year. It should therefore be back in the out year of next year's budget.

Ms J.M. FREEMAN: If it is in the budget for 2017–18—I gather the $16.8 million is for further planning—and the minister is now saying that the beds are not required, does that mean that the $16.8 million will be for different buildings at Osborne Park Hospital?

Dr K.D. HAMES: The amount is still there. In fact, it is $34 million in 2017–18 because there was some in the following out year. It still appears there because the final decision by the minister has not yet been made. Although the minister is looking at alternatives and may not want those facilities at that location, that decision has not yet been made. The member will therefore be able to ask her today what she plans to do and whether she

will require those facilities. But we have it still in our forward planning so that if the decision is still to put those facilities there, we have the financial capacity to do so.

Mr C.D. HATTON: I refer to the second line item, "Care for Palliative Patients", under "Government Initiatives and Budget Priorities" on page 130. This total commitment adds up to $19.5 million over four years. Can we have some further detail around what this represents for patients? Is there a component for patients in regional areas outside the metropolitan area?

Dr K.D. HAMES: When we came to government after the election in 2008, we made a commitment to significantly increase funding for palliative care patients across the state and to provide funding accordingly of $14 million across the forward estimates for four years, and we put that in place. It was interesting to see the opposition's media release on election commitments. Although I presume the opposition knew that its commitment to funding did not go through to the forward estimates, as it did not appear in any of the previous three budgets, it did not commit any funding to palliative care services in this state. That meant, presumably, that the funding would have dropped off because there was no ongoing budget for it. We committed to keep the funding going. The $19.5 million represents the continuation of the current programs—that is, the growth in cost from $14 million in the previous four years. Yes, a component of that is for country services. Some services will be paid for by royalties for regions to make sure that we provide high-quality palliative care for patients in the dreadful circumstance at the end of their life, particularly care in a person's home so that they can pass away peacefully with their family.

The CHAIRMAN: I will go to the member for Kwinana and then to the member for Eyre, just so that members know where we are heading.

Mr R.H. COOK: I refer to pages 135 and 139 in regard to Aboriginal health services. I have commended the minister in this place before for providing bridging funding for the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. I am really providing the minister with an opportunity to provide an update on re-signing the national partnership agreement on the Closing the Gap program, if it was re-signed. If it was not re-signed, what is the loss of federal money both in 2012–13 and 2013–14 for not re-signing the Closing the Gap agreement; is that figure represented in the commonwealth grants expenditure line item; and will the state government make up the complete shortfall through state finances?

Dr K.D. HAMES: I thank the member for the question. I must say that I would have very much liked to have that question as a dorothy dixer!

Mr R.H. COOK: You just cannot buy a decent backbench nowadays!

Dr K.D. HAMES: It is a very sad tale about how the commonwealth operates its agreements. The Closing the Gap program is part of a four-year Council of Australian Governments agreement that committed funding from both state and commonwealth governments. We as a state met that commitment; $117 million over four years was put up by the state with a similar amount from the commonwealth government. I have no idea what the commonwealth spent its money on. It mostly did that through its own means directly into Indigenous communities. I was told by the manager of the Aboriginal Medical Service in Geraldton that the program we put in place is one of the best in Australia. Sometimes those services, with very strong key performance indicators around the work, are provided by the Western Australian Council of Social Service, the Aboriginal Medical Service and other non-government organisations. I am constantly told how good the system is. As we came up to the last COAG meeting, the Premiers' discussion on the items on the federal government agenda did not include this COAG agreement. I therefore asked COAG to contact the federal government and ask why it was not there and whether the federal government intended to keep it going. We were very keen on progressing this agreement—and there was nothing. Subsequent to that, we heard that the federal government had decided to continue the funding for one year, although I did not read the federal government's recent budget to see that it was in there.

Ms J.M. FREEMAN: The minister did not see it?

Dr K.D. HAMES: I did not read the federal government's budget to see whether or not it was there. The federal government said that it would put it in the budget that it has just released, but that it would fund the services through its own sources and through whatever it was doing before. I still do not know what the federal government was doing. We therefore committed to continue the funding for one year while those negotiations and discussions with the commonwealth were underway. I read a letter from Mr Snowden recently criticising Western Australia for not signing up to the agreement as had other states. I have not seen the agreement yet, let alone been able to sign up to it. Health department people have been having discussions with the commonwealth about the proposal, but there is no final document and there is no final agreement that can be signed. We

therefore remain keen to be part of a national agreement on the Closing the Gap program, and as soon as this caretaker period has concluded, we will have discussions with the new federal government to make sure that this very important program is not stopped.

[11.40 am]

Dr G.G. JACOBS: Understanding the high incidence of deafness in children in remote communities and the impact on their education, I direct the minister to the line item "Ear health services in remote Indigenous communities" on page 130 of the *Budget Statements.* Over four years, $6 million has been allocated to that. What service will that buy, if you like; and, what is the status of our Earbuses and our potential surgical buses to treat children with ear problems and deafness?

Dr K.D. HAMES: The issue of ear health in Indigenous communities is very dire with a significantly higher incidence of poor ear health and, in fact, hearing loss in remote communities. For many years I have constantly heard quoted that 30 per cent of children in remote communities have hearing impairments, but I have since heard subsequent figures from some particular communities that it is as high as 40 per cent and 50 per cent. That means that those children who go to school are not able to hear their teachers, and kids who get a bit behind and perhaps do not do so well tend to sit at the back of the class where they can hear even less and thus their ability to be schooled is not developed. Kids who do not do well at school tend to find other ways to be dominant in the community, and often that is by fighting in the schoolyard. These kids tend to get into strife as a result of the fact that they cannot hear what the teacher is saying. An alternative model of health care was put to us by Harvey Coates, and we have subsequently had discussions with a range of specialists who provide ear health. Their recommendation to us was that in every Indigenous community there needs to be a person whose job is to look after ears—check ears, treat them and properly manage them. This $6 million of additional funding will start the process.

After discussion with the ear health specialists, we came up with the way the process will work. First, there needs to be a model of care for ear health. There are questions such as when to give antibiotics and how often to give them, issues to do with ear toilets and issues to do with long-term antibiotics, such as whether a child with a recurrent middle ear infection should be given long-term low-dose antibiotics; and, in what circumstances that should be done. Collectively, the ear specialists have developed for us that model of what needs to be done. We will then probably employ existing Aboriginal health workers, who are fairly certainly already working in the communities part-time, as a 0.2 or 0.3 full-time equivalent, depending on the size of the community. The bigger communities such as Bidyadanga or Balgo, for example, would have a 0.3 FTE and the smaller communities would have a 0.2 FTE. That person will walk around all day with a tonometer in their hands, checking pressures, looking in ears and doing ear toilets. If antibiotics are needed, patients will be taken to the health clinic. The workers will make sure that patients get them; they will work with parents to ensure that children are given the antibiotics. They will be able to use an otoscope with the capacity to upload an image to a computer or an iPad and then use a telehealth link with a specialist in Perth or wherever to guide the ongoing treatment. If a patient gets to the stage that grommets need to be inserted, the ear health worker will help coordinate the children from their communities who need to have those grommets inserted. We will train those people to ensure that they have the knowledge and we will provide them with the equipment they need. Subsequent to that plan, the director general made a very good suggestion about how we could further use those staff in two particular areas. One is in oral health. It is very easy for that health worker to look in the mouth of the child to see whether obvious dental caries need treatment at the same time as they do the ear checks. There is a new method of treating children's teeth now—that is, to paint their teeth with fluoride every six months. That significantly reduces the incidence of decay for those children. The other thing that the health worker will do is look at eye health. As we know, there is a high level of trachoma in some of those remote communities, and those health workers will be able to identify that and make sure that people get treatment.

The surgical bus is just a concept we are thinking about for the time being. A suggestion was made by some that the surgical bus could go to communities such as Fitzroy Crossing or Halls Creek and a specialist would then go there to do the surgery. There is not enough in it to warrant doing that just for ear health; we are thinking whether other things could be done.

Ms J.M. FREEMAN: I have a point of order. This is very interesting and I understand that this is mentioned on page 136 of the *Budget Statements*, and that the minister has provided $6 million of funding when he gave a commitment for $8 million, but we are getting an $8 million answer instead of a $6 million answer in terms of its shortness.

The CHAIRMAN: The minister was asked about the Earbus as part of the question.

Dr G.G. JACOBS: It is an important issue.

Ms J.M. FREEMAN: I agree, but the answer does not need to go for quite so long.

The CHAIRMAN: It would be good if the minister could complete his answer.

Dr G.G. JACOBS: Seventy per cent of Indigenous kids can be deaf.

The CHAIRMAN: Order, members!

Dr K.D. HAMES: I think this is one of the most important programs we are putting in place for the future of Aboriginal people in remote communities. I think the member is being quite insulting to those people.

Ms J.M. FREEMAN: I think it is fantastic, minister, but —

The CHAIRMAN: Order, member for Mirrabooka.

Mr R.H. COOK: We are just objecting to the minister using up time to filibuster.

Mr V.A. CATANIA: It is a very important question.

Mr R.H. COOK: This has nothing to do with the importance of it.

The CHAIRMAN: Minister.

Dr K.D. HAMES: Madam Chair —

Mr R.H. COOK: If the minister is not taking this seriously, why does he not give up?

The CHAIRMAN: Member for Kwinana, I call you for that comment. I have called for order and I have asked the minister to finish his answer, and the member continues to shout across the chamber. I will note him down.

Dr K.D. HAMES: The final component of the question related to the surgical bus. For now we are just waiting to see. The possibility being considered is to use a bus like that for other services in remote communities—dentists, for example—that might need that facility. We are exploring that option. In the meantime we will get on with starting those FTEs, particularly in those bigger remote communities.

Ms J.M. FREEMAN: On page 156 of budget paper No 2, there is mention of commonwealth grants expenditure. A number of people who are very concerned about the community physiotherapy program have visited my office, including a lady called Dawn Mielans. What programs did the commonwealth grants contribute to in 2012–13, and how much was contributed to each program? What is the status of the community physiotherapy program funding, particularly with respect to commonwealth grants in 2012–13, 2013–14, 2014–15 and 2015–16? Has the minister put these programs at risk because of his failure to sign up to agreements on community physiotherapy programs?

Dr K.D. HAMES: I will address the last part of the question first, which shows again the failure of members opposite to understand the difficult relationship we have with commonwealth. There has been no offer to sign up to any agreement relating to this community physiotherapy program. I have been begging the federal Minister for Health and Medical Research to continue funding for this program, and up until now the commonwealth has refused to do so.

Mr R.H. COOK: When?

Dr K.D. HAMES: When which?

Ms J.M. FREEMAN: When did the minister beg?

Dr K.D. HAMES: When did I beg? I have sent letters to the federal minister on, I think, two occasions.

Mr R.H. COOK: Did the minister table them?

Dr K.D. HAMES: I do not have them with me.

Ms J.M. FREEMAN: Supplementary.

The CHAIRMAN: Order, member.

Dr K.D. HAMES: I am happy to get them.

Mr R.H. COOK: Can they be provided by way of supplementary information?

Dr K.D. HAMES: No; I would just like to answer this question.

Mr R.H. COOK: So there is no evidence that the minister begged the federal government.

The CHAIRMAN: Order, member; please allow the minister to finish his answer.

[11.50 am]

Dr K.D. HAMES: The original program was state funded, so the state, through the previous government, ran it. I guess I got involved because the then Minister for Health, Jim McGinty, was going to cancel that program in 2005. There was a huge community outcry about cancelling it and he agreed to continue it partly in its current form, but to morph it into providing more services for subacute patients coming out of hospital. Then four years ago, the commonwealth came up with a four-year program to provide additional funding for subacute patients. That additional funding allowed us to significantly expand the services that were being provided in this state; in fact, there was so much demand and so many services were being provided that it overshot the mark a bit and by April a significant portion of the state and federal funding had been spent. It was eased back over the next month and a half to get to the next financial year, but at that stage there was no further commitment of commonwealth funding; hence, I wrote to the federal minister asking what she was going to do and whether she would continue that funding.

Since then we have done two things. Firstly, our staff have worked with commonwealth officers, not the minister, and have managed to get funding for one year from commonwealth funds that are provided under the national partnership agreement but were not specifically allocated for this use. The commonwealth has agreed to allow us to redirect uncommitted funding of $940 000 for one year. State funding has grown with inflation and demand, so it will continue to grow. As I said on radio last week, I have had a conversation with the person running the program, and when demand outstripped commonwealth and state funding in April, the program had to be cut back. I asked that person what it would cost to keep it going at that level, because clearly that was the demand. I talked to her about the importance of the program and I asked her whether it was really important for the state to provide that service and her answer was that it was absolutely and definitely a fantastic service. I have asked her to put to us a proposal that outlines the funding required to provide that level of program until April next year. That will probably require us to put in extra state funding of $300 000 or $400 000. That happened only last week. The program will continue. We are still in discussions about whether it will continue beyond that year and whether the commonwealth has the capacity and preparedness to continue funding for the subsequent three years. Whether the commonwealth provides its share of the funding will be critically important. This was part of the negotiations with the commonwealth about total state health funding. Part of that package was to provide additional funds for subacute care. This is what we used it for and now we are having trouble getting the commonwealth to commit to its share of the funding.

Ms J.M. FREEMAN: Can I tell Mrs Mielans that the Minister for Health recognises the importance of her health and of not going to hospital for acute care and that he will ensure that the program continues at all the places it was being provided previously?

Dr K.D. HAMES: If the constituent wants an answer from me, she should write a letter to me, if she has not done so, and I will provide the answer about those services.

Ms J.M. FREEMAN: She has written a letter to the minister.

Dr K.D. HAMES: I have said that we will continue the program, so the funding will continue. I hope that the member explained to her constituent that her federal colleagues refused to provide the funding, which had been provided previously, and that that was the very reason that this program was under so much pressure.

Mr R.H. COOK: I am looking for an answer to the member's question about whether the program will continue at all the centres.

Dr K.D. HAMES: The answer to that was that I will provide an answer when the patient writes to me. My answer is that I would expect so. I cannot see why not, but I do not run the program; I just provide the funding. The department will make the decisions on how that money will be spent and the standard of service provided based on demand and the locations of demand. The funding will be increased above the present level. From a state government funding point of view, there is no reason why that might be the case. The only reason that the service may not be provided at a particular venue is that the people who provide the service are of the view that that is not the best location, but they will make that decision.

Mr P.B. WATSON: I refer to the corrective measures outlined in the table on page 130 of the budget papers. There is a $300 million global savings target. What is the reduced spend on legal services, and will there be cuts to specific hospital legal services?

Dr K.D. HAMES: I will hand that to the acting director general.

Prof. B. Stokes: We are trying to reduce the use of external legal consultants and to use more in-house consultants and provide more services from our legal branch to individual health services. It is to try to reduce the use of outside legal consultants.

Dr K.D. HAMES: Now that the acting director general has said that, I recall that the state government policy is to try to stop using so many external legal advisers.

Mr P.B. WATSON: Firstly, will there be cuts to specific hospital legal services, how many full-time equivalent staff are currently in legal services and how many will be cut because of this?

Dr K.D. HAMES: Professor Stokes.

Prof. B. Stokes: No legal services staff will be cut in the department. The cut will be in the use of consultants. I think that Mr Salvage, who looks after legal services, will confirm that.

Mr R.W. Salvage: That is the case. This was part of a whole-of-government decision to look at the arrangement for the provision of legal services to government departments and at the role played by the State Solicitor's Office versus outsourced or departmental legal service staff. As part of that, we are taking an adjustment to the budget to reflect the fact that there is a resource transfer to the State Solicitor's Office that was authorised through a previous budget process. There will be no cut to the legal services staff within the department; the existing number of FTEs will be maintained.

Mr P.B. WATSON: There will be no cut in services because the department will not use outside legal services; it will use the in-house lawyers. The advisers are saying that there will be no cut to staff, but will the department save all this money just through cutting the use of outside legal services or will it provide fewer legal services through the hospitals?

Dr K.D. HAMES: Professor Stokes.

Prof. B. Stokes: There is no cut in the staff in our services; it will be a cut in the use of outside services. That is where the funding is.

Mr P.B. WATSON: Will there be any cut in the services to people at the hospitals? I know that there will be no cut in staff; I just want to make sure that there will be no cut in the services.

Prof. B. Stokes: There will be no reduction in the services.

Ms J.M. FREEMAN: Given that the contract negotiations with Serco over the delays to Fiona Stanley Hospital will be so complex and bound up in contractual law, will the department use in-house legal counsel in those negotiations, and will this have any impact on that?

Dr K.D. HAMES: No. The State Solicitor's Office is used to provide that legal advice, and that is what we would have done anyway.

Mr V.A. CATANIA: I refer to page 148 of the budget papers, which refers to the commencement of construction for the Carnarvon health campus redevelopment and the Exmouth Multipurpose Service redevelopment. The opposition made some announcements during the election campaign about those campuses. It made a commitment of $19 million to the Carnarvon health campus, but it obviously missed the budget projection of $26 million for the redevelopment that had already been accounted for. Can the minister give an update on those two campuses, how they are progressing and whether they are part of, or on top of, the northern inland health initiative?

[12 noon]

Dr K.D. HAMES: Madam Chair, I can answer that, but I need a quick break to check the colour and consistency of the china! Can I get my staff to answer that in my absence because they certainly have the capacity to do it?

The CHAIRMAN: I was going to suggest that as we get to the changeover in chairperson, because everyone has been here for three hours.

Meeting suspended from 11.59 am to 12.04 pm

[Mr N.W. Morton took the chair.]

The CHAIRMAN: Minister, I think the member for North West Central had just asked you a question. Did you need him to repeat that question?

Dr K.D. HAMES: I need to reply, but I would like to bring to the committee's attention a further answer to a previous question. I was asked if I knew that Serco was being investigated by the Serious Fraud Office in the UK over a contract. Some advice has been provided to me. I said that I was aware—I thought I was aware, but my advice says that Serco has not, and is not, being investigated by the Serious Fraud Office. Another company, G4S, was investigated as it did not agree to comply with the British government's own review. I am just clarifying my previous answer.

I thought one of the advisers was going to answer the question from the member for North West Central.

Mr S. Matthews: The complete design and development of the Carnarvon and Exmouth health campuses will be completed by October this year, and detailed contract documentation by November of this year. Both will go to tender, hopefully, by March 2014; to commence construction in May 2014. The complete redevelopment is proposed for April 2015. The balance of $6 million—the difference between $19.8 million and $26 million—will come out of WACHS' capital funds.

Mr V.A. CATANIA: The other question I asked was: is the redevelopment of the Carnarvon and Exmouth health campuses part of the northern inland health initiative?

Mr S. Matthews: No. This is on top of the northern health initiative. That $161 million is in addition to those approved projects in Carnarvon and Exmouth.

Mr V.A. CATANIA: Is Karratha health campus part of the northern inland health initiative?

Dr K.D. HAMES: No, it is not either. I think that is $207 million. These are all significant investments in the future health of the north west of the state. Significant amounts are going to Exmouth and Carnarvon. The northern inland package is $161 million. It will further enhance services. There is something like $207 million for the new hospital to be built in Karratha. That is funded through royalties for regions. It is a fantastic package.

Mr P.B. WATSON: As promised, will the Carnarvon health campus redevelopment include new or expanded dental health care facilities?

Mr S. Matthews: A new ambulatory care centre will be created in Carnarvon. Mental health will be located in that centre. There will be a refurbishment of the emergency department and a building and infrastructure upgrade; so no is the answer to dental.

Mr P.B. WATSON: A broken promise—thank you.

Mr R.H. COOK: My question relates to the commentary at the bottom of page 132 and over onto page 133 about the state transitioning price and community service subsidy. I am aware from that commentary that the state transitioning price is around $5 319. At this stage, is the minister able to advise the differential between the state transitioning price and the national efficient price? How will the minister reduce the difference between the state transitioning price and the projected average cost at hospitals like Rockingham General Hospital? What work has been done thus far to determine how much of the $387.4 million community service subsidy is due to genuine service and system delivery in efficiencies as opposed to what the minister has described in Parliament as simply "the cost of doing business in Western Australia"? What structural inefficiencies have been identified thus far?

Dr K.D. HAMES: There are two components to the figures. The state price is $5 319 per service; the national efficient price is $5 152—a difference of $167. When I said it is the cost of doing business in WA, I do not think I said that exactly because it is a combination of things —

Mr R.H. COOK: No; that was my paraphrasing, I appreciate that.

Dr K.D. HAMES: It is a combination of that and recognition that we can be more efficient in the services that we provide. We need to work to see where we should be on that continuum. Our argument with the commonwealth, and in fact with Treasury, will be around identifying those things about which we have no choice. One of those is the high cost of nurses in WA compared with other states. Our nurses are the highest paid. We need to keep doing that to ensure we attract the number of staff needed. Doctors are the same. We have to pay considerable amounts. As members have heard before, there are costs involved in flying people to WA from around the country to provide coverage. The cost of getting those services to the people of Western Australia will clearly be more expensive. We will be mounting the argument during the years to come as to exactly what that differential should be. In my view, it should be somewhere between those two costs. There is no question that we can be more efficient.

[12.10 pm]

I do not know whether the member has ever compared the provision of services in a private hospital with a public hospital but I have worked assisting in surgery in both and there is a vast difference between how those services are provided. I would rock up to assist in a private hospital and we would change, scrub up and walk into the theatre where the patient was. We would go out and grab a cup of tea and when we came back, the next patient would be there. We would do the same thing in a hospital such as Swan District Hospital. We would walk in, sit down and have a cup of tea and a sandwich because they would send for the patient once they saw that the doctor was there. Then we would come out and scrub up and go back and sit down again because the patient would be delayed getting to the theatre and getting ready. When it comes to knock-off time, that is it; it is knock-off time. We can gain a lot of efficiencies. As I said, I think the figure will be somewhere between those two. I think that has covered the question.

Mr R.H. COOK: The minister is essentially admitting that there is a $130.7 million black hole in the budget because of that differential. They are the savings that have to be found.

Dr K.D. HAMES: No; I am not saying that at all. This year we are getting money from Treasury at a state price. That funding is to provide services at the level we are providing them. Over the next four years we will see a reduction in the community service subsidies. We need to mount an argument during that time that it should not reduce by that amount, otherwise, if we cannot get our level of service down to the cost of the national efficient price, the member will be correct. My view is, as I said, that the true figure will be somewhere between the two. In the out years—not in this year's budget because we are fully funded for it in this year's budget—we will see a figure that is somewhere between the two, providing we win our argument with Treasury, of course.

Mr R.H. COOK: Just to get some context, can the minister tell us the kill date?

Dr K.D. HAMES: There is no kill date. If the member turns to the top of page 129, he will see the total cost of delivering the service is $3.9 million in 2013–14, $4.1 million in 2014–15 and $4.5 million in 2015–16. Under the estimate for 2013–14 is the figure of $156 507 000, which then reduces in the forward estimates. The $156 million is the difference between the state price and the national price. Treasury fund us the full amount for this year. When we get to the next year, that will reduce by $35 million. We may lose $35 million from next year's budget. For me, the killer time will be before next year's budget to convince Treasury that we need to become more efficient, but the rate of change needs to vary. The full impact is in the fourth year, for which only $30 million has been appropriated. That is the year when we get to the full national efficient price, or close to it. We should remember that in 2015–16, as part of the national health commitment, we have an extra $1.6 billion from 2014–15 in additional commonwealth funding. The commonwealth is funding 40 per cent of current services. At present, it is still funding at that level, but from 2014–15 it will provide us with additional funds as part of the national health agreement, regardless of that national efficient price, as it moves towards its commitment to provide up to 50 per cent of our state health funding.

Mr R.H. COOK: I request supplementary information. Can the minister please provide the average cost at Rockingham, Armadale, Swan District and, to a lesser extent, Joondalup hospitals—all those secondary hospitals?

Dr K.D. HAMES: Why does the member not just put it on notice? He asks lots of questions all the time and we answer fairly promptly. That seems a logical question to put on notice.

Mr R.H. COOK: Why does the minister not just provide it by way of supplementary information?

Dr K.D. HAMES: Because then it gives us a time limit to get it all together.

Mr R.H. COOK: The minister should have that stuff at his fingertips.

Dr K.D. HAMES: The advice I am getting is that the department is doing some work on that right now for Treasury to finalise those details and it will be better to have it on notice rather than as a supplementary. I ask the member to put it on notice.

The CHAIRMAN: Member, you are allowed to lodge that as a question on notice through the normal process.

Dr K.D. HAMES: We will get an answer as quickly as we possibly can within the time given to provide answers to supplementary questions, if that is easily done.

Mr R.H. COOK: I ask a further question. How much has the department spent on Ernst and Young for the work that it has done on Rockingham General Hospital on these cost structures? For all those millions, why does the minister not know what the average cost is?

Dr K.D. HAMES: I have given the answer; we require that question to be placed on notice.

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

Dr K.D. HAMES: We will take that as a supplementary question and provide information on how much has been spent on Ernst and Young's review of service provision at Rockingham General Hospital.

[*Supplementary Information No A28.*]

Ms J.M. FREEMAN: I refer to the bottom of page 130 and the line item "Saint John Ambulance Contract Extension to June 2014" for which funding is allocated. June 2014 will be here before we know it. When are the negotiations on the contract due to be undertaken and when will they be completed so that we will have a long-term budget for the contract for St John Ambulance? Will the new contract implement all the recommendations of the Auditor General's "Delivering Western Australia's Ambulance Services" report? How will the contract negotiations ensure value for money?

Dr K.D. HAMES: I will ask Professor Dorothy Jones to answer that question.

Opposition member: It is a $4-million question.

Dr K.D. HAMES: We will give a $4-million answer.

Ms J.M. FREEMAN: I should think it would be more than $4 million if it is going to be a contract over a long period.

Dr K.D. HAMES: I am just repeating what the member said. In fact, it is much bigger than $4 million.

[12.20 pm]

Prof. D. Jones: We have commenced negotiations with the St John Ambulance Association for contract extension. St John is in a year of extension at the moment, and I met with Mr Ahern and his staff only two days ago.

Ms J.M. FREEMAN: I am not talking about the extension. Keep going, thank you.

Prof. D. Jones: We are working through the issues around new performance arrangements within the contract. We are also making sure that all the recommendations in the most recent Auditor General's report are incorporated. I think that report demonstrated where significant progress has been made since the original investigation and there has been an increase in paramedic staff and an increase in the number of ambulances and in the clinical service design so that St John now reports clinical incidents to the Department of Health. They are part of the Department of Health review process for improving patient safety. My advice to date is that our negotiations are going well and my feedback from the St John executive is that it is comfortable with the process.

Ms J.M. FREEMAN: When will it be completed? I am not talking about the one-year extension. I am assuming the contract is for a three or four-year period to give St John certainty. When will that contract process be completed?

Dr K.D. HAMES: It will probably be a four-year contract. I think that is what we did last time. The member might remember that I had Greg Joyce undertake a review when we came to government because St John was not able to meet its target response times in a number of areas, and as a new government, we significantly increased St John's funding to address some of the shortfalls it had experienced under the previous government. It now meets all its targets despite the ambulance ramping and the huge increase in demand we have seen. We have extended for a year to give us plenty of time to do that negotiation. I do not have a fixed time at which it will be completed; needless to say, it will be completed during this one-year extension.

Ms J.M. FREEMAN: Will it go out for a competitive tender process or is it the government's intention for it to stay with St John Ambulance?

Dr K.D. HAMES: It will stay with St John; it will not go out for tender.

Dr G.G. JACOBS: My question is around Kalgoorlie hospital or, as it shows in the budget, the Kalgoorlie regional resource centre, an important hub for my region.

The CHAIRMAN: Sorry, member, which page are you referring to? I remind members to be specific with their references.

Dr G.G. JACOBS: I am referring to works in progress on page 148, which refers to redevelopment stage 1, $58 million, of which nearly $15 million is allocated this financial year. The current number of beds is 99, of which seven are mental health beds. Can the minister provide an update on this development and what services will be provided for my region as a hub?

Dr K.D. HAMES: As the member can see, this funding has been provided over the last four years, particularly when we have done a huge redevelopment at the Kalgoorlie hospital, with a new emergency and radiology department transforming the hospital from what it used to be. I recall, as I am sure the member will, that this is one of the hospitals the previous government promised to upgrade. I think it was put off in two elections in a row. I recall the then minister saying that it was not going out to contract because there were not enough contractors to do the work, without ever going out to ask. This is a magnificent development. I was there not long ago doing that official opening. I will hand over to Shane Matthews from the WA Country Health Service to go through in more detail the extra services that have been provided as part of this redevelopment.

Mr S. Matthews: Yes, obviously, the emergency department was the centrepiece of the works and the staff of the emergency department have been operating out of that new site for some months now. It is particularly functional. Things are going really well. The next stage of the redevelopment is the medical imaging, medical records and allied health areas. I understand that is ready for tender in the coming months and due for completion next year.

Dr G.G. JACOBS: Are there any plans to look at revamping the operating theatre section of the hospital?

Mr S. Matthews: There has been a review of the theatre, particularly the air flows and temperatures. Those works will be incorporated in the next phase of the redevelopment.

Mr D.A. TEMPLEMAN: I refer to the mosquito control initiative on page 137. I would like the minister to outline a breakdown of the expenditure over the next four years, including where, in fact, that money will be spent in his objective of eradicating mosquitos. His Liberal candidate from Maylands put out a press release claiming that the $1 million was for Maylands, and I do not think that was quite right. Will the minister outline the breakdown of where this money will be spent, which areas will have access to those dollars and what will be set aside for the funded research to investigate and develop new approaches to managing mosquitoes in hot spots around Western Australia?

Dr K.D. HAMES: The word “eradicated” can be interpreted in different ways.

The CHAIRMAN: Thank you, members!

Mr D.A. TEMPLEMAN: I know how I am interpreting it.

The CHAIRMAN: Member for Mandurah, you have asked the question.

Dr K.D. HAMES: This is a $1 million commitment over four years. Its breakdown is for $800 000 a year in funding to go to the better treatment of mosquitos and $200 000 in research; that is a total of $800 000 over four years for research. Expressions of interest will be sought and the research will be done depending on where the best proposal is and I think Lyn Beazley will be asked to oversee that. I would love to get that research done down in Mandurah. As the member knows, we have a massive estuarine system, with significant problems with mosquitos and a great university and TAFE combined down there, so it seems to be the ideal place in my view. But I will not let those personal views interfere with where it goes; it will have to be done independently. The $800 000 will be fed through the Department of Health contiguous local authorities grants, and it will work in conjunction with local government for treatment of mosquitoes. I think one FTE on the ground helps coordinate, and that will be increased to two or three, depending on how we decide to roll it out. Funds will be allocated to work with councils in providing additional spraying opportunities.

Members may have noticed that the candidate against me from his electorate down our way claimed that we had reduced funding in our region for mosquito sprays. That was clearly incorrect when the figures showed a significant increase in state funding. The odd mistake is made by candidates. There has been a significant increase in funding in our region because of the high levels of mosquitoes in that year. We fund the initial spray capacity and the council helps fund the distribution of that, although we make contributions by helicopter where that needs to be done. Since then I have had meetings with the City of Bayswater, which put a presentation to me for increased spraying for the Maylands area, and there is an opportunity to increase aerial spraying across the whole riverine system. It is being done in South Perth but not further south where their sprays cannot get to. Mosquitoes in the Kimberley are a significant problem also. We will be looking across local governments and working with them, as we do through a system that is in place. That additional $800 000 is available for increased management and control on mosquito issues which, as we know, plague our region and others.

[12.30 pm]

Mr D.A. TEMPLEMAN: So, effectively, any area that has a mosquito issue can apply to be included in this allocation.

Dr K.D. HAMES: That is true, but there are some areas that are a lot worse off than others. Our area is certainly one of those. Maylands and some of the upper reaches of the Swan are as well. So, the money will go where the need is.

Mr D.A. TEMPLEMAN: I have just a final question.

The CHAIRMAN: Final further question.

Mr D.A. TEMPLEMAN: When does the minister expect to eradicate mosquitoes from Western Australia?

Dr K.D. HAMES: If members use an iPad to search for "eradicating mosquitoes", they will see there are devices that can be put in a garden that trap mosquitoes. It is called a mosquito eradicator, so clearly the word "eradicate" is used in different versions. If anyone was silly enough to assume that using the term "eradicate mosquitoes" means that no mosquitoes were left in the Mandurah region, then I put it to them that they have a silly interpretation.

Mr D.A. TEMPLEMAN: You used signs during the election campaign —

The CHAIRMAN: Member, you said that was your final question.

Mr D.A. TEMPLEMAN: Eradicate mosquitoes —

The CHAIRMAN: Member for Mandurah, thank you; do not make me call you to order.

Ms J.M. FREEMAN: Is there consideration, like in the Florida Keys, to use drones to eradicate mosquitoes in Western Australia?

Dr K.D. HAMES: I am not aware of the use of drones to eradicate mosquitoes, but this is managed by Professor Weeramanthri's department. I do not know whether he would like to make a contribution.

Prof. T.S. Weeramanthri: I think the minister covered the points.

Ms J.M. FREEMAN: Are you going to use drones?

Dr K.D. HAMES: I have covered the points, was my advice.

Ms J.M. FREEMAN: But I need the answer: will you use drones?

Dr K.D. HAMES: I do not know whether we will use drones. Management comes under the department and it will work out the best mechanism to reduce mosquito populations throughout the state, particularly in areas where they are in plague proportions.

The CHAIRMAN: Thank you, minister; I think we have covered mosquitoes!

Mr P.B. WATSON: I refer to the second dot point on page 137, which is about health and medical research. I have looked right through the budget papers and I have seen everything that shows how we help people when they are sick, but I cannot find anything in the budget that states we are stopping people from being sick in the first place.

Dr K.D. HAMES: Preventative health.

Mr P.B. WATSON: Preventative medicine or preventative programs. Can the minister tell me whether there are some in the budget that I have missed?

Ms J.M. FREEMAN: Good question, member.

Dr K.D. HAMES: It is a very good question and I am sure that Tarun Weeramanthri who is in charge of that section of our health department will be able to list numerous areas in which we fund preventative health.

Prof. T.S. Weeramanthri: It is under service 7, "Prevention, Promotion and Protection", in the budget papers.

Mr P.B. WATSON: On which page is that?

Prof. T.S. Weeramanthri: Page 131 is the one that I am looking at. That includes the work of not only the public health and clinical services division that I look after, but also the Child and Adolescent Health Service and some other areas related to the broad area of prevention and promotion. But I will talk a little about my area in particular. There are a few key areas: one is the promotion of health, the next is the prevention of disease and the third is the management of risk. The promotion of health is in the area of lifestyle risk factors, such as alcohol, obesity and tobacco. A new health promotion strategic framework, which came out at the beginning of this year, shows the areas in which we wish to work over the next five or so years. Some key areas in the prevention of disease are the screening areas, which the member will be well aware of. The three evidence-based screening programs run on a national basis are breast cancer screening, cervical cancer screening and colorectal cancer

screening. Obviously, there are other areas in which we look to prevent disease, including through our interaction with the primary care services. The management of risk particularly looks at environmental health services, which is a large area of public health. We have just discussed mosquitoes, but there are many other areas of environmental health, from asbestos to lead or whatever, that we look at in preventing the exposure of people to environmental determinants of disease. There are also broader social factors that predict disease. I am talking about things such as education, housing, employment and poverty, which we look to work with other government agencies on. So it is a very big area. I will not try to give the member a complete thesis on it, but there is consistent investment from the health department, which is at or above the national average and has been so for some years, in prevention and the promotion of health.

Mr P.B. WATSON: Has the government looked at the idea of combining sport and recreation with health? That is done in Scotland where I think both health and sport and recreation are under the one minister. Does the minister think that that would be a good idea?

Dr K.D. HAMES: No, I do not, because sport needs a huge amount of time and effort on its own. But I think that these figures are pretty impressive; 6.6 per cent of our total budget is spent on this area of health. We fund a lot of those things; in fact, $5 million of our funding last year went to the KidSport program run by the Minister for Sport and Recreation that helps pay registration fees for children who cannot afford it. We were happy to do that because getting kids involved in sport obviously significantly reduces future health costs. Healthway has a large amount of money to fund programs, particularly sponsoring sport, to try to get across healthy messages working together. I do not disagree with the member that the concept really ties in well together but, frankly, the workload of a Minister for Sport and Recreation who has to cover a range of other things as a part of that portfolio would be too much to try to add to my portfolio.

Mr P.B. WATSON: Even if just the preventative things—child obesity, getting kids to exercise and things like that—shifted into the health department, with ideas from sport and recreation, would that not save the government money in its bottom line?

Dr K.D. HAMES: I think the member should suggest to his leader, if ever Labor is in government again, to give the Minister for Health also the sport and recreation portfolio. I think they would go very well together for exactly the reasons the member said.

Ms J.M. FREEMAN: I am assuming that the health promotion area is a discrete area in the department or it is under a policy area. Can the minister tell me the FTE for that area last year and this year and what it is projected to be in future years?

Dr K.D. HAMES: I do not know that it is all in one area. Certainly, a lot of it is in Professor Weeramanthri's area.

Ms J.M. FREEMAN: I am happy for Professor Weeramanthri just to tell me what his FTE is.

Dr K.D. HAMES: Professor Weeramanthri, do you have an answer for that?

Prof. T.S. Weeramanthri: I believe the question is about health promotion —

Ms J.M. FREEMAN: I am happy for it to be your broader area.

Prof. T.S. Weeramanthri: There is a specific directorate within the public health and clinical services division called the chronic disease prevention directorate, but there are also significant areas, for example, within the Child and Adolescent Health Service, that deal with health promotion as well. But just in my area, the FTE has remained stable; it is in the order of 15. I am happy to provide the member with an exact number, but it has not changed. I will tell the member what has happened over the last three or four years. The new Council of Australian Governments National Partnership Agreement on Preventive Health is a $60 million investment from the commonwealth government over what is now an eight-year period—it was a six-year period and has been extended. With all that new money coming in and continued and maintained state investment, we have managed to get most of that money out into the non-government sector, where much of the activities are provided, with an increase in FTE of about two. Therefore, we have $60 million of new investment and we have managed to push that out into the sector in Western Australia with a very minimal increase of staff in the department. I think that is a very efficient use of resources to get a lot of new money in and put that out into the non-government sector.

[12.40 pm]

Ms J.M. FREEMAN: I have a supplementary question. Could the minister provide me with the funding for and number of full-time equivalent positions from 2012–13, 2013–14 and 2014–15 for the chronic disease prevention directorate? Is the minister also able to provide as supplementary information the non-government organisation agencies that are funded?

Dr K.D. HAMES: What does Professor Weeramanthri think?

Prof. T.S. Weeramanthri: Some of the years the member said were future years.

Ms J.M. FREEMAN: No, no. Sorry, just the last two years and the budget years, plus information on those agencies that the government is funding would be great.

Dr K.D. HAMES: Professor Weeramanthri, the member is asking whether we can provide this as supplementary information or whether there will be any difficulty getting that information within the time period. What is the time period?

The CHAIRMAN: It is 30 August.

Dr K.D. HAMES: Is that all right?

Prof. T.S. Weeramanthri: Yes.

Dr K.D. HAMES: Yes, we will provide that then as supplementary information.

[*Supplementary Information No A29.*]

Mr C.D. HATTON: I direct the minister to page 149 under the heading "Works in Progress" and the line item for Sir Charles Gairdner Hospital "Cancer Centre Stage 2". I notice that the sum of just under $46 million has been allocated for that work. I understand that the minister recently opened the new centre. Can the minister outline what services are provided at the centre? I also understand that some technology by the name of "CyberKnife" is in use there. I would be fascinated to know more about what that would mean for a cancer patient.

Dr K.D. HAMES: That question is about the significant funding that has been invested in providing additional cancer services at that hospital. I had the pleasure of opening it and it is absolutely magnificent. Of course, the federal minister for health, Tanya Plibersek, also provided some funding for CanTeen to provide services at the hospital. We also provided funding for doctors who provide a special homeopathic medication support service. It is a service provided by doctors assisting in a cancer treatment called Solaris, which has been extremely successful. I will ask Dr Kelly to answer the rest of the question.

Dr S.P. Kelly: The minister has outlined some of the range of services the cancer centre provides. It provides medical oncology services, which is medical treatment for a range of cancers, and clinical haematology services, which are specific services for conditions such as lymphomas and leukaemias. The centre is quite actively involved in clinical trials and, of course, it provides radiation oncology services and has a number of advanced machines to provide linear accelerator services and the like. The CyberKnife, which is under procurement, is a special form of targeted radiotherapy that provides a greater focus of the radiotherapy beam to the tumour in question, and is used particularly for head, neck and skull-based radiotherapy services.

Dr K.D. HAMES: I think that without that machine we had to send patients overseas to get treatment. In fact, did we not send one to the US?

Prof. B. Stokes: No, that was proton therapy.

Dr K.D. HAMES: That was proton therapy. Sorry, it is slightly different.

Dr S.P. Kelly: Not that I am aware of.

Dr K.D. HAMES: I got that wrong. It is a different type of focus radiation therapy.

Mr R.H. COOK: I note the call from the Cancer Council Western Australia to fund three new full-time equivalent medical oncologists for the WA public sector every year for the next four years. That is not just three new medical oncologists over four years; it is three in each year. I think the council also called for a number of related positions to be filled. I am wondering whether the minister could outline what stage the government is at with funding and recruiting cancer doctors and nurses to meet the growing need for cancer care in the state. What roles would they be recruited for and when are the positions likely to be filled? Further, what is the long-term plan for the recruitment of oncologists and cancer-related positions? Clearly, Cancer Council Western Australia is pointing out that there is a significant shortfall at the moment.

Dr K.D. HAMES: In recent weeks we have been having significant discussions about those numbers. The funding for those positions is in the growth funding that we have in the budget. As members know, and as I said earlier, it is seven per cent growth funding. We are having discussions with Cancer Council WA and senior oncologists based at Princess Margaret Hospital for Children and Sir Charles Gairdner Hospital about exactly what number of FTEs we need and when we need them. Some positions have been advertised and some of those

places have been filled with new staff to meet some of the commitments we have made. Professor Stokes has been involved in those negotiations.

Prof. B. Stokes: I can add to that. The issue for some of the radiation oncology is, of course, that physicists, as well as radiotherapy technicians are required. We have looked at the number of those who are required and we have put aside sufficient money to fund those positions. Also in oncology, we are looking at providing a further oncological bone marrow transplant clinician to do that work. In addition, the support of some radiotherapy nurses and others is required. Most significant is the importance of trying to get good radiation oncologists, particularly those with paediatric experience and training. They are very hard people to get and we have been advertising for some time for a paediatric radiation oncologist. We do not have the demand at the moment or in the foreseeable two years for a full-time paediatric radiation oncologist, but one who has both adult and paediatric experience. It is very difficult to get those people at the moment, but we are working through this and we have set money aside for this in the out years.

Dr K.D. HAMES: But we have just appointed people. Who will know the individual hospital?

Prof. B. Stokes: Shane will know. He will tell you the one we have just appointed.

Dr K.D. HAMES: Dr Kelly, can you tell us who you have just appointed? I will talk about Princess Margaret Hospital for Children afterwards, but if you could just tell us what the current FTE level is for oncologists because I know you have appointed additional registrars just recently. Dr Kelly will speak first.

Dr S.P. Kelly: Thank you. There are approximately nine FTE radiation oncologists at Sir Charles Gairdner Hospital. Until earlier this year, only one was able to provide paediatric radiation oncology services, which created a challenge when she wanted to take leave. That has been rectified by the appointment in March this year of a radiation oncologist who will do both adult and paediatric radiation oncology.

Dr K.D. HAMES: Phil Aylward, who is the director of Princess Margaret Hospital for Children, would normally know the answer. Mark, do you know any of the other answers?

Mr M. Morrissey: I have nothing to add at this point, but I am happy to find the information.

Dr K.D. HAMES: We did not have enough staff in the oncology department at Princess Margaret Hospital for Children, partly because someone was away in training and someone else was on leave. However, the person who was on leave has now come back and we have managed to recruit additional registrar services at that site. There is a need for further assistance and that is what we are going through now.

[12.50 pm]

Mr R.H. COOK: I have a concluding question. I want to establish whether the minister accepts the position of the Cancer Council Western Australia as it was articulated at the time of the election around the quantum of staff needed. Also, with reference to the comments from the director general about funding having been set aside for recruitment in cancer services, will that funding meet that position that was put by the Cancer Council for recruitment?

Dr K.D. HAMES: The Cancer Council called for a significant number of full-time equivalent staff in each year. I think it is fair to say that at one stage we did not realise that it recommended that number for every year. When we look at the demand as it is, we could not possibly justify having that number of additional FTEs every year.

Mr R.H. COOK: So, it is wrong?

Dr K.D. HAMES: We have had discussions with the Cancer Council to clarify the position it put forward on FTEs and have looked at numbers, growth and demand. Professor Stokes spent a lot of time with the Cancer Council going through its figures and our numbers, and they have reached agreement on what would be the level of demand growth. I think the agreement reached was not for an additional three FTEs a year, making an additional 12 over four years, because we have two now. I think therefore it was recognised that the Cancer Council's level of demand was not accurate. However, I am pleased to say that between us we have now reached agreement on the number required. It still represents a significant increase in the number of FTEs required across the system over the four years of forward estimates.

Mr R.H. COOK: My question goes to the issue of FTEs as detailed on pages 152 and 154 of the budget papers. Page 152 refers to FTEs from 2011 through to 2014 and page 154 refers to the cost of employee benefits. Can the minister confirm that we will gain an extra 1 080 staff, or three per cent growth, off the back of a 10 per cent growth in the cost of wages?

Dr K.D. HAMES: The member has obviously done his maths. What is the percentage increase for each of those three years?

Mr R.H. COOK: It is 5.7 per cent, 2.6 per cent and three per cent.

Dr K.D. HAMES: Mr Salvage knows the answer to that.

Mr R.W. Salvage: Is the value for the growth in employment costs that the member referred to taken from the income statement?

Mr R.H. COOK: It is "Employee benefits" referred to on page 154 under the statement of cash flows versus the FTE, both reported and forecast, under the income statement.

Mr R.W. Salvage: The value that I have before me for a budgeted growth in employment costs over the period is about eight per cent, I think, and that reflects the increase in funding that came from the adjustment to the budget to reflect the additional demand coming through the system. There was, of course, an announcement by government around the capping of growth in salaries across the public sector. Obviously, that growth factor is above the growth that was announced, and reflected the subsequent rebase to activity that has provided us with some additional capacity to grow the workforce outside of that parameter announced on capping salaries growth in the public sector. Health salaries growth therefore will be higher than the 2.5 per cent referred to in the announcement, and will provide for growth of about three per cent in the total workforce next year. I think that compares with growth of about 3.5 per cent for total FTEs across the department in the 2012–13 financial year.

Mr R.H. COOK: It is 2.6 per cent actually.

Dr K.D. HAMES: Can I read that to mean that our existing staff will cost considerably more because of that wage decision, particularly around payment for nurses? A chunk of that eight per cent growth in salary level will go to paying existing nurses, and that will give capacity to grow numbers by the amount on page 152. Is that correct from what you said?

Mr R.W. Salvage: That is correct.

Mr R.H. COOK: In that context and in the context of program rationalisation and efficiency dividend, does that mean we will have to shed staff to meet those capping requirements?

Dr K.D. HAMES: How can we be shedding staff when the figures clearly show that we have increased numbers?

Mr R.H. COOK: It is because the minister's representative said that it was over and above the salary cap set by Treasury, so clearly something has to give there.

Dr K.D. HAMES: The government is moving away from salary caps and going to budgeted activity. We are therefore budgeted for a certain amount of activity, and the FTEs that we manage within that are up to us to work out. As the member can see, we will have an increase in FTEs under that budget allocation.

Ms J.M. FREEMAN: I am a bit confused by what the minister just said then.

Mr R.H. COOK: I usually am after Wayne's made a contribution!

Ms J.M. FREEMAN: Yes, that is right. I would like to drill down a bit more into that question. I have another question and I know we have lots of time. Just drilling down into that, the minister is saying that the department is going to go to increased activity. There is an increased salary number and an increased salary amount that is above all of those parameters that are set by Treasury. How does the minister deliver to Treasury the efficiencies he is supposed to deliver in the parameters that Treasury and the government have announced in the budget fiscal principles?

Mr R.H. COOK: Fiscal action.

Ms J.M. FREEMAN: Yes, whatever it is called. What the minister intends to deliver does not make any conceivable sense to me, given what the Treasurer said when he stood before this house and referred to capping salaries and the reduction in staff in workforce reform throughout the public sector. Is the minister telling me that the health portfolio is exempt from that because of some new funding model?

Dr K.D. HAMES: No. Reform in the public sector refers to 1 000 redundancy packages. Our members are able to participate in that. Remember that it is 1 000 —

Ms J.M. FREEMAN: Your employees.

Dr K.D. HAMES: — employees across the whole of state government. I do not know how many employees there are in total across the system but, as the member can see, we have 35 000 in our system. I expect the number that comes out of health will be fairly minimal because we have such a strong demand for them. We have a total budget for the delivery of services. We estimate that the number of FTEs we will require to deliver that increase in demand will be covered by existing FTE numbers.

Ms J.M. FREEMAN: Further to that, the issue in the education portfolio is that the budget had significant reductions that could not then deliver on FTEs and the undertaking to not undermine service delivery. There were cuts to public services in the department and the education system above and beyond the cuts that had been considered. Are there the same sorts of hidden aspects to this budget that require the department to meet the expectation of government on the fiscal program and salary cap? Will a similar situation to that of cleaners at Sir Charles Gairdner Hospital and orderlies at Osborne Park Hospital arise, or any action to reduce FTEs, or will the minister grow the number of people employed? Obviously, Fiona Stanley Hospital in the public health system will come into that.

Dr K.D. HAMES: The problem I have, Mr Chair, is that I do not understand where the member is going with this question. I have answered quite clearly that we have a budget that has the opportunity for an eight per cent growth to fund activity, and of course, as I said before, the midyear review provides a further opportunity for growth. Within that, we employ a certain number of FTEs to deliver the services we are currently delivering. The member can see that there is growth in the number of FTEs over the out years, so I do not understand the question basically.

Ms J.M. FREEMAN: Just further, I mean —

The CHAIRMAN: Member!

Ms J.M. FREEMAN: If the minister does not understand the question, I have a right to clarify. I do not understand how the minister can meet the fiscal plan and grow FTEs and salaries when that is exactly what this government said it would not do in coming into government. Again I ask: does the minister just keep managing the health budget by aspiration and hope or is he actually applying what is supposed to be done by the budget?

Dr K.D. HAMES: Does anyone understand what she is asking?

The CHAIRMAN: I think the minister has given an answer to that question. The member does have more time. We are adjourning very shortly. If the member wants to reframe some questions after the lunchbreak, she will have a chance to do so in the hours after that. Does the member for Kwinana have a further question?

Mr R.H. COOK: Yes, I have a question in relation to FTEs. Can the minister provide us with the number of staff currently working at Royal Perth, Rockingham General and Fremantle Hospitals who are expected to be transferred from the public sector payroll to Serco's payroll and will be part of the reconfigured service provision at Fiona Stanley Hospital?

Dr K.D. HAMES: I do not know that we can. I will get Dr Russell-Weisz to answer, but I do not think we know how many staff will transfer. Serco will employ its own staff. The decision by our staff to choose to work for Serco will be up to them. That service will be provided largely as an additional service. There will be some downsizing, of course, of staff at Fremantle and at Royal Perth as a result of that. However, there is still significant demand within the system; we have normal turnover numbers; and my understanding is that no-one will be sacked within the system. I will ask Dr Russell-Weisz whether he can provide a further answer to that.

Dr D. Russell-Weisz: Yes. I think the minister has covered it very well. The additional number of staff with which Fiona Stanley Hospital will run is about 4 500, of which approximately 1 000 will be Serco staff. We are going through a process at the moment of working with our current South Metropolitan Health Service staff who may be affected by the move to Fiona Stanley Hospital because services are transitioning from, say, Fremantle or Royal Perth to Fiona Stanley. We are going out with a preference registration form process to actually seek the staff who may be affected from those sites and where they are likely to wish to work.

Meeting suspended from 1.00 to 2.00 pm

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

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

Mr R.H. COOK: I refer to the comment the minister made before the lunchbreak that no staff would be sacked as a result of the commissioning of Fiona Stanley Hospital or other aspects of that. I draw his attention to the line item "Public Sector Workforce Reform" on page 130, which shows that $2.4 million and $23 million will be

carved from the budget in savings. Could the minister please explain what is involved in public sector reform in the Department of Health if it does not mean that any staff will lose their jobs over the forward estimates?

Dr K.D. HAMES: Mr Salvage will answer that.

Mr R.W. Salvage: It is an extension of the response I endeavoured to provide previously, which is that when government announced its reform, an adjustment was made to the Department of Health's budget, which we can see in those numbers, to bring our expense growth for employment costs into line with the announcement. Subsequent to that announcement, it was decided that additional funding would be provided for activity and $2.2 billion was awarded through the 2013–14 budget. That reflects that more activity will be undertaken and more staff needed to deliver the activity. It is a timing sense. The reduction was made at one point in the budget cycle and is reported accurately, but we have to look at that in the context of the subsequent decision, which was to rebase health's budget to provide for additional capacity to deliver activity.

Ms J.M. FREEMAN: It is not really there; it has been negated by something else in the budget, so it is neutral. Is it netted off? Is it a neutral prospect?

Mr R.W. Salvage: It was a real reduction to the budget at the time. There was another addition to the budget for activity. Members can characterise that as they will.

Mr R.H. COOK: The Treasurer must love you guys!

Dr K.D. HAMES: They are the bloody ones who do it! Do not blame us.

Dr G.G. JACOBS: The member for Albany talked about renal dialysis. I want to specifically talk about —

Dr K.D. HAMES: I need a page number.

Dr G.G. JACOBS: I refer to "Wheatbelt Hospital and Home Dialysis Service" on page 130. An amount of $3.5 million is allocated over four years. It is very important to my constituents with end-stage disease and renal failure to have an area in the regions where they can have dialysis. Can the minister outline where the $3.5 million will be used? How many chairs will this fund provide and for how many patients? How will this alleviate the workload in the metro area? Maybe the minister can talk about the support for home dialysis as well as hospital-based dialysis.

Dr K.D. HAMES: This was a specific election commitment made around Northam and for patients from Moora who were put on renal dialysis. This election commitment was to address those particular areas of deficiency. There will be extra renal dialysis chairs in Northam and some home-based renal dialysis services in that region, including at Moora to cover the needs there. It has always been difficult in that area because there is a fair bit of competition between those smaller country towns about where facilities should be, in particular aged-care services. Moora has some aged care there and they are pretty desperate to get more, yet other communities, such as Jurien, want them built in their towns. This was an attempt to cover that region. That is why the amount of money is not that great; it provides additional renal chairs in Northam and the capacity to spread outside that. Does Mr Matthews have further information on that?

Mr S. Matthews: Only that it is for chair satellite renal dialysis services and to enhance home-based renal services across the wheatbelt. It will coincide with the Northam redevelopment, which is due for completion in 2016–17.

Dr G.G. JACOBS: How many extra chairs will this provide for the region and how many extra home dialysis units of care will allow patients to have home dialysis?

Mr S. Matthews: It is four chairs.

Dr G.G. JACOBS: Is that in Northam?

Mr S. Matthews: That is in Northam.

Dr G.G. JACOBS: What about Moora; what is happening there?

Dr K.D. HAMES: Moora is not having specific chairs put in, but they will have access to the home-based service. How many services is it up to? Is it 20?

Mr S. Matthews: I do not have that in front of me, I am afraid.

Dr K.D. HAMES: I am pretty sure it is up to 20 additional services in that area.

Dr G.G. JACOBS: Does that include Northam and Moora?

Dr K.D. HAMES: It does not include the four chairs. The specific chairs in the hospital —

Dr G.G. JACOBS: I am not talking about chairs; I am talking about the home service now.

Dr K.D. HAMES: The home service can go wherever it is needed, including Moora.

Mr R.H. COOK: Earlier today the Treasurer and Under Treasurer gave evidence to a parliamentary committee about an external report that was commissioned in early 2012, we believe, on the commissioning of Fiona Stanley Hospital. We understand from the Treasurer that that report was delivered in December or late 2012. Could the minister please provide us with the details of that report and the main recommendations?

Dr K.D. HAMES: I will hand over to Dr Russell-Weisz in a minute; he is fully across that report. It was done to see where we were up to with Fiona Stanley Hospital and it provided a number of recommendations. It said we were behind at the time when it was provided. I think the report was provided sooner than December; it was provided earlier in the year. The director general at the time worked through the people providing those services for Fiona Stanley Hospital, especially through the South Metropolitan Health Service, and talked to government about what needed to be done to fix that. That led to the appointment of Dr Russell-Weisz in November. He was the former CEO of the North Metropolitan Health Service and moved to that specific role.

Dr D. Russell-Weisz: I can only assume the report that the member is referring to is the University Hospitals Birmingham NHS Foundation Trust report. They visited in May 2012 and the final report was completed in July 2012. It was submitted to cabinet and the Fiona Stanley and major hospitals taskforce.

Dr K.D. HAMES: We are not allowed to talk about when it went to cabinet.

Ms J.M. FREEMAN: He can say when it was submitted to cabinet.

Dr D. Russell-Weisz: No, I just said it was submitted to cabinet.

Dr K.D. HAMES: Members can work it out.

Mr R.H. COOK: Carry on.

Dr D. Russell-Weisz: The two key recommendations that came out of that report that government acted on were the establishment of the task force, which was established, and a dedicated team to commission Fiona Stanley Hospital, which the previous director general put in place in May last year.

[2.00 pm]

Mr R.H. COOK: The recommendation, in a nutshell, was that the hospital was behind time and would be delayed. Is that correct?

Dr K.D. HAMES: Well, not that it would be delayed, but that it would be delayed if we did not do things to rectify the things that it was behind time on.

Mr R.H. COOK: And it made that recommendation in July 2012?

Dr K.D. HAMES: Yes.

Mr R.H. COOK: So about midway through last year, the minister knew that the hospital was running behind time?

Dr K.D. HAMES: That is why I have just clarified the member's previous statement. It was not accurate. What the member said was that we were advised that there were delays in what was going to be done, so therefore I knew that the hospital was going to be behind time. My response to that is: no; we were told that there were delays, and that if we did not take remedial action, the hospital would be behind time. The member's next question was: so you knew in the middle of last year that it was behind time? That clearly does not fit with the answer that I have.

Mr R.H. COOK: No. The minister contradicted me around the issue of delay. The minister admitted that the report said it was behind time.

Dr K.D. HAMES: I will say it again: the report said that the progress to prepare for the opening in 2014 was behind time and remedial action needed to be taken to correct that. That is what I knew in July.

Mr D.A. TEMPLEMAN: I refer to page 149 and the line item "Peel Health Campus – Development Stage 1". Can the minister outline what plans there are in this budget for any expansion of Peel Health Campus, given the change of contract?

Dr K.D. HAMES: I will answer that, but I should not, really, because that line item refers to work that is being done; it does not refer to any potential future contract, and as far as I can see it provides no opportunity to do that. Nevertheless, it is a good question, so I will answer it. As the member knows, the previous mob, Health

Solutions, put up a proposal for an extended lease to build a new private hospital on the site. Under that proposal, it would hand over the beds for the current private hospital, and there would be an expansion of the emergency department and some other works alongside that. At that stage, it was not a bad proposal. We recognise that there is growth in demand at that hospital and there is certainly a need to do these things. However, during that process, the hospital was purchased by Ramsay Health Care. Ramsay has indicated to us that it is interested in putting forward to us the same or a similar proposal. It has not done that yet, but, when it does, we will need to consider it. We will need to consider it also in light of the fact, as the member knows, that St John of God is talking about the potential of building a hospital. The contract as it stands goes up until 2018, and the contract then requires negotiation in good faith for an extension for another five years. So provided we negotiate in good faith with Ramsay in 2018 when its contract expires, we would expect that its contract is likely to go to 2023, provided also that Ramsay meets all the requirements of its current contract. So if we were to go to another operator after Ramsay's contract finishes in 2020 something, we would need to think about what a delay that would be. We therefore need to look seriously at what is being put forward.

Mr R.H. COOK: That is why you do not privatise hospitals, because they tie you up forever.

The CHAIRMAN: Thank you, member.

Dr K.D. HAMES: I do not think that is a good answer at all. I like my answer much better. I think it works exceptionally well. It saves us a huge amount of money, as we all know from the contracting-out of services in other hospitals. Therefore, the proposal that was put by the previous operator, and that presumably is still coming from the current operator, is one that government should take very seriously.

Mr D.A. TEMPLEMAN: So the contract will expire in 2018, and in the lead-up to that, the context is negotiations in good faith?

Dr K.D. HAMES: From 2014 I think we have to negotiate in good faith.

Mr D.A. TEMPLEMAN: Yes. Has the minister had any correspondence with Ramsay Health Care about its current impasse with Medibank Private? Medibank Private ran a full-page advertisement in last week *The West Australian*, highlighting that it is having difficulty in signing up with Ramsay for private patients, and that if that is not concluded by the end of this month, that will affect Joondalup campus, and of course also Peel Health Campus. Has the minister had any involvement in this matter, given that, as the minister knows, a sizeable proportion of people in the Peel have private health cover, and it would be a problem if this impasse were not resolved?

Dr K.D. HAMES: I have not involved myself. But it would be an issue if that were to occur. Of course I have seen these sorts of disputes come and go in the past, and inevitably they are resolved, because private patients comprise half of the patients in private hospitals. So either someone will have to cave in, or they will reach agreement somewhere along the way, and I have no doubt that they will do that. Ramsay Health Care is a private hospital operator that has dealings throughout Australia. I imagine that Ramsay is under more pressure than Medibank Private. These things get resolved. I do not think my interference would make any difference. I am concerned, though.

Mr D.A. TEMPLEMAN: It might help.

Mrs G.J. GODFREY: I refer to page 135 of budget paper No 2. The third dot point under the heading, "Aboriginal Health" refers to the remote Aboriginal health clinics project and the $22 million in royalties for regions funding that was provided for this project in 2012. I refer also to the line item at page 149 for remote Indigenous health. Can the minister please outline the progress on works undertaken to date and what funding will be provided in this financial year?

Dr K.D. HAMES: Yes. This was a fund that we started through royalties for regions two years ago, when we had gone to Mulan, which is south west of Balgo. The health clinic at Mulan was very ordinary. It was a donga that was nowhere near big enough. It did not have separate access for men and women. In Aboriginal communities we need the ability for men to be kept separate from women, particularly with issues of domestic violence. This was just one little clinic, with one little waiting room, to provide that service. So we determined that there needed to be better health clinics in remote Indigenous communities, and we went to Minister Grylls to seek his support for funding that would enable us to do that, and he provided a chunk of money for this project. The first clinic built was at Bayulu, because the Army was prepared to help provide that service, and it provided its architect and its construction team, at a very good rate. So we built that clinic first, and there is now a series of other clinics. Mr Matthews will know the exact answer about those that have been built and those that are coming.

Mr S. Matthews: Yes. Mulan and Billiluna have just been completed and are about to be operational. As for the future, there are two in the Kimberley—I do not have their names in front of me, I am afraid. In the Pilbara, the next one on the list is Wakathuni.

[2.20 pm]

Mrs G.J. GODFREY: Can those other two names be provided as supplementary information?

Dr K.D. HAMES: I have them somewhere. There is Nookenbah and Billiluna. Mulan became operational on 1 July, and Nookenbah and Billiluna became operational on 12 August.

Mr R.H. COOK: Surely the minister could rehearse this better.

Dr K.D. HAMES: Yes. I will provide that as supplementary information. I am relying on a briefing note. The reason I know that there are five others is that a week or two ago I had a briefing note that I read, and it referred to those five other proposed clinics. The point is that in my answer I did not need to talk about those five others; I needed to talk about the two that have just been opened and the two that are about to open. My problem is that I have extrapolated them and I should have interpolated them.

The CHAIRMAN: Members, can we have a bit of quiet to get this in *Hansard*, please.

Dr K.D. HAMES: As my regional director is unable to provide the names of those other clinics off the top of his head, we will provide as supplementary information the next round of Aboriginal health clinics to be opened under that regional country health funding program.

[*Supplementary Information No A30.*]

Dr G.G. JACOBS: My question relates to the Esperance Health Campus redevelopment, which is referred to on page 148 of the budget papers. I have not seen any work start in earnest on the development, other than a sign that has gone up at the front of the hospital. It is a $32.7 million project. When will work start on the redevelopment and when will it be completed? There is also another part to the question about the interim medical clinic—the doctors' clinic—co-located on the health campus. When are negotiations with the WA Country Health Service likely to be completed so that we will see doctors in that clinic for which we put up $1.4 million?

Dr K.D. HAMES: I thank the member. I understand from previous answers that I am able to withdraw a supplementary because I have found the answer. It was not five additional clinics; I was including the ones that are already there. The clinics are at Bayulu, Mulan, Billiluna and Nookenbah. The two additional ones that are coming are at Yandeyarra—otherwise known as Mugarinya—and Wangkatjunka. That is the list of those communities that will have those additional clinics.

Mrs G.J. GODFREY: Well done, minister.

Dr K.D. HAMES: To answer the question about the hospital in Esperance, I will give Mr Matthews another go.

The CHAIRMAN: I make a comment for *Hansard* that the minister has now provided that information and we have noted that.

Dr K.D. HAMES: Mr Matthews will tell us about Esperance Hospital.

Mr S. Matthews: Yes. The anticipated construction date for Esperance Hospital is June 2014, with practical completion expected by September 2016. In relation to the interim medical centre, we are still in negotiation with the particular medical group. There have been several meetings with that group on site in Esperance, and with the architects as well. The group has requested some minor changes to the building to suit its needs and they are being worked through at the moment, so we hope that we will reach agreement in the next little while.

Dr K.D. HAMES: I will just add to that that the member will be aware that the group that had originally decided to go there decided that it was a bit too difficult. Some of that was around the times that they would need to open and what cover there had to be. I asked the health department to modify its request to ensure that that was sorted out. I gather that subsequent to that we have now reached in-principle agreement and, as the member has heard, it is subject to some minor issues that the group wants sorted out.

Ms J.M. FREEMAN: Will Esperance Hospital have similar information technology provision of patient records and various other aspects of delivery of medicines—all the whiz-bang sort of IT—that Fiona Stanley Hospital has, given it is a new hospital coming online?

Dr K.D. HAMES: It is not a new hospital. It is not like Albany. Of course, Albany Hospital, which is new, has lesser versions of that IT, but it is still interchangeable and supportive. At Esperance, it is some upgrade works on the existing hospital. I am not aware of any IT changes in that. Does Mr Matthews know?

Ms J.M. FREEMAN: Mr Matthews indicated "no" by shaking his head.

Mr S. Matthews: There will be nothing new as such, other than potentially the rollout of web pads down the track.

Mr R.H. COOK: I refer to the nurses' enterprise bargaining agreement, which is referred to on page 130, and to the $158.8 million relating to that agreement. Do those moneys include the negotiations around conditions or is that simply a salary component at this time?

Dr K.D. HAMES: The Deputy Leader of the Opposition could well be from the nurses' union, asking that question. That is the amount of money that has been allocated. There will be no provision of anything outside that. The union suggested at one stage, "Okay; now you've agreed on the percentage increase for our wages, let's start negotiating all the other things that we want." The response to that is no; whatever else is negotiated should not have a cost that goes outside the funds that have been promised.

Mr R.H. COOK: As the member for Mirrabooka just said, "Good luck with that."

Dr K.D. HAMES: There is no choice. Everyone else will have the new wages policy of consumer price index increases, and there will be no going outside those CPI increases.

Mr W.J. JOHNSTON: On that topic of the nurses' EBA, as I understand, this was negotiated during the caretaker arrangements. Who did the negotiations?

Dr K.D. HAMES: We had our health department people. It must be remembered that it is not my responsibility, as Minister for Health; it comes under the Minister for Commerce, I think, who is responsible for all wage negotiations. But our health team was involved in those negotiations along the way. Some of those discussions that led to the final agreement that was put forward were held by the Premier's office.

Mr W.J. JOHNSTON: Was it the government of Western Australia that negotiated? Was it the Liberal Party of Western Australia?

Dr K.D. HAMES: I was not involved, so I have no idea. The member would have to ask the Premier.

Mr W.J. JOHNSTON: How were the results of the negotiation communicated to the health bureaucracy for it to implement that?

Dr K.D. HAMES: It was told.

Mr W.J. JOHNSTON: By whom?

Dr K.D. HAMES: By the Department of the Premier and Cabinet, I presume.

Mr W.J. JOHNSTON: The minister presumes. I do not understand what that means.

Dr K.D. HAMES: It means I presume. It means that I do not personally know because —

Mr W.J. JOHNSTON: Somebody must know because it has been implemented.

Dr K.D. HAMES: Yes. As I said, the member would need to ask —

Mr W.J. JOHNSTON: We have the Department of Health here.

Dr K.D. HAMES: The people who were involved in those negotiations —

Mr W.J. JOHNSTON: Is there anybody in the room who can tell us how it was communicated to the Department of Health that it had to pay more money to the nurses? How did that happen?

Dr K.D. HAMES: Professor Stokes has advised me that, no, there is no-one here. The people who were involved in the negotiations are not represented in this room.

Mr W.J. JOHNSTON: Okay. All I want to know, minister—I have no idea why this is a complex answer because it is a very simple question—is who communicated to the Department of Health that it had to pay more money to the nurses that the Department of Health employs?

[2.30 pm]

Dr K.D. HAMES: My answer remains the same; that is, someone from the Department of the Premier and Cabinet. As minister I am not—I repeat again—involved in the negotiations. I might not be right. It might have

been someone from the office of the Minister for Commerce. The Minister for Commerce is responsible for the negotiations of wage outcomes. It could well be that he was the one. His office is involved in putting together final deals on wages. We do not make the final deal; rather, the final deal is struck by a combination of Department of Health and Department of Commerce staff. It may have been the Department of Commerce that finalised that negotiation, as one would expect. It was not the Department of Health. The Minister for Commerce would have advised the health department of the agreement. Our people were involved in the final negotiations; they would have sat down with members from the Australian Nursing Federation.

Mr W.J. JOHNSTON: If I have asked the question the wrong way around, I will ask it in a different way. It is a very simple question and it is extraordinary that the minister is not capable of answering a simple question.

Dr K.D. HAMES: I am capable of answering it. The answer is I do not know.

Mr W.J. JOHNSTON: Who in the department received the advice to increase nurses' salaries? That has to be within the minister's department because someone in his department was told to increase nurses' salaries. Who was that?

Dr K.D. HAMES: The person who does our negotiations —

Mr W.J. JOHNSTON: No, no. The question I have asked is very simple: Who in the department received the advice?

Dr K.D. HAMES: Madam Chairman, I am trying to answer and I am struggling to do so.

The CHAIRMAN: Member, please let the minister answer.

Mr W.J. JOHNSTON: Well, he has to answer the question I ask him.

The CHAIRMAN: Member, I call you for the first time. Please do not interrupt the Chair.

Dr K.D. HAMES: We have a staff member, Marshall Warner, who is involved with all salary negotiations on behalf of the Department of Health. He—I am not sure whether he has support—with officers from the Minister for Commerce's department sit down together and negotiate wage outcomes with the union. My presumption is that he was not necessarily personally told. He would have been at a meeting with that group at which the minister probably said, "This is the direction we are going to take." That is how the Department of Health would have found out. We would have been part of the meeting at which the decision was made. Of course, I knew about it because it was announced that that agreement had been reached. I cannot recall who announced it. It was probably the Minister for Commerce. It is not my responsibility, so it is not up to me to find out who did it, when or where.

Mr W.J. JOHNSTON: Can I get by way of supplementary information the date on which the Department of Health was notified of the need to increase the salaries of its nurse employees, and what specific instrument was used to advise the Department of Health of the need to increase the salary of its employees?

Dr K.D. HAMES: Why does the member not ask the Minister for Commerce? It is his responsibility.

Mr W.J. JOHNSTON: It is the Minister for Health's responsibility.

The CHAIRMAN: Is the minister saying no—he does not want to provide supplementary information?

Dr K.D. HAMES: No, I will not provide it. The member should ask either of the ministers involved—the Premier or the Minister for Commerce. I am not responsible for that, and I will not chase up information about when we were told. What relevance could it possibly have? We have heard from the shadow Minister for Health the importance of having this opportunity to go through and ask lots question about the budget, and the member for Cannington is ferreting down about something of interest to him that is the responsibility of another minister! The member should find out himself. Do a question on notice to the minister.

Mr W.J. JOHNSTON: It is ridiculous for the minister to argue that he is not responsible for his budget. That is a stupid position to take.

The CHAIRMAN: Unless members are asking question and ministers are answering them, we are not going to enter into a general debate about whether the minister is stupid, which I think is what was said.

Dr K.D. HAMES: Madam Chair, the funding for the increase in nurses' salaries is in our budget—we are responsible for that—and we were provided those funds by Treasury. We were given the parameters and percentages of increase, presumably from the office of the Minister for Commerce, and we will proceed with applying those.

Mr R.H. COOK: I note that there is provision in the budget for the nurses' enterprise bargaining agreement. Is there a similar provision for the agreement with the Australian Medical Association? If so, what is that provision?

Dr K.D. HAMES: No, there is no provision for an agreement with the Australian Medical Association because its current agreement has not expired. It will expire this year, so any changes in that will be reflected in the midyear review.

Mr R.H. COOK: So there is no provision in this budget in anticipation of what that might be.

Dr K.D. HAMES: No, because we do not know what it might be.

Mr C.D. HATTON: I refer to page 135 of the *Budget Statements* and to the $161 million has been allocated to improve health and aged care facilities. One hundred and sixty-one million dollars is a huge investment. I am aware that the Southern Inland Health Initiative has been very successful with the tele-line and so forth. Can the minister outline the benefits of the funding for the North West Health Initiative and what services it will provide to the people on the north west?

Dr K.D. HAMES: Again, I will shortly defer to one of my staff. The $161 million was part of a commitment by the National Party during the last election campaign—one that we in Health strongly support. We are very pleased to have that money included in our budget from royalties for regions. It will be used to upgrade hospitals in Newman, Tom Price, Onslow, Roebourne and Paraburdoo. I will ask Mr Matthews to provide more information on the nature of those upgrades. It will also be used to increase telehealth and improve other health services within the region. That money will largely be spent in 2015–16 with all the planning and development work being done prior to that. I will hand over to Mr Matthews.

Mr S. Matthews: The $161 million comprises a $50 million capital allocation for Newman Hospital, which will be supplemented by $10 million from BHP–Billiton, to make the total spend on rebuild of Newman Hospital $60 million; $40 million for a new hospital in Tom Price; $19.8 million, which will be supplemented by $22 million from Chevron, for a new hospital in Onslow; $15 million for a new facility in Roebourne in conjunction with discussions with Mawarnkarra Health Service; and, a $2 million refurbishment of Paraburdoo Hospital. A further $15 million from the Mid West Development Commission will be used for a new $6 million nursing post for Mt Magnet and a $10 million primary health care centre will be co-located at the Meekatharra Hospital, which will involve the Royal Flying Doctor Service. There will be a $2 million refurbishment of aged residential care in Meekatharra; a $200 000 audit of aged care services throughout the north west; $14 million for a new aged care facility in Carnarvon; a $2 million contribution to improve the sustainability of Karlarra House in South Hedland; $5 million of recurrent funding over the four-period to incentivise general practice with an emphasis on Newman and Kununurra; and, a telehealth and e-health investment scheme, which includes $8 million for telehealth over the four-year period with the view of rolling out the emergency telehealth service that was mentioned earlier today.

Dr K.D. HAMES: As you know, Madam Chair, the Southern Inland Health package was a significant investment in the south west. We looked at the next region north, where in the past these services have traditionally been provided with construction by the mining companies. They have not invested for a long time, and the facilities are significantly rundown. This gives us the opportunity to redevelop those, but with great contributions from local mining companies—as we have heard, $10 million from BHP Billiton and $22 million from Chevron—to allow us to do those major capital works programs in the north.

[2.40 pm]

Mr W.J. JOHNSTON: I refer to page 151 of budget paper No 1 and the line item "Metropolitan Plan Implementation Bentley Hospital – Development", under "New Works". The estimated total cost is $10 341 000, but the estimated expenditure for 2013–14 is zero, and then $10 000 for each of the out years. Can the minister let us know when the government will complete the upgrade works for Bentley Hospital?

Dr K.D. HAMES: I have the timing for that here. The majority of the funding is in 2017–18 and 2018–19—roughly $5 million in each of those years.

Mr W.J. JOHNSTON: I thank the minister very much, that is very interesting. There is great consternation at Bentley Hospital—as I am sure the minister will be aware, because it has been talked about in the media quite a bit—about general surgery services being withdrawn from Bentley on the opening of Fiona Stanley Hospital, and general surgery then being conducted instead at Royal Perth Hospital. Is it still the government's intention to move down the track of reducing the use of Bentley Hospital for general surgery?

Dr K.D. HAMES: The configuration of which services are to be provided at which hospitals was largely undertaken by the previous Labor government under then Minister for Health Jim McGinty. We have not moved away from that, other than in one particular detail, which is maternity services. The format for where services need to be provided was undertaken as part of the clinical services framework review that was commenced in 2005. That review listed Bentley's role as changing significantly, largely to rehabilitation and mental health services. As the member knows, there is significant investment of $2 billion in the new Fiona Stanley Hospital to make sure services for that region can be provided there. Fairly early on in the piece I added some more waitlist surgery. Some were not happy that Jim McGinty's original plan took most of that away, so I added some of it back in, but I do not have the latest information on where we are up to or whether there have been any further developments since that time. Does anyone know?

Mr I. Smith: I cannot provide that level of detail.

Dr K.D. HAMES: There have been no changes from what was in the clinical services framework review from 2005–10 and now moved to 2010–15. Whatever is there, is there.

Mr W.J. JOHNSTON: I just want to clarify what that answer means.

Dr K.D. HAMES: I am confirming that the current plans, whatever is in the clinical services framework plan for Bentley, are unchanged, other than maternity services, and that decision is yet to be made. It will be made depending on what demand remains there after Fiona Stanley Hospital opens, but there will be some waitlist surgery. I am confident that that is in the current clinical services framework plan.

Ms J.M. FREEMAN: I refer to page 148 of budget paper No 1 and the line item "Fiona Stanley Hospital – Development" in respect of the Birmingham University report which, as I understand it, was commissioned in May 2012 and released the same year.

Dr K.D. HAMES: I will just wait until the conversations behind the member have concluded, because it makes it hard to hear.

Ms J.M. FREEMAN: Okay. I am talking about the Birmingham University report. Given that IT has been a major aspect of the delays at Fiona Stanley Hospital, did the report look at any aspect of the rollout of IT at Fiona Stanley Hospital?

Dr K.D. HAMES: It is difficult to recall, but my recollection is that yes, it did, and it was identified that that area needed a lot of work to get it on track.

Ms J.M. FREEMAN: Given that it was an area on which the government had to do a lot of work, did the report reveal that that work would cause significant delay, so that the government knew in July 2012 that there would be significant delays because of the IT issues?

Dr K.D. HAMES: Again, I seem to have trouble getting my message across. I knew in July that if we did not take remedial action, there would be a delay; we did take remedial action.

Ms J.M. FREEMAN: And there still was a delay.

Dr K.D. HAMES: As it turns out, yes, but we did not know at the time that the remedial action would not be successful in preventing a delay.

Ms J.M. FREEMAN: But the minister says that the Birmingham University report included the issues surrounding IT, and the IT issue is the reason for the delay. How is it that the remedial action was insufficient to stop the delay? Was it known that the delay would be such that there would be a significant length of time during which the hospital would not be operating at its maximum intake, and that significant costs would be borne out of that?

Dr K.D. HAMES: The director general of the Department of Health at the time was very confident that the remedial action he initiated and put in place would result in the opening of the hospital not being delayed. In fact, right up to and following the election, that was his view. As it turned out, and as I said the other day, he was not correct and there has subsequently been a delay. He was of the view that the remedial action that he had put in place in response to the Birmingham University report would prevent a delay in the opening of the hospital. Remember, we still had a year and a half to go at that stage until the estimated opening date.

Ms J.M. FREEMAN: Can the minister outline what the remedial IT action was? What was recommended to prevent the delay, such that the director general at the time could have had such misplaced confidence in its efficacy, and such that the minister could have such misplaced belief in him, with the result that we did not know about the delays sooner? Clearly, in July 2012, those recommendations had been put on the table.

Dr K.D. HAMES: In July 2012 there were suggestions that additional action needed to be undertaken. Some of that was to work with the Health Information Network and to get it cranked up, to make sure that it was going out and procuring all the programs required and working within our hospitals to make sure that those systems can be put in place. When we got to November, I think, the director general was then of the view that he needed to do more than that. He subsequently removed Dr Russell-Weisz from his role in charge of north metropolitan, and put him into the role of driving that IT service. Subsequently, I think Mr Giles was co-opted into the team to further drive putting that IT in place. As we worked harder, it became obvious that it was more complex than people had anticipated, and hence there was a six-month delay in finalising the massive number of IT programs required for a brand-new, state-of-the-art $2 billion hospital.

Ms J.M. FREEMAN: Firstly, "massive number" is not really accurate, because many of them are just enhancements of the minister's own project and the minister knows there is evidence in respect of that. When was Mr Giles appointed to work on the IT? When did that remedial action occur?

Dr K.D. HAMES: I will hand over to Dr Russell-Weisz, who is the one who did the recruiting, if you like, and he can give that date and perhaps also comment on the member's dismissive concerns about the complexity of the IT.

[2.50 pm]

Dr D. Russell-Weisz: Just to put it into perspective, when I started in the role, I recognised that the information and communications technology was inordinately complex. Yes, as is on the public record, there are 48 core systems that needed to be upgraded or there were new systems that needed to be put in place, and a number of other systems needed to be brought on board. Going back to what the previous director general did, late last year he put in place a lead person from Health Information Network for the Fiona Stanley Hospital project. When I took over as acting director general in March last year for four weeks—when I was doing both roles—I knew we needed additional resources in relation to ICT, and at that time we appointed Mr Giles Nunis for a period of four months from 3 April, from recollection.

Mr R.H. COOK: Between July 2012 and January 2013, did the minister receive interim reports from the task force or Dr Russell-Weisz on the progress of the hospitals—the commissioning?

Dr K.D. HAMES: I cannot recall. What I do know is that I had regular meetings with the director general, and how we were progressing was certainly a topic of discussion, but as I said, his view right up to and beyond the election was that while it was complex and difficult, he had great faith that Dr Russell-Weisz would be able to pull it all back together and still be able to open on time.

Mr R.H. COOK: So, minister, what was that interim advice in terms of the task force report, and what was it that —

Dr K.D. HAMES: Just wait a second: this is a question from Hansard. What does CLAG stand for?

Mr R.H. COOK: What does what?

Dr K.D. HAMES: For the mosquito program—what is it called?

Mr R.H. COOK: The minister has reinvented a whole new language around eradication for that one, minister, so we cannot possibly help the minister.

Dr K.D. HAMES: What does CLAG stand for? It is continuous local authority groups.

Mr W.J. JOHNSTON: Why is he doing this during this time? It is very arrogant.

Mr R.H. COOK: What was the advice from that task force between July 2012 and January 2013; and why is it that the director general was providing the minister with advice that everything was okay—tickety-boo—when everyone else in the health sector knew that that project was going belly up?

Dr K.D. HAMES: The task force did not report to me and was not under my control. I had information that came to me through the director general about the total progress of the project.

Mr R.H. COOK: Did the minister have no meetings with Dr Russell-Weisz or the task force?

Dr K.D. HAMES: I met Dr Russell-Weisz in March, did I not, of this year?

Dr D. Russell-Weisz: Yes.

Dr K.D. HAMES: He was then acting DG and he provided that update, but, no, I did not have meetings with the task force. The management of hospital constructions is done by a task force team led by, largely, Treasury staff; I have had staff who sit in on that, but the advice was not provided to us until after the election, as I have said on numerous occasions, that there was going to be a delay. The view was that it could be rectified. Remember that

even by the time of the election we still had a year to go. I have read some of the transcripts—I presume the member for Kwinana has, too—of the committee that said, "You knew it was going to take a year; why didn't you know it was delayed?" There was still a year to go; there was still a year left until the official proposed opening time.

Mr R.H. COOK: And the lead-up time is a blink of the eye.

Prior to the election, at no stage did the minister seek advice directly from the task force involved or from consultants to HIN, or something like that, about the progress of the most important infrastructure development in Western Australia?

Dr K.D. HAMES: I have a director general, who reports to me, who is responsible for oversight of all the major capital works programs we have in this state. I get advice through that as to how things are going. The advice I got, through the DG, is that he was strongly of the view that it would be open on time.

Mr R.H. COOK: At any stage did the minister say to his director general, "I appreciate what you're saying, Kim, but I want to talk to the people at the coalface. I want to hear what's going on, because this is, politically, a very important issue for us."

Dr K.D. HAMES: This hospital has been funded and under construction for three years. We have had numerous questions along the way about progress and about funding. Every five minutes we see this ream that comes from *The Sunday Times* about the fact that the construction and commissioning is going to cost $3 billion instead of $2 billion, which is just not true. I did not need to personally say for any reason, when I am not getting any feedback from anybody to suggest that it is not going to be ready at the appropriate time, "Look, I don't believe you, director general; get someone else to come and talk to me just in case there's an alternative view." Why would I have done that in February or December—or December of the previous year or the December of the year before that? Why would I? It is a project that is under construction. We have the children's hospital under construction at $1.2 billion. I am not calling up; I am not saying to the acting director general, "Look, I'm not taking your word for the fact that the children's hospital is all being constructed as it should; I want to go and meet the task force." That is just not appropriate.

Mr R.H. COOK: Did HIN engage external consultants in terms of advice in relation to the commissioning of the hospital around those IT issues?

Dr K.D. HAMES: I am fairly certain they did. Professor Stokes?

Prof. B. Stokes: There were consultants, but not for advice. There were consultants about how to do the programs, yes.

Dr K.D. HAMES: They had consultants involved in providing the programs.

Mr R.H. COOK: This is my final, concluding question. Can I please have, by way of supplementary answer if that is what it takes, details of the consultants engaged in relation to the commissioning of Fiona Stanley Hospital, the value of the contracts and the period of the contracts?

Dr K.D. HAMES: I do not know how much of that is commercial-in-confidence—those contracts. But right next to the member for Kwinana is a member of the Education and Health Standing Committee, which has been drilling down on this for the past six months, including the Chair who is here.

Mr R.H. COOK: The deliberations of another committee are not of any consequence.

Dr K.D. HAMES: I would have thought that whatever questions they want to ask, they have the capacity to get information on a whole range of things, and that is what they should do.

Mr R.H. COOK: Point of order, Madam Chair. The minister cannot say, "Look, there are other committees; get them to do it." I asked him a question.

Dr K.D. HAMES: No; I am saying that the answer was no. My belief is that the value of those contracts would be commercial-in-confidence.

The CHAIRMAN: Thanks, member. Asked and answered.

Mr R.H. COOK: What a rort!

The CHAIRMAN: Member for Cannington.

Mr R.H. COOK: What a complete rort!

Dr K.D. HAMES: It is easy to work out; put it on notice. I will consider it in more depth if the member puts it on notice. Sorry, Madam Chair.

Mr R.H. COOK: It is a committee of Parliament —

The CHAIRMAN: Member, I call you for the second time.

Mr R.H. COOK: But Madam Chair —

The CHAIRMAN: Member, it is not okay to continue interjecting like this. Wait until you are called next time and pick up the issue again. We have another question waiting to be asked on the same topic.

Mr W.J. JOHNSTON: As I understand it, there have been external consultants hired to try to resolve the issues that have arisen during the commissioning process. When was the first one of those consultants hired?

Dr K.D. HAMES: Can the member start the question again?

Mr W.J. JOHNSTON: I am just following up the exact answer the minister gave a few minutes ago. What was the date on which the first of those consultants was hired by Health Information Network? What date was the first one hired?

Dr K.D. HAMES: My staff do not know that off the top of their heads, but I do not see any problem with providing that as supplementary information.

Mr W.J. JOHNSTON: So can we get the dates of the —

Dr K.D. HAMES: I will provide—I will need to make sure, of course, that there is no reason not to, but I cannot see why there should be.

Mr W.J. JOHNSTON: Well, of course there is a reason not to—because the minister wants to hide the truth!

The CHAIRMAN: Member!

Dr K.D. HAMES: What do I care? What do I care when the first person was given a HIN contract? It is no skin off my nose. Provided I do not get any legal advice that it is inappropriate for me to provide those answers, yes, I will provide the answer to that as supplementary information.

The CHAIRMAN: Can we just put information on record, please, member for Cannington; what are we asking for?

Dr K.D. HAMES: Exactly the question the member asked—which was?

Mr W.J. JOHNSTON: The dates on which these consultants were hired.

Dr K.D. HAMES: That is not what the member said. The member said the date of the first.

Mr W.J. JOHNSTON: The first, if the minister wants, yes.

Dr K.D. HAMES: That is what the member asked.

[*Supplementary Information No A31*.]

Mr W.J. JOHNSTON: Because let us understand, minister, that the reason I am asking that is because the minister would not have hired them unless he knew there was a problem.

[3.00 pm]

Dr K.D. HAMES: That is not true.

Mr W.J. JOHNSTON: No; I am just stating a fact.

Dr K.D. HAMES: If that is what the member is expecting to get from the answer, it will not help him at all because a lot of contracts were given to those Health Information Network consultants to do specific works as part of developing the plan.

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

Mr W.J. JOHNSTON: That is contrary to the evidence the minister gave. His answer to the member for Kwinana was that the consultants were hired when the problems became evident.

Dr K.D. HAMES: No.

Mr W.J. JOHNSTON: That is what the minister said. He can go back and refer to *Hansard* now, but he cannot rewrite the facts.

Dr K.D. HAMES: The member can read *Hansard* and he will see that he is wrong.

Mr W.J. JOHNSTON: I was sitting here and I know what the minister said.

Dr K.D. HAMES: The member has been wrong before.

Mr W.J. JOHNSTON: When? Tell me a date?

Dr K.D. HAMES: Read *Hansard*.

The CHAIRMAN: Members, thank you. The member for Eyre has the next question.

Dr G.G. JACOBS: I want to talk about foetal alcohol spectrum disorder. I refer to the table on page 130, "Government Initiatives and Budget Priorities", and the line item "Better Health Services for Fitzroy Children". The minister would be aware of the Lililwan project in the Fitzroy Valley, which has an allocation of $400 000 over four years. Significant work already done on that project by a community-led strategy with Indigenous leaders partnered by experts has had three components: the diagnosis and prevention of FASD; the support of parents and carers of children with FASD; and advocacy and raising awareness about FASD. I am concerned about the high rate of this disorder in the Kimberley. How will this funding go towards addressing this issue?

Dr K.D. HAMES: We have been concerned about this issue for a long time. When I was on the committee that the member currently chairs, we went to some of those remote communities, particularly Fitzroy, and part of the discussions about the alcohol restrictions put in place in Fitzroy was the awareness of the high level of FASD in that area. The Aboriginal children in Fitzroy have some of the highest levels of FASD in the world. These children are often born with intellectual and other learning disabilities that totally affect their options in life. Programs are needed to help those children, so we made an election commitment of $400 000 over four years to help improve those services. The funding goes to a range of groups including nursing, community allied health, paediatrics, and specialists, all of whom are involved in trying to improve the outlook for these children in the Fitzroy Valley. This will be done as a collaborative model with the Nindilingarri Cultural Health Service and other services, including the University of Sydney, will assist in managing the program. Dr James Fitzpatrick, a past Young Australian of the Year, is one of the doctors working on that program and providing a great service.

Ms J.M. FREEMAN: I refer to the table on page 148 and the line item, "Fiona Stanley Hospital – Development". We have discussed the nature of the delays and the Birmingham University report flagging that there will be delays. When was the cabinet subcommittee told that the delays, including the delay to the closed loop medication system, would push out the April 2014 opening date?

Dr K.D. HAMES: I am not able to refer to any of the dealings of cabinet or of its subcommittees.

Ms J.M. FREEMAN: I just want to know the date it was told, not what was considered or debated. The minister can tell us—

Dr K.D. HAMES: It does not matter. Members opposite never did. I am not able to talk about cabinet or any issues around cabinet, dates of considered things, or matters that were considered—none of those things. That is my advice.

Ms J.M. FREEMAN: When did the minister tell the Premier that there would be delays, including the delay with the closed loop medication system, that would push the opening past April 2014?

Dr K.D. HAMES: The advice was given to the Premier after I had my advice in March, so it would have been sometime in March or April of this year.

Mr R.H. COOK: I refer to page 148 of the *Budget Statements* and the new children's hospital. The minister may have answered questions in this place before about how he was considering the needs of the hospital capacity, particularly with regard to the expansion of its capacity by a further 100 beds. Can the minister reveal, for the purposes of the budget, what further investigations have taken place and what is the order of magnitude of costs that the minister is looking at, understanding that those costs will now be off-budget in terms of where we are at the moment?

Dr K.D. HAMES: I cannot talk about what is not in the budget, and I made that point prior to the estimates committee. We are currently in the middle of doing an evaluation of the demand, the bed capacity, and what opportunities there are to rectify that. As the Premier said a week ago, those decisions would be made within the next few weeks; we are still in that process.

Mr R.H. COOK: I understand that the minister is not yet at the point of making a decision, but he must have an understanding of the magnitude of the associated costs and, therefore, the impact it will have on the overall budget.

Dr K.D. HAMES: There are a number of options for what we can do at the hospital. One includes doing nothing further. The hospital already has a capacity for growth; it can build an additional five storeys in the middle to expand its size. Whenever King Edward Memorial Hospital for Women is built on the co-located site, 24 beds will come out of the hospital and go to the new King Edward Memorial Hospital, so there is future growth

capacity. Although one decision is to do nothing, we still have to follow our plan to provide paediatric services across the metropolitan area, which will expand the peripheral ring of paediatric services available in the regions of Joondalup, Midland, Rockingham and Peel. That needs to be done regardless of the option we choose for the hospital. Peel does not need additional expansion capacity but it needs additional service capacity and better use of the paediatric section of the hospital. Those things must be done whatever option we pick. Option 1 is to do nothing. Option 2 is to reconfigure something within the structure of the hospital if we want more beds straightaway. Option 3 is to put on an additional floor, which can provide up to 48 shell beds, and opening some beds. The decision on which of those options we take has not yet been made.

Mr C.D. HATTON: I refer to the table on page 148, the heading "Works in Progress" and the line item "Harvey Hospital Redevelopment".

Mr R.H. COOK: The member said "a work in progress".

Mr C.D. HATTON: I did not find it that funny, but fair enough.

Mr R.H. COOK: We have been arguing over this one for five years.

Mr C.D. HATTON: Really, well I am glad to say that there is a work in progress in a $13.9 million redevelopment. I understand there are currently 26 beds there and that will remain so. Will the minister provide details of the development and what is happening?

[3.10 pm]

Dr K.D. HAMES: The development of Harvey Hospital is one of those projects that bit the dust four years ago when, on coming to office, the government had to find significant capital works savings. It was not ready to be progressed, and a business case and design work had not been done. That project was put off at that time by four years when the government had to make considerable capital works savings. Now, at this stage, it is ready to go. The business case has been completed, the funds are in the budget and as soon as the business case gets ticked off, work is ready to start. I hand over to Mr Matthews, who will tell us details of what that work will be.

Mr S. Matthews: Those works will not go to tender until December 2014, based upon the Building Management and Works procurement schedule. The contract will be awarded in February 2015 and works will commence shortly thereafter. The due-for-completion date is August 2016.

Mr D.A. TEMPLEMAN: I refer to page 129 under "Amount Authorised by Other Statutes" and to the estimated actual of $121.424 million for the Lotteries Commission in 2012–13. In this budget, the amount declines by $7 million and climbs again in the out years. Why is there a decline in that budget estimate?

Dr K.D. HAMES: It does not decline in the out years; it goes up in the out years. The member for Mandurah will see that it goes up to $120 million, $123 million and $129 million. However, it is a good question and I do not know the answer. I did not get around to asking that question, so I will ask it now of Mr Salvage.

Mr R.W. Salvage: Under the Lotteries Commission Act, a fixed percentage of net proceeds through gaming activities is directed to the Department of Health. This line records that value.

Dr K.D. HAMES: It means that the member is not buying enough lotto tickets.

Mr SALVAGE: Forty per cent of net proceeds from gaming activities go to the Department of Health, and that is recorded here. What has happened—this is not unusual—is that at the end of the financial year a stocktake was conducted into the amount of money received by the Lotteries Commission, and further funding flowed to the Department of Health, which is reflected in the estimated actual for that year but is not reflected in the budget estimate for this year. However, should the same gaming activities be undertaken again this year, we would anticipate an adjustment in the budget figure to reflect that; in fact, that would occur as a matter of statute.

Dr K.D. HAMES: Those figures are interesting. The budget for 2012–13 was down to $110 million, and we got $11 million more than that, so the $115 million is a $5 million increase on the budget of the previous year.

Mr D.A. TEMPLEMAN: I have a further question on Lotterywest's contribution to health. Does the department identify significant projects that have received moneys from Lotterywest as part of these proceeds as Lotterywest projects? This is a significant amount of money paid ultimately each year by the gamblers of the state, and it is a significant fill-up to the health budget. I think Lotterywest deserves a greater acknowledgment for its contribution to the health budget. I am interested in how WA Health appropriately recognises Lotterywest's significant contribution. No-one can sneeze at $120 million.

Dr K.D. HAMES: The answer is that we do not. It is not a bad idea, except that as soon as we start identifying one particular thing and we want to change it, it creates constraints. At present, it becomes part of the total budget. As the member would know, having been a minister, the boot is often on the other foot. This state is different from other states where all lotteries money just goes into consolidated revenue. The Lotteries Commission in Western Australia puts the rest of the money back into the community. In effect, it is state government money that the state government would otherwise not get. When lotteries cheques are handed out, people often say to me, "I have $200 000 from Lotterywest and the state government hasn't put in a cracker." The Lotteries Commission is always very good at getting recognition for the money it provides to community groups when, in effect, it is state government money.

Mr D.A. TEMPLEMAN: Not necessarily.

Dr K.D. HAMES: It is compared with what all the other states do.

Mr D.A. TEMPLEMAN: The difference between the Western Australian lottery system and those of the other states is the historic private operation of lotteries in those states, which were created by the big lottery families. A family entity, such as the Tattersall family, did not start a lottery here in Western Australia, as occurred in the eastern states. In Western Australia it is the contribution by Western Australians to, not the state government, but an entity —

The CHAIRMAN: Is this a further question?

Mr D.A. TEMPLEMAN: Yes. Would the minister look at ways to reinforce to the Western Australian community and give greater prominence to the fact that, particularly for big projects, their investment in Lotterywest contributes significantly to the Department of Health?

Dr K.D. HAMES: I am prepared to consider that and talk to other members of government, but the reality is that it is a tax on gambling. Lotteries are a gamble. People invest money in Lotterywest in the same way they bet money at the races. The government gets a percentage of money from people who bet on horses or gamble in other ways. That money goes into the government coffers. Does that mean we should recognise the gamblers' contribution at the races to state government projects in the same way those who are fined for speeding make a good contribution to state government coffers to fund a whole range of projects? I am not sure whether that is appropriate. I am happy to find out what others think. It would not be difficult for the government to do that and to recognise that.

The member says that families started the lotteries in the other states; nevertheless, there is a significant tax on that form of gambling in those states. That money goes straight into the coffers of government in exactly the same way that money gambled on racing does. I do not see how buying a lotto ticket is different. They are not doing it because they want to make a contribution to government. It is tax they pay because they gamble on buying lotto tickets.

The CHAIRMAN: I think the minister has covered that.

Mr R.H. COOK: I refer specifically to the payments under "Cash Flows from Operating Activities" on page 154. I am interested in the dip in the figures for accommodation and also in the payments for direct patient support costs and the payments for indirect patient support costs. Some numbers go up dramatically and others reduce. Would the minister let Wayne Salvage off the leash to clarify the different points to that aspect of the budget?

[3.20 pm]

Dr K.D. HAMES: Madam Chair, I have no intention of letting Mr Salvage off the leash, but I am happy for him to answer this question—there is a distinct difference!

Mr R.W. Salvage: To be quite frank, this is a question where I would rather be kept on the leash! There should be a direct correlation in the relationship between what will be seen in the income statement and what will be seen in the cash flow statement.

Dr K.D. HAMES: Indeed.

Mr R.W. Salvage: If the member wants me to go through individual lines, we would probably need to have an opportunity to reflect on that and take the question on notice—if I could be so bold.

Dr K.D. HAMES: Is there any sort of answer that the member would like at this stage that does not require him to do that?

Mr R.H. COOK: It is promoted by a sense of curiosity about what things are defined as accommodation for direct and indirect patient support costs. That is the threshold question. I am very keen to understand why there is a fairly large deviation across all those areas—some go up and some go down. Obviously, it is important to get an understanding of that. I am happy for that information to be provided as supplementary information —

Dr K.D. HAMES: It is the sort of thing that the member would probably like to have someone sit down and explain. Perhaps the member could arrange a meeting with Mr Salvage and work through it, because he will not get an answer to that in writing without an explanation.

Mr R.H. COOK: I am happy to put that on the list of briefings that I have requested—that will be good.

Dr K.D. HAMES: I am sure that the member gets every briefing that he asks for.

Mr R.H. COOK: Not yet, minister.

Dr K.D. HAMES: The member should do that because I think that would be the sensible way. The member may want to write and ask a specific question on notice, as has been suggested; alternatively, if he wants to have a briefing with Mr Salvage, I am sure we can arrange that.

Ms J.M. FREEMAN: I refer to the reference to the Fiona Stanley Hospital on page 148 of budget paper No 2. I have had the opportunity to look at the public evidence from the Education and Health Standing Committee on Tuesday, 6 July. It outlined that there were 48 IT systems, 25 of which were existing applications, 17 related to a range of existing applications and six required procurement. Was the procurement of the closed-loop medication management system one of the issues in the Birmingham University report that was issued to the minister in July 2012? Given that on 11 August 2012, the minister did a virtual fly-through release that had the robots, which I understand are the closed-loop medication management system, how could the minister release information that the minister will have this closed-loop medication management system when he knew from a report in July 2012 that there were IT delays, the procurement of the system was approved to go to market on 7 January 2013, it went to the market on 5 February and the tender closed on 1 March? At the time of the committee hearing, we were not able to hear who the preferred supplier was because the company had not been notified. Why did those delays occur, given that on 11 August 2012, subsequent to the report, the minister knew that the closed-loop medical management system would be used, but it was then some months before he went to market? Can the minister release who the preferred supplier is now?

Dr K.D. HAMES: Madam Chair, there is only one person in this room who can answer that question—the person who did it. I hand over to Dr Russell-Weisz.

Dr D. Russell-Weisz: I will try to remember all those questions. At the Education and Health Standing Committee, we talked about the suite of services that we were looking at under closed-loop medication management. There was a suite of nine—in the end we picked four.

Ms J.M. FREEMAN: Four, yes.

Dr D. Russell-Weisz: One of the robots at that time was the pharmacy robot. That is different from the other robots that the facility manager will be using, which I can only assume was the one that was shown through the fly-through. They are different robots. We eventually chose the pharmacy robot to store and issue drugs and automated medicine units for pharmacy and anaesthesia. We also went to the intensive care clinical information system for the closed-loop medication management. I would imagine that this reflects mine and Mr Nunis' evidence at the committee. When I came in in November–December, closed-loop medication management was outstanding—outstanding but a very important package—but it was not the only package in relation to ICT; there were a number of others. Yes, this was a complex package and we were not necessarily going to take the suite of nine. We had to go through quite a complex procurement process, which we did, and then we made a decision about which ones we would take for day one. That is how I found it in November, and that is what we did from there. I know I have not answered a couple of the member's other questions.

Ms J.M. FREEMAN: That was in November 2012. It went to market in February 2013, and the tender closed on 1 March. The preferred supplier was not able to be released to us at that point in time. Has the closed-loop medication management system now been procured?

Dr D. Russell-Weisz: We are still in negotiation with one supplier, but if possible I would like to take that question on notice through the minister in case I cannot release that information, because it was a package of four and I do not want to release potentially —

Dr K.D. HAMES: We will provide that as supplementary information. The member would like the name of the supplier?

Ms J.M. FREEMAN: Yes, and has it been contracted?

Dr K.D. HAMES: Has it been contracted —

Ms J.M. FREEMAN: The name of the supplier is fine, but what is more important at this time—given that this is the crux of the delay—has the minister gotten on with it? Thankfully, you came in in November 2012, given that clearly in July 2012 —

The CHAIRMAN: Order, member! We are defining the question and do not need to go over old ground. We need to define what the minister will be providing as supplementary information.

Dr K.D. HAMES: I will provide whether or not the four contracts have been awarded, and if so, the name of the company to which they were awarded —

Ms J.M. FREEMAN: And when they will start operating.

Dr K.D. HAMES: And when they will start operating.

The CHAIRMAN: I will allocate —

Mr R.H. COOK: Further to that request —

The CHAIRMAN: Can I just finish with allocating the supplementary number, member for Kwinana?

Mr R.H. COOK: Yes; I am just keen Madam Chair.

The CHAIRMAN: I know; it is fabulous. After all these hours, I am amazed.

[*Supplementary Information No A32*.]

Dr K.D. HAMES: Keep going, the longer those opposite spend on this, the less time to spend on other stuff, so that is good.

The CHAIRMAN: Member for Kwinana, do you have a further question on this issue?

Mr R.H. COOK: Yes, about the letting of those contracts. Minister, if it was discovered in November that those contracts had not even been let, let alone decisions about which system would be used being finalised, surely the minister was made aware at that point that there was no way in the world that that procurement process would be concluded in time for the opening of the hospital in April 2015.

Dr K.D. HAMES: I can only reiterate my previous answer which is: no, that is not the case.

Mr C.D. HATTON: I refer to "Works in Progress" on page 149 of budget paper No 2, the Queen Elizabeth II Medical Centre and the state mortuary extension. Bereaved families have expressed concerns with the state of the mortuary viewing rooms. Can the minister advise what improvements will be made to the state mortuary and if any further works are planned?

Mr R.H. COOK: They have eliminated double-bunking!

[3.30 pm]

Dr K.D. HAMES: I do not know how appropriate that is.

Mr R.H. COOK: It is true that they were double-bunked.

Dr K.D. HAMES: There is no doubt that the previous mortuary was in a very poor state. It had been many years since the construction of the hospital, and little work had been done on it. We have all seen media coverage of a poor lady who had a very poor experience when she had to go down through the loading area to find the mortuary. We had money in the budget for that for quite a while, but the company that started the work filed for bankruptcy and we had to find a new company to finish it off. They have done it very well. Just recently, I met with a number of Aboriginal people who were part of the opening because they had been involved in designing the gardens around it, particularly the back area where people can go out and reflect on circumstances. Members should remember that in quite a few instances people have been killed, either intentionally or by accident—as a result of violence or motor vehicle accidents—and people have to go in and identify the body of their loved one who has been subject to whatever the event was. The new mortuary provides for a much more tasteful display area. The budget also includes funding to upgrade the mortuary to create additional capacity so that we do not have the problems to which the member for Kwinana referred. There has been a significant increase in the space there, with a much better reception area and places where people can view a person who has passed on. There are three viewing rooms within that. A total of $2.4 million was spent in providing this significant upgrade to the mortuary so that we no longer have those issues that were exposed during that media presentation.

Mrs G.J. GODFREY: I refer to service 7, "Prevention, Promotion and Protection", on page 145. Can the minister advise what steps were taken to ensure all Western Australians had access to the influenza vaccine?

Dr K.D. HAMES: As all members know, there have been some issues around the influenza vaccination and the percentage of people in Western Australia who are vaccinated. Western Australia has not been one of the best states for vaccinations. We do very well in some areas, but in others our percentages have been slightly less than in some other states. People suggest there is a group of conscientious objectors who believe they should not get their children vaccinated. They have formed that view mostly from discredited information on the net; nevertheless, they represent only one or two per cent of the population. The gap between the 90-ish per cent who vaccinate their children and 100 per cent is still only seven or eight per cent, and it is not that they object to vaccinations, but they just do not get around to them. We have worked very hard this year to promote vaccinations and encourage people to vaccinate; and we make sure we have sufficient stock to do it. The member for Eyre would know that the alternative to vaccinations is catching those infections. People can be extremely damaged or even die from infections. Pertussis and measles are examples of this, and children die as a result of these infections that they can be easily vaccinated against. The fewer people vaccinated the more we get outbreaks that suddenly spread like wildfire in the community. Dr Weeramanthri is responsible for our program, and I ask if he wants to make some additional comments about our vaccination program.

Prof. T.S. Weeramanthri: I would like to make a couple of extra comments. I will begin with the at-risk groups. There is commonwealth-funded vaccine to the elderly, so people 65 and over; Aboriginal and Torres Strait Islander people aged 50 and over; as well as adults with chronic medical conditions. That is when the vaccine is subsidised. Those programs have been running for many years with reasonable uptake by the elderly and not so great uptake in those with chronic disease; we are working on that. In addition to that, vaccine was recommended, but not funded, for children. For about the last five years Western Australia provided state government–funded vaccine for children under five. It was that group in particular that was affected by the vaccine withdrawal in 2010. As the member knows, there was a loss of confidence by the community in vaccinations, particularly for that age group but not extending to other age groups or other vaccines. We are slowly rebuilding confidence in the Western Australia community over the safety of the vaccine for young children. As the member will also recall, the vaccine safety issue related to one vaccine only out of the three vaccines that were on the market at the time, so we have other vaccines available that can be given safely to kids in that age group. We have also seen greater demand since the pandemic in 2009 for uptake of the vaccine amongst otherwise healthy adults, if you like, who do not have chronic disease but who do not want to be absent from work either because of illness or to look after kids at home who might be affected as it has a knock-on effect in the family. People are prepared now to pay for the vaccine for themselves and their children, particularly older children in high school, which is not a subsidised vaccine. In 2010 and 2011, a couple of years after the pandemic, the influenza seasons were fairly moderate, but last year, in 2012, there was a fairly early and moderately heavy season and as a result of that this year we have gone out early and heavily promoted vaccine uptake, both in subsidised and unsubsidised groups. We have shipped out many thousands more vaccines this year than at the same stage last year, so the uptake has risen. We have also improved surveillance.

The CHAIRMAN: I ask that you bring your answer to a close, please.

Prof. T.S. Weeramanthri: We have also upgraded our surveillance systems so that we now have a much better ability to monitor uptake in various groups, including, importantly, health care workers themselves, because we do not want health care workers passing on flu inside hospitals and health care centres. The last point, which the member will be glad to know, is that this year we have had a very late and, up to now, very mild season. That could be because of natural variability from season to season, but we are also glad we have a lot more vaccine out there.

Mrs G.J. GODFREY: I have a supplementary question. In light of the spate of vaccine reactions that we are talking about, what is the department's advice regarding the influenza vaccine to parents of children under five?

Dr K.D. HAMES: We strongly recommend that those children have that vaccine. The vaccine with which we had the problem was a particular brand. The CSL brand of vaccine caused a significant number of children to get high temperatures, and with that a significant increase in the number of febrile convulsions. As members know, one child with febrile convulsions had a very poor outcome. That is no longer the case, and the vaccines are safe. We recommend everybody, particularly those who are at risk of particular health problems, have the vaccine, but all children should have the vaccine. My children asked whether they should get the vaccine and I told them absolutely yes.

[3.40 pm]

Mr R.H. COOK: I refer to the sixth dot point on page 132, which talks about the update of the clinical services framework. I refer the minister also to the findings of the Education and Health Standing Committee in its report "Destined to Fail". One of the key criticisms that the committee made in that report was about the low population projections in the Australian Bureau of Statistics figures that were used for estimating future demand and location of demand for health services. Can the minister provide information to the committee about what population projections he will be using this time around and whether he will be making the same mistake?

Dr K.D. HAMES: The member talks about whether we will be making the same mistake. I can tell the member that we did not have a great deal of choice over which population growth figures we used at the time; the figures that we used were the figures that we were allowed to use. The reality is that the population has surged since that time. There were a lot of things in that committee report that I did not agree with. But that was not one of them. I agree that we should have been using higher population projections at that time. We have since moved on from that, and I am sure Mr Salvage will tell us exactly what population projections we are using at the moment.

Mr R.W. Salvage: I can make a comment on the setting for the activity profile going forward over the next little while. I think that, as recognised in the 2012–13 midyear review adjustment of the health department's budget by $85 million, at some point our service delivery parted company with the forecast as derived from the CSF. That has been a particular issue for us in terms of service planning. As is reflected in the figures in the 2013–14 budget, the overall growth that is factored into the next four years above activity levels in 2012–13 is a growth factor of about three per cent in weighted activity terms. That compares with a weighted activity growth over the same period, if we had tracked at the CSF growth level, of about two per cent per annum on average. So although we are in this phase where we have not refreshed the clinical services framework fully —

Dr K.D. HAMES: Which we are doing now, I might add.

Mr R.H. COOK: And that is what the budget papers say, yes.

Mr R.W. Salvage: — what the 2013–14 budget will deliver for health is greater certainty around a growth that is above the trend that would have been predicted through the existing CSF.

Mr R.H. COOK: What is the projected publication date for the CSF?

Dr K.D. HAMES: I will ask Professor Stokes to comment on that.

Prof. B. Stokes: There are a couple of issues there that I would like to comment on. The ABS figures for the population growth of Australia and this state unfortunately are delayed and will not be available to us until November. We are in the process of working through the new clinical services framework. But it will not be available until we get those figures in November. So early next year is when I suspect it will be available.

Mr R.H. COOK: Just to further clarify that, would we be expecting that inside the 2012–13 financial year?

Prof. B. Stokes: It will be by June 2014, yes.

Dr G.G. JACOBS: I would like to ask the minister a dental health question. I do not think the minister has had a dental health question. I also want to thank the minister for the work that he has done in my area of Esperance in resuming the much needed public dental clinic. I refer to the table on page 146, which shows that in 2013–14 there will be funding of $85.5 million for dental health. Does the increase in funding from $81.7 million in 2012–13 to $85 million mean that we will have greater capacity to provide dental health services for, as the minister knows, Health Care Card holders, as well the important school dental service?

Dr K.D. HAMES: I will need to get some help with this answer—I am not sure who would be best—but I do know that there is a combination of two things here. The first is that we are increasing state-funded dental health services. The second is that there is a commonwealth proposal—I assume it is still active, despite the commonwealth government being in caretaker mode—to provide additional funding for dental health services. The question is how we can use that additional commonwealth funding. There are two clear ways in which we can do that. One is to use some of that funding to boost our state services. The other is to use that funding to get the private sector to do additional work. I think the end result will probably be a combination of those two.

I have to say that the provision of dental health services has always been very difficult. There is a constant argument about who should provide that service. I would like to have a national dental health scheme —

Dr G.G. JACOBS: Denticare! Mr Abbott believes in it!

Dr K.D. HAMES: Yes, that would provide a service in the same way that Medicare provides a service, because that is absolutely essential if we are to provide decent dental care across the state. At the moment, we are struggling with the system that we have. When we were in opposition, I was planning to come up with a dynamic policy to blast the government of the day as to how we could provide better dental care, and I had a lot

of experts give me advice, but at the end of the day I could not get anyone to provide me with a sensible program that would reflect state government responsibilities and provide a better dental care service but would not bankrupt the state. So it has been very frustrating. Dr Kelly has a much better answer than I could give, I am sure.

The CHAIRMAN: But briefly, please, Dr Kelly.

Dr S.P. Kelly: I will be brief. The minister has already alluded to the fact that as well as the ongoing and increasing state contribution to dental services, there is a commonwealth proposal for a national partnership agreement to treat more public dental patients. That agreement has been signed by both parties, so that funding is assured, and it will see Western Australia receive over the period from June 2013 to March 2015 an additional $28.9 million. With that funding, we will be able to deliver an additional 34 330 dental units of activity.

Ms J.M. FREEMAN: Morley Government Dental Clinic is quite overbooked. I have had complaints to my office about the wait times to get into that dental service. There was some discussion at some stage about establishing a public dental clinic in Mirrabooka.

Dr K.D. HAMES: Yes, as of last week when we had the conversation during your debate!

Ms J.M. FREEMAN: Yes, probably! It has been a long day! Has any consideration been given to opening a public dental health clinic in Mirrabooka, and is there an estimated time of arrival for such a clinic?

Dr K.D. HAMES: Yes. I will give the same answer that I gave last week. On that land that we are looking at and that the member keeps referring to —

Ms J.M. FREEMAN: I was going to get to that!

Dr K.D. HAMES: — we are looking at some aged care provision as part of that development. I am also looking at the provision of other services on that site, and one of those would be a public dental health service. We need to expand that service, especially in that region. So that is my hope. I cannot give the member an exact time frame. I think we are fast reaching agreement on the aged care. There is commonwealth funding for that already, and now we are looking for land. That has not been officially approved by government yet, but state health is pretty keen on it. As soon as we have done that, we can work out what space is available for those other services and how we can go about providing them. It may be the case that as part of our providing the land, the commonwealth will provide the facilities that we need, as part of its construction, for that public dental health service.

Ms J.M. FREEMAN: I have another question, and it is actually about that land.

Dr K.D. HAMES: Funny about that!

Ms J.M. FREEMAN: We could not let estimates go by without getting to that! I refer to page 150 and the line item "Land Acquisition". That refers to the 2.5 hectares of land that I understand has been purchased by the Department of Health. The last time we came into this place, the title for that land still had not been transferred to the Department of Health. Has the title now been transferred to the Department of Health; and, if not, when will it be transferred? The minister has said that there have been some discussions. Are there any time lines for development? But, firstly, has the title been transferred?

[3.50 pm]

Dr K.D. HAMES: No, it has not yet been transferred. One of the issues was arguments between us and the Department of Housing about the value of land, and that is the answer I gave last year. From that, the department had to get a valuation of the Mirrabooka land. That has been done now. I might add that $9 million is the value of the land. I do not think that is confidential, is it?

Ms J.M. FREEMAN: It is bad luck now!

Dr K.D. HAMES: If it was, it is not any more. But it says that the title has been issued, which is something that had not occurred last time, and that housing is seeking ministerial approval to progress the land exchanges; we have to do a land exchange.

Ms J.M. FREEMAN: The minister can be assured that I will ask the same question of the Housing Authority tomorrow.

Dr K.D. HAMES: Very good; and ask it why it has taken so long to progress it. While the member is doing that, she can say that I said to ask that.

Ms J.M. FREEMAN: Yes.

Mr R.H. COOK: My curiosity is piqued by two line items on page 130, "Program Rationalisation" and "Other Saving Measures", which is no small amount; I think it is about $20 million in itself. Can the minister provide a run-down for the committee of what is involved in those two line items?

Dr K.D. HAMES: I will need to hand over to Mr Salvage.

Mr R.W. Salvage: The first item is an agreement that the minister gave to the Treasurer to offer up savings across the forward estimates. It is largely going to do with, at least as far as 2013–14 is concerned, the timing of the implementation of programs, which will free up some budgeted cash to pay for the items in the current financial year. The items in the next three years will not be resolved in terms of where that funding will come from, but at least as far as 2013–14 is concerned, it is largely to do with timing of program implementation, as I recall. I do not have any detail on the "Other Saving Measures" line.

Mr R.H. COOK: The department cannot provide details about $20 million worth of savings across the forward estimates. When will it be able to provide that information?

Dr K.D. HAMES: That is a good question. Mr Salvage?

Mr R.W. Salvage: We have prepared some advice, but we still need to have confirmation of the minister's agreement. Once that has been done, we will be able to provide some further information on that.

Dr K.D. HAMES: We will provide that as supplementary information. Does the Chair want the detail of the question again for the record?

The CHAIRMAN: Yes, please. Who is going to do that for me?

Mr R.H. COOK: My question was about "Program Rationalisation" and "Other Savings Measures", but I think that at that point of the discussion, Mr Salvage was talking about other savings measures.

Dr K.D. HAMES: We will provide details of the other saving measures under the heading "Other" in the table.

[*Supplementary Information No A33.*]

Ms J.M. FREEMAN: I did not catch what was in program rationalisation. I did not catch whether that included holding positions that are vacant.

The CHAIRMAN: Is this a further question, member for Mirrabooka?

Ms J.M. FREEMAN: No, that was part of the question and Mr Salvage answered it.

Dr K.D. HAMES: And the member did not catch the answer. Would the member like me to send her a copy of *Hansard*?

Ms J.M. FREEMAN: No. It did not make —

The CHAIRMAN: I think we are getting very close to the end of the time.

Ms J.M. FREEMAN: He did not say what had gone; he just said that something was deferred.

The CHAIRMAN: We will move to the member for Eyre.

Dr G.G. JACOBS: I refer to the goldfields emergency telehealth service. I do some part-time doctoring, and I am on call at Esperance Hospital. Can the minister run through how this will work for me when I am a doctor on call in the emergency department at Esperance Hospital or Kalgoorlie Hospital? How will the funding of $8 million over four years be used to benefit goldfields patients? People talk about telehealth, but do they really understand how it works?

Dr K.D. HAMES: This refers more to the northern half of the member's electorate and his job as a member of Parliament than it does to the member's other work in health.

Dr G.G. JACOBS: I have Boulder as well.

Dr K.D. HAMES: During the election period, I regularly asked all my regions what was important to them for the next four years of government and whether there was anything of particular importance that would make a difference. The manager of the region in Geraldton indicated that her highest priority for providing additional services was to grow the region's telehealth service. Under this initiative, an extra three specialist emergency physicians will be employed in the Kalgoorlie–Boulder region.

The CHAIRMAN: Excuse me, minister. You said Geraldton. Did you mean Geraldton or Kalgoorlie?

Dr K.D. HAMES: I apologise; I meant Kalgoorlie.

Dr G.G. JACOBS: The minister means Geraldine.

Dr K.D. HAMES: Yes; Geraldine is the person—not Geraldton. Geraldine gave the advice about Kalgoorlie. Three emergency physicians, as well as two project administrative support officers, will be employed to expand that telehealth service. It is based in Kalgoorlie and provides services to the regions. It links Esperance—so the member will be linked to that telehealth service when he is working in Esperance—Norseman, Kambalda, Coolgardie, Laverton and Leonora with the specialists who are working at Kalgoorlie Hospital.

During the election I was very pleased to make a commitment to provide that funding. The member will know that that additional funding came from royalties for regions. It gave us the capacity to provide that fantastic extra service for people such as the member who work in those areas. The member is pretty experienced, but not everyone who works in those towns is.

Dr G.G. JACOBS: It is pretty much part time, I must say.

Dr K.D. HAMES: Yes. Whatever comes in, it will give the member the opportunity to have a direct telehealth link with three new emergency physicians—not three at once, of course; they are on a rotation roster. I do not know exactly what hours they will cover, but we have made sure that we have coverage for people on leave and for protracted hours, so that when people need that service, they can get it. The member could be a locum in Laverton and there may be a severe accident, for example, or a severe medical problem. The vision of his patient will go directly to people in Kalgoorlie Hospital, and they will direct the member on the things that he needs to do. It is great while the member is there, but that service is also provided when the member is not there. A nurse practitioner or a registered nurse may be out there in some of the remote communities. We saw that with the accident in Southern Cross. Following a severe accident, the nurse was able to link directly to the hospital through telehealth and save people's lives there and then.

Ms J.M. FREEMAN: I refer to page 130 of budget paper No 2. Has the temporary advertising freeze prevented advertising for vacant positions, including the director general of Health?

Dr K.D. HAMES: I do not think that affected the advertising for the director general of Health, because that was done over a long period. It must be remembered that that was just a three-month advertising block. Quite some time ago we switched from newspaper advertisements to online advertisements for jobs in the Department of Health, and that has been extremely successful. Mr Salvage would like to make a comment.

Ms J.M. FREEMAN: Just as long as it makes sense.

The CHAIRMAN: Order, member! I think that is uncalled for.

Mr R.W. Salvage: The advertising freeze expired on 30 June, and I think it came into force after the advertisement for the director general's job was completed, so it would not have affected that position.

Dr K.D. HAMES: Will I be asked any further questions about our acting director general? I think he is doing a great job.

Ms J.M. FREEMAN: Does the acting director general of Health have the minister's full confidence?

Dr K.D. HAMES: Absolutely; he has my full confidence. I think he is doing a wonderful job. Did the acting director general want to make any comments?

Prof. B. Stokes: No!

[4.00 pm]

Mr R.H. COOK: We had trouble finding out what the forward savings will be. Perhaps the minister could provide us with a quick summary of the $94.2 million worth of savings in the efficiency dividend for 2013?

Dr K.D. HAMES: Again, I will pass that on to Mr Salvage.

Mr R.W. Salvage: A $94 million efficiency dividend was applied to the budget last year. The Department of Health did various adjustments over the course of the year. The Department of Health came in on budget at the end of the year. Those efficiency savings were absorbed within total spending. As far as a future look of the forward estimates view of the efficiency dividend is concerned, the allocation of additional funding for activity essentially rebases Health's budget from 2013–14.

The CHAIRMAN: That concludes consideration of division 9.

The appropriation was recommended.