Division 13: WA Health, $4 548 041 000 —

Mrs L.M. Harvey, Chairman.

Dr K.D. Hames, Minister for Health.

Mr K. Snowball, Acting Director General.

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

Mr P. Aylward, Executive Director, Department of Health.

Dr R. Lawrence, Executive Director, Innovation and Health System Reform.

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

Mrs R.A. Elmes, Executive Director, Public Health and Ambulatory Care.

Professor K. Wyatt. Director, Aboriginal Health.

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

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

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

Dr S.C.B. Towler, Chief Medical Officer, WA Health.

Mr W. Salvage, Director, Finance and Contracting.

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

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

It is the Chairman's intention to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point.

The minister may agree to provide supplementary information to the committee rather than asking that the question be put on notice for the next sitting week. For the purpose of following up the provision of this information, 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, 11 June 2010 so that members may read it before the report and third reading stages. If the supplementary information cannot be provided within that time, written advice is required of the day by which the information will be made available. Details in relation to supplementary information have been provided to both members and advisers, and, accordingly, I ask the minister to cooperate with those requirements. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office. Only supplementary information that the minister agrees to provide will be sought by Friday, 11 June 2010.

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

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

[Witnesses introduced.]

The CHAIRMAN: Member for Albany.

Mr P.B. WATSON: I refer the minister to page 202 of the *Budget Statements* and the line item "Visiting medical practitioners". I notice that the actual income was approximately $97 000 in 2009–10 and that the estimated actual for that year was approximately $104 000. Minister, fly in, fly out doctors provide a 24-hour service to Albany Regional Hospital. It is a great service, but what is the cost to Albany Regional Hospital to fly in these doctors?

Dr K.D. HAMES: The member knows that there have been concerns in dealing with issues at Albany hospital. Some of the general practitioner groups in particular were not prepared to continue to provide the service that they had been providing through the emergency department. We took the view that we need to improve that service, particularly in preparation for the construction of the new hospital. Accordingly, we have doctors who work full time in the hospital and other doctors who fly in. I will hand over to Mr Snowball, who will provide some details about costs.

Mr K. Snowball: I might add that in terms of the costs, there is an offset between the visiting medical practitioners who are paid a fee for service to provide the service in the emergency department against a salary or sessional payment for those doctors currently providing that service in ED. There is actually a gross cost and a net cost post the VMP payments —

Mr P.B. WATSON: Mr Snowball, I am after the air fares, the accommodation and what it is costing —

The CHAIRMAN: Member for Albany, your further question needs to be directed to the minister.

Mr P.B. WATSON: Sorry.

Dr K.D. HAMES: Yes; the member needs to wait until Mr Snowball finishes. We understand the question. We will need to take that question on notice for the detail, and, having said that we will try not to take too many supplementary questions, that will be our first supplementary question. Specifically, the member is seeking the detailed costs of the provision of fly in, fly out doctors to —

Mr P.B. WATSON: Including the New Zealand doctor.

Dr K.D. HAMES: We will provide whatever details of the cost of fly in, fly out doctors to provide the service to Albany hospital.

[*Supplementary Information No A25.*]

Mr P.B. WATSON: Under freedom of information, I am led to believe that for the previous five months it has cost over $27 000—and that is for airfares alone. Does the minister think that this situation is sustainable when he looks at the costs for visiting doctors; it is $27 000 straightaway for visiting doctors in Albany alone. Is this sustainable? Can it be maintained or are there plans to have full-time doctors at the hospital?

Dr K.D. HAMES: The particular figure provided under freedom of information obviously does not include the offset discussed by the director general in terms of what it cost us before this arrangement was put in place. The member would need to do the full comparison. It costs what it costs. We are committed to providing that service and we will pay whatever cost is required. Obviously, it would be best to, and we will, provide that service with the minimum possible cost to the taxpayer, but providing the service is of critical importance to us.

Mr P.B. WATSON: Does that cost come out of the Albany Regional Hospital's budget or does it come out of another budget?

Dr K.D. HAMES: It certainly does not come out of the hospital's budget; that hospital's budget is a construction budget and has nothing —

Mr P.B. WATSON: No, no; I refer to the current running of the hospital.

Dr K.D. HAMES: The recurrent cost—yes. It adds to the recurrent cost of the hospital. The recurrent cost of the hospital is, again, whatever the recurrent cost is. We pay to provide a service; it is higher in some areas and lower in others, depending on the staffing that we have at a particular time. That just becomes part of the overall total health budget.

Mr P.B. WATSON: I thank the minister.

Mr A.P. JACOB: I refer the minister to page 179, "Appropriations, Expenses and Cash Assets" and the line item "Total Cost of Services" under the specific subheading "Expenses". I see an increase of 6.7 per cent on the 2009–10 estimated actual. What does this increase represent and what will be the overall effect on the health budget?

[9.10 am]

Dr K.D. HAMES: The 6.7 per cent is actually a very good result for the health department because it comes on top of what we called, when in budget discussions with Treasury, "stable and certain budgets". It has been traditional in health—I do not know whether it is has been in other areas as well—that each year an amount in the budget has been spent by the health department that has not been recouped by Treasury. In the last year of the Labor government, that amount was $40 million and it was taken from reserves. In our first year of

government, when it was $70 million, there were no reserves from which to take it. As the member knows, we got into strife for using special purpose account funds to pay that off. I do not like leaving bills unpaid. I thought it was in the best interests of the government to look after those people who provide the service rather than worry about the niceties of where the funds came from. In effect, that $70 million had to be repaid the day after we got the new budget on 1 July. That left us with $70 million less in our total budget, which did not provide certainty within the health system and resulted in a significant reduction of funds that were available to provide a health service. By the time we factored in new election commitments, we were left with very little money to move forward; hence, the additional $210 million that has been required for the current year. The provision of that $210 million, which is the equivalent of another four per cent, took us to a new base level that covered all the actual costs of running the health system in the current financial year. The 6.7 per cent growth is in addition to that and it allows for growth in demand and growth in service, while at the same time ensuring that that we have been able to show restraint in health because spending by the previous government was out of control. In the last year of the Labor government, spending growth was 12.8 per cent based on minimum growth in demand of three to four per cent. In our first year of government, it was 12.3 per cent because we were unable to rein in that expenditure. We have been able to do that this year. Indeed, the Department of Health and all the regions have done a magnificent job cutting back that overexpenditure. In particular, it was done by reducing staffing in backroom areas; that is, the service areas in Royal Street, where there was a reduction of 350 staff. At the same time, there was the provision of an extra 700 nurses and doctors—frontline staff. We ended up with a 7.2 per cent overall growth in expenditure on previous years' expenditure. We were criticised by the Deputy Leader of the Opposition who said that traditionally growth had averaged well over nine per cent and that the 6.7 per cent was behind the eight ball. The reality is that the Deputy Leader of the Opposition compared the final expenditure for the previous year with the budgeted expenditure for the following year. When we consider Labor's time in government and compare those two figures, the percentage increase was five to six per cent—less than what it is during our time in government. The nine per cent is final spend to final spend, which is a different comparison. We do not know whether the 6.7 per cent is the final spend. A good example of what may change is if we do a deal with the commonwealth government for increased funds. We may end up with an additional $100 million in the first year, which would add about two per cent to the budget growth when we get to outturn. The member needs to compare apples with apples to get those figures. The 6.7 per cent is above the percentage growth comparing the two figures for every previous year during the past 10 years. It is a very good figure and it enables us to have certainty. When we tie that to activity-based funding, it gives us more certainty about the cost of providing a health service in this state. The South Australian Minister for Health said that since his department had moved to the activity-based funding model, although the department still had overruns of budget, it is was much more predictable and certain.

Mr R.H. COOK: I have a follow-up question.

The CHAIRMAN: Further questions need to be asked by the proposer of the question. However, I have the member down for a question now regardless.

Mr R.H. COOK: I refer to page 198 of the *Budget Statements* and to "Works in Progress". What is the current timing for the development of Midland health campus? Can the minister guarantee that it will be operating by 2015? Is the $345 million the full cost of developing the hospital? Will the private sector partner that the government is proposing to operate the hospital be required to contribute towards the capital costs; and, if so, what are those costs?

Dr K.D. HAMES: The total budget for Midland health campus is $360.2 million, of which the state government has budgeted $180.1 million. There has been some criticism by the local federal member about that amount not being in the budget. It is in the budget; some of it is in the out years, such as 2014 and 2015. All the funds are in the budget from a state and commonwealth point of view. The completion date, contrary to her press release, is mid-2015. We are on target. We have asked for expressions of interest for a build–own–operate model that includes the potential for funding. There are two ways funding can occur. The first involves the private sector putting up the funds. The commonwealth has agreed that its funds could be used as part of the pay-off of the capital cost of the hospital. That is not looking the most promising at present. More than likely the state and federal money will be put in for the capital construction of the hospital. It will be a design–build–operate–maintain model.

Mr R.H. COOK: So the state will put in the capital, but there will be a private sector operator?

Dr K.D. HAMES: In effect it would be the same as what has happened with Joondalup Health Campus. The state government would provide the funding and the private sector would build and run the hospital. In effect, it will be an identical model to Joondalup. Construction is on schedule and the hospital is due for completion in 2015. I have read comments about a previous proposed completion time for this project. If we consider press

releases by the former government, in 2005 it was going to be built in 2010. After a series of press releases we get to 2007 and a completion time of 2012. As we move out two years, so had the completion time. In March 2008 a $193 million hospital was due to start by the end of 2009 with no specific completion date. The problem with that was that in the intervening period the former government had moved from doing additional construction at Swan District Hospital, which in the initial release was going to have 120 beds, and moved from 206 to beds to 326 beds. During that time—I forget the exact year the former minister announced it; I think it was about 206 beds—I released a policy statement whilst in opposition that stated that we would move the hospital to a new stand-alone site and build a new hospital. The government at the time then announced it was going to do the same. The $180 million was in the budget to build the extra beds at Midland; but the money to replace the beds that were already in existence at Swan District, once the location changed, was never added. When we came to government at the end of 2008, there were no designs, no plans had been drawn up and there was no commitment of the money that was needed to transfer the Midland health campus to the new site. We of course came to government without the full funds being available and in the middle of an international financial crisis, so we did push the time out for the completion of that hospital. The completion time is now set at mid-2015. Have I missed something?

[9.20 am]

Mr R.H. COOK: No; that is fine, minister. The minister answered the question on the private sector partner providing capital costs for the project.

Dr K.D. HAMES: I think that is unlikely.

Mr R.H. COOK: That is unlikely. The government has already put in $354 million, so it is probably not necessary.

Dr K.D. HAMES: That is the full cost.

Mr R.H. COOK: What are the annual dollar savings for the taxpayers by going through a private sector model rather than the government operating the hospital itself?

Dr K.D. HAMES: I will get the director general to answer that question in more detail. This model was recommended to me by the Department of Health; I did not say, "I want this model." It was put forward as the best model to provide certainty of outcomes and certainty of growth in the budget. It was financially much better. We have been extremely happy with the outcomes of the Joondalup model.

Mr R.H. COOK: Ideologies aside, I want to know about the rigour behind that.

Dr K.D. HAMES: I am getting to that. Patience is a virtue. Mr Snowball.

Mr K. Snowball: It is done on a case-by-case basis basically to establish the most efficient way of delivering these services. Part of this model is about testing the private market to see how it in fact stacks up against the public sector comparator. We basically model the delivery of services as though it were being run as a public hospital.

Mr R.H. COOK: What was the —

Mr K. Snowball: I am just describing the model we apply. It depends on the range and types of services that we are offering. As the minister described, Joondalup is probably a good example. It has gone through that entire process and we have got to the point now at which we can demonstrate a clear cost benefit by using that model for that range of services. Midland is yet to have tested the market sufficiently for us to say that it is five, 10 or 15 per cent, but we are using the experience of Joondalup. We would not go out to the market if we did not expect a cost benefit associated with it. If I could, I will ask Dr Russell-Weisz, who looks after the Joondalup contract in particular, to describe —

Mr R.H. COOK: I am not asking about the Joondalup contract, minister.

Dr K.D. HAMES: Yes, but I would like Dr Russell-Weisz to answer because I think it provides a good comparison.

Dr D.J. Russell-Weisz: Just to add to the director general's comments about the Joondalup contract, when we extended the public–private partnership for Joondalup, a public sector comparator on both capital and recurrent was done at the time. It was shown at that time that if the private sector rather than the state extended the hospital, it would be at a significantly reduced cost. Also, in terms of the benefits that we get out of the Joondalup contract for the recurrent funding, we get discounts on certain items of service. We contract a volume of service, which is specified within the clinical services framework parameters and which will be specified for the Midland health campus. Those occasions of service, including providing general medical, general surgical,

obstetrics and paediatrics, are then paid for by the state but at a less expensive price than the state could do it for. That is how the Joondalup contract works, and it has advantages in both capital and recurrent. When we did the analysis for the procurement model for Midland, those advantages also held strong that there would be the same outcome whilst delivering sustainable and quality services for the people of Midland.

Dr K.D. HAMES: It has always surprised me that the private sector in those circumstances can deliver a service at a discounted rate and still make a profit.

Mr R.H. COOK: It does it by paying its staff less, minister.

Dr K.D. HAMES: No, it does not. The staff at Joondalup are paid the same.

Mr R.H. COOK: There are substantially different conditions.

Dr K.D. HAMES: In Peel the registered nurses are paid the same wages as are nurses anywhere else.

The CHAIRMAN: Members, this is not an opportunity for debate.

Mr R.H. COOK: The minister is telling me that he has not yet done the public–private comparator for Midland hospital, if I am to take the director general's word, and therefore we have a policy decision to go down the Joondalup route. But the minister cannot at this stage present any evidence about cost savings to the taxpayer for Midland hospital.

Dr K.D. HAMES: It is the case that that comparator has not yet been done; and, if it comes in unfavourably, we will change the model. We are not philosophically locked into that model. We have gone out for expressions of interest from the private sector. We will do an analysis of the cost benefits to the state of the proposal that the successful company puts up. If it does not stack up against what we are able to provide through the public sector, we are not locked into a contract until we sign the contract. We will look at changing that model if that is the case.

Mr R.H. COOK: What is the timing of that analysis?

Dr K.D. HAMES: I need Dr Russell-Weisz to provide the details.

Dr D.J. Russell-Weisz: We have done a significant market sounding. We are planning for the formal expressions of interest to occur in September 2010. There will then be a request for proposals in early 2011. The commencement of construction is aimed at mid-2012 and the completion of construction in mid-2015.

Mr R.H. COOK: Finally, at what point will the decision be made on whether the capital commitment, which I believe is fairly substantial, that will be made for Midland hospital in the next two years will be an operate-only venture versus a capital-injection venture by the private sector? If we go with that exercise, where is the value for money for the Western Australian taxpayer? I assume Joondalup provides some public sector services at a cut-price rate because it is skimming the private sector market. I apologise if this is extending the scope of the question, Madam Chair. Does the minister also intend for private hospital beds to operate out of the Midland campus in addition to the public hospital?

Dr K.D. HAMES: To answer the last part of the question, no, that is not the case, but there is always the opportunity for the private sector to do what it has done at Joondalup—that is, to build a private hospital adjacent to the public hospital.

Mr R.H. COOK: But that is not part of the model.

Dr K.D. HAMES: No; that is not, but there is always the opportunity for that to occur. In fact, we would encourage that. As the member knows, there is no private hospital operating in the entire eastern corridor region and I think it desperately needs one. We are strongly of that view and we will encourage that to occur. To answer the first part of the question, the request for proposals will be in early 2011, and a decision on that will be made by that stage.

Mr P. ABETZ: In one of the minister's earlier answers, he referred to activity-based funding. At page 184 of the budget papers, it is referred to as a major initiative in the forthcoming financial year. Can the minister clarify exactly what is activity-based funding and what is considered to be the advantages of that funding compared with the current budgeting processes?

Dr K.D. HAMES: Activity-based funding relates to funding for the delivery of specific services based on an evaluated cost of providing that service. It is done across the system and allows for a level of activity to be set, but also for changes to be reflected in activity in specific locations. This system operates currently in other states, particularly in Victoria and South Australia. As the member will be aware, as part of the conditions of the national agreement on health, the federal government has provided that all states undertake this system with a

centrally determined cost per occasion of service. We had already initiated that process, being of the view that it gave us not only much more certainty of costings and funding for hospitals, but also the opportunity to improve efficiency within those hospitals. Therefore, it will encourage hospitals funded according to the service they provide on a specific cost basis to provide a more efficient service, particularly in the area of waitlist surgery whereby hospitals are funded on the basis of the number of procedures that they do. As I said earlier, focusing on outputs will give us much more certainty in costings and funding. We will move to that model in a very careful way because currently hospitals are funded on an in globo traditional basis per hospital in relation to growth in that hospital. We do not want to suddenly move to a new system if the hospital is not particularly efficient in all those areas and there are additional costs; for example, in Port Hedland there are huge rental costs that add significantly to the costs of running the service. Therefore, we cannot have a one-cost-fits-all approach for the whole state. As members know, the commonwealth proposed a one-cost-fits-all approach for the whole of Australia. That is obviously not practical and we discussed that at length with the commonwealth. However, we will move forward on that in a similar way in which we introduced the four-hour rule—with clinical leads and people with expertise in that area working as a team to bring the hospitals along with them to ensure there is a smooth transition into activity-based funding. I will hand over to the director general to provide further detail.

[9.30 am]

Mr K. Snowball: I guess there are three key things that we are eager to see come from the implementation of activity-based funding. One is to get very clear efficiency across our hospitals. This system highlights areas in which we have relative inefficiency or efficiency. We will then be able to test that and determine whether the efficiency problem is a consequence of structural issues, whether there are small economies of scale and so on—which are quite legitimate but we need to identify them—or whether it is purely management inefficiency or, in other words, whether it is simply poor management of that activity. That will be highlighted in all our hospitals from 1 July when we apply this model. It will then be a process of ensuring that basically all our hospitals are operating at a similarly efficient level. That will give us reassurance, and, hopefully, will give the government reassurance as well that it is getting value for money on its investment in health. It will also highlight issues for individual hospitals and clinicians in hospitals, such as why does it cost more to do a hip replacement at Fremantle than it does at Royal Perth Hospital? Therefore, hospitals will be able to get onto the front foot and examine the differences in where they might be able to improve their outputs. For us, too, I guess the clearest thing is to then take that government investment in activity to ensure there is a safety–quality component. Therefore, it is not just about cost and price; it is about achieving a level of quality and safety in our system. That will be very transparent to not only the hospitals but also the wider health system, the government and the community. Consequently, we think it is a really important step for the health system to take. It is significant, so it will take time for our system to adapt. Some of our information and communications technology systems need to change and our clinical coding needs to get quicker. There are some step-up things that we need to do across the system to accommodate it. However, I think the future is good because as we move over the next three years to an even more sophisticated approach to activity-based funding, going beyond inpatients and emergency departments into other areas such as community health–type areas and so on, we will be able to measure our delivery for health outcomes in the community beyond just hospital-type activity.

Ms J.M. FREEMAN: I refer to the Fiona Stanley Hospital development on page 198 of the *Budget Statements* and the criticisms from the Department of Treasury and Finance —

Dr K.D. HAMES: Sorry; I cannot hear the member. The member could speak slower, perhaps.

Mr R.H. COOK: He is very old.

Ms J.M. FREEMAN: He is very old—yes, I forgot. I got that on the record!

I refer to the Fiona Stanley Hospital development and the criticisms from the Department of Treasury and Finance about the sustainability of both developing the new hospital and retaining Royal Perth Hospital as a tertiary hospital. Does the current capital allocation for the development of Fiona Stanley Hospital include equipment and fit-out? Does the government contemplate the need to seek supplementary funding for the equipment and fit-out? Is the current equipment replacement program an attempt to simply build equipment numbers in order to equip a hospital that would have otherwise relied on RPH for a good deal of its needs?

Dr K.D. HAMES: That is a complex question that deals with the issue of Royal Perth Hospital and Fiona Stanley Hospital. I will focus on the part of the member's question about equipment replacement. The $1.76 billion allocated for Fiona Stanley Hospital by the former government did not specifically have an amount that covered all the equipment needs at that hospital. It was always proposed—this is my understanding; correct me if I am wrong, staff—that there would be new equipment in the new hospital. It was not proposed that old equipment at Royal Perth Hospital would be transferred across to Fiona Stanley Hospital. I might clarify that

later, just in case I am wrong. The funding supplies a significant component within the budget for equipment replacement. Remember that in a budget of $1.76 billion there is a fair bit of contingency flexibility within that total budget on the cost. Currently it is progressing exactly on time and exactly on budget, which will leave an amount at the end that we presume will also be available. However, the equipment budget that we have put forward—$120 million over four years—is to provide for a total level of equipment for tertiary beds. Remember while those tertiary bed numbers go up at one hospital, they go down at another hospital—Fremantle and Royal Perth. That is a reflection of the demand listed initially by the 2004 report into equipment shortfall in this state. That will make up for that shortfall; equipment will be provided where it is needed.

I am advised that I was marginally incorrect; 20 per cent of the equipment for Fiona Stanley Hospital will come from Royal Perth Hospital. However, remember that there will be a significant reduction from the 680 beds currently at Royal Perth to 400 beds—that is, a 280-bed reduction at Royal Perth Hospital. That 20 per cent would obviously be the best equipment, and certainly with that reduction in the number of beds, there will be the capacity to move that equipment across. Does the director general want to add anything further?

Mr K. Snowball: We are also reviewing our full equipment needs for Fiona Stanley Hospital. Obviously, 20 per cent will come from Royal Perth Hospital but it is also subject to the bids that come forward for the facility and management contract for Fiona Stanley Hospital. Therefore, if we get a good outcome from that contract, it will allow us to, obviously, support more of the equipment required for Fiona Stanley Hospital when it opens. At this point we are reasonably confident that we have the equipment covered but it is subject to the outcome of those final contract proposals.

Dr K.D. HAMES: I will ask my staff to provide an explanation, if they know, why the full equipment costs were not in the original $1.76 billion budget for Fiona Stanley Hospital.

Ms N.M. Feely: In relation to the 20 per cent issue, when we look at which services are moving from Royal Perth Hospital to Fiona Stanley Hospital, say, the burns unit, it was always assumed that the equipment attached to that burns unit would move lock, stock and barrel to Fiona Stanley Hospital. When we look at what will happen between Royal Perth Hospital and Fiona Stanley Hospital by 2014, that 20 per cent covers the majority of services that were deemed appropriate to move to Fiona Stanley Hospital. At this stage, as we look at the clinical services planning for both Fiona Stanley Hospital and Royal Perth Hospital, there may be some change to that percentage depending on how it all pans out, but we fundamentally think that 20 percent is about right. We are not talking about moving old equipment. We will move just the equipment associated with the services. Similarly, there was talk about not having an emergency department at Fremantle Hospital. That equipment will move from Fremantle Hospital to Fiona Stanley Hospital. Across the board, the South Metropolitan Area Health Service will have equipment moved around to accommodate the continuation of the current services at the current tertiary facilities and also at Fiona Stanley Hospital.

[9.40 am]

In relation to the facility and management consultant bids, without going into the detail of each, the catering FM bid, for example, looks at providing a shell for the provision of the catering services. Part of the bids will come back in to provide the equipment and the fit-out of the shell for the catering and cooking side of things. Minister, depending on how these bids roll out, we are confident that the current costs will cover the FM requirements for Fiona Stanley Hospital, subject to the other parts of the health system that will be moving into Fiona Stanley Hospital.

Ms J.M. FREEMAN: Is 20 per cent moving from Royal Perth Hospital because there is a reduction in the number of beds? I would like the minister to confirm whether there has been a change in the movement of equipment because of the retention of Royal Perth Hospital and whether the government intends to move more of the equipment. I understand that the old equipment is not to be moved because there is a replacement program for the old equipment. Given that the government is retaining Royal Perth Hospital as a tertiary hospital, has there been any change in the arrangements for the equipment that will be moved, and what impact has that had on the equipment replacement program?

Dr K.D. HAMES: There was a question I was going to answer at a later stage that I might as well cover now.

Ms J.M. FREEMAN: Does the minister write his own questions?

Dr K.D. HAMES: I was keeping my powder dry for another day. I am handing out a summary of the bed frameworks.

Mr R.H. COOK: That saves me asking the question.

Dr K.D. HAMES: I have highlighted on the framework the issues that I have referred to in terms of bed numbers. It shows the difference between the clinical services framework in 2005 under the former government and over 2010–20, under our government. Members need to remember that the clinical services framework 2005 was based on the completion date of Fiona Stanley Hospital by 2010. As members know, by the time we came to government, that time had been pushed out to 2014–15, for reasonably logical reasons, and stage 2 of Fiona Stanley was therefore five years behind. We need to compare 2020 with 2015. If members look at the first column regarding the number of beds in for Royal Perth Hospital, they will see that the number of beds for 2004–05 was 708 and that that number was to reduce to 64 beds. There were to be 72 beds in 2015. That is the first yellow column. That represented a reduction in the number of beds at Royal Perth Hospital. In the next column, members will notice that the number of beds at Sir Charles Gairdner Hospital goes from 645 up to 1 046. That is a gain of nearly 400 beds. The 400 beds that were to close at Royal Perth Hospital were never going to go to Fiona Stanley Hospital. The services were going to be delivered for the southern corridor at Fiona Stanley Hospital, but the beds were being transferred to Sir Charles Gairdner Hospital. Some equipment was obviously going to go to Fiona Stanley Hospital—for example, when the burns unit was moved—but the rest of the equipment was to go to Sir Charles Gairdner Hospital to meet the 1 046 beds that the former Minister for Health had proposed putting into the Sir Charles Gairdner Hospital site. Instead of having 1 046 beds at Sir Charles Gairdner Hospital, we have stuck with the original figure of 645 beds at Charlies and 400 at Royal Perth. The total the number of beds in the final outcome under us is the same across those two hospitals as it was under the former government's proposal. Just before the election, the then Minister for Health changed that because he realised that he could not fit 1 000 beds in Sir Charles Gairdner Hospital, and so he moved all those beds to Fremantle Hospital, which was to remain at about the same size that it is currently. That comparison shows where the beds went. All the talk about how keeping the beds at Royal Perth would take away beds from Fiona Stanley Hospital is just not true. Let us look at what happens to the beds for Fiona Stanley Hospital. Under the former government's proposal—I have not highlighted that in yellow—the number of beds at Fiona Stanley Hospital were going to increase to 1 058 beds by 2015–16. Does the member see that in the middle section?

Ms J.M. FREEMAN: The minister lost me after he said, "Have a look at Royal Perth Hospital."

Dr K.D. HAMES: I have highlighted it in yellow.

Mr R.H. COOK: Are we dealing with the beds at Rockingham General Hospital?

Dr K.D. HAMES: Remember that I made a comment about the beds from Fiona Stanley not being affected by Royal Perth Hospital. We have now ended up with 838 beds at Fiona Stanley Hospital. That includes the 643 beds that are being constructed plus moving 140 beds across from Shenton Park and the additional mental health beds that are presently there. Fiona Stanley Hospital was going to have 1 058 beds but now it will have 838. There are roughly 200 beds missing. The suggestion has always been—I get back to the issue of Royal Perth—that we have taken them and put them in Royal Perth. We have not. They have gone to Rockingham. Members will notice under the fourth yellow column that in 2015–16, Rockingham will have 356 beds, compared with the 306 beds that it currently has. Fifty of the Fiona Stanley Hospital beds are going to Rockingham.

Mr R.H. COOK: Rockingham was always going to have at least 340 beds in its stage 2 development.

Dr K.D. HAMES: This is the former government's clinical services framework. It is the member's government's document. Rockingham was to have 306 beds and now it will have 356 beds.

Mr R.H. COOK: With respect, minister, that is not right.

Dr K.D. HAMES: It is right. It is the clinical framework document.

Mr R.H. COOK: In documents tabled in Parliament on 10 April 2008, Minister McGinty made it clear that the stage 2 development of Rockingham General Hospital would have 341 beds.

Dr K.D. HAMES: He did that but he changed it after the clinical services framework was released because he could not put 1 000 beds at Sir Charles Gairdner Hospital. He did exactly what I am doing. I am not saying that we initiated putting the 50 beds at Rockingham General Hospital; I am saying that that is what happened.

Mr R.H. COOK: The minister did say that. He just said they were extra. The minister can check *Hansard*.

Dr K.D. HAMES: We have also put an additional 150 beds at Fremantle Hospital. By "we", I mean the Department of Health. The last yellow column shows that 217 beds were proposed to go to Fremantle Hospital in the 2005 framework. There will be 362 beds, increasing to 382 beds. That is where those 200 beds from Fiona Stanley Hospital have gone. They have not gone to Royal Perth; they have gone to Fremantle Hospital and Joondalup Health Campus, which is exactly what the Reid recommendations were. The Reid report

recommended moving away from tertiary beds to secondary beds. It is much better to have cheaper secondary beds, and that is where those beds have gone.

Ms J.M. FREEMAN: That was a long way of telling me that the minister has shifted around capacity to maintain capacity at Royal Perth Hospital. The minister still has not answered my question. The estimated expenditure for 2009–10 for the equipment replacement program under "Works in Progress" on page 198 of the *Budget Statements* shows that the estimated expenditure was $58 million in 2009–10, $40 million in 2010–11 and 2011–12, and $1 million in 2012–13. That is a massive equipment replacement project. Is that being done because the government has kept Royal Perth Hospital open and therefore the government needs additional equipment for Fiona Stanley Hospital? The minister still has not answered my original question. Now that the minister will be retaining Royal Perth as a tertiary hospital, will that make a change to the equipment that will be going across?

[9.50 am]

Dr K.D. HAMES: I point out to the member that under the former government, Royal Perth was going to continue —

Ms J.M. FREEMAN: But not as a tertiary hospital.

Dr K.D. HAMES: Yes, as a tertiary hospital—the member needs to wait until the end of the sentence—until Fiona Stanley opens in 2014. The equipment costs required for Fiona Stanley Hospital are not in any of these budgets. This is funding for the current hospitals that exist under our government and that would have existed exactly the same under the member's government. Nothing was ever proposed to change until Fiona Stanley opens in 2014. So, we need to buy that equipment, as we have done—for 2009–10, $58 million; for 2010–11, $40 million; and for 2011–12, also $40 million. That covers our current demand for equipment. That was not covered under the member's government previously; hence the report that the former minister initiated in 2004, which showed a massive backlog in funding for equipment. We have now funded it. Whether we keep Royal Perth or not makes no difference, because that equipment is required now in these current financial years. It is not future funding for Fiona Stanley.

Ms J.M. FREEMAN: I have a further question. So the minister is not stockpiling equipment for Fiona Stanley.

Dr K.D. HAMES: Absolutely not.

Ms J.M. FREEMAN: I have a further question. In terms of the facilities management for Fiona Stanley, I have been told by one of the minister's advisers that the minister is going to use facilities management for the supply of, for example, catering equipment. Has the minister decided which services will be contracted out at this point in time in terms of the minister's planning for equipment for those areas?

Dr K.D. HAMES: I will hand over to the director general for those details.

Mr K. Snowball: The contracts for facilities and management have already gone to tender, so they are under the procurement process right now. That is for the full range of facilities and management activity at Fiona Stanley. I will ask Nicole Feely to elaborate on the list of services and functions that are subject to that tender. But, effectively, it is very comprehensive and one of the largest facilities and management contracts ever let in this state.

Dr K.D. HAMES: We will leave it at that.

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

The CHAIRMAN: Member for Nollamara, you are pushing the further questions and you are broadening the scope of your original question. I am happy to list you for another question. The member for Geraldton.

Mr I.C. BLAYNEY: I refer to page 183 of the *Budget Statements* and the heading "Infrastructure". The fifth dot point refers to the new children's hospital. What progress has been made towards the start of the new children's hospital on the Queen Elizabeth II Medical Centre site, and when will work commence on that new hospital?

Dr K.D. HAMES: We are fully committed, as members know, to the construction of the new children's hospital. Construction is expected to commence in early 2012 and be completed in 2015. There will be 250 beds, 75 per cent of which will be single rooms. Before we came to government, we committed to an earlier start date than that—I think it was 2014

Mr R.H. COOK: You were going to complete it by 2014.

Dr K.D. HAMES: Yes; it was to be opened by 2014. But I have to say that when I made that commitment, there had been no public disclosure by the minister of the day that two buildings would have to be demolished and in

effect rebuilt to enable that to occur. That was well known to the health department but not known outside. So we certainly made an error in listing that date through lack of that knowledge. What we found when we came to government was that an error had also been made in the floor space required for the new hospital. We found that a lot of the open areas that were required had not been included in the total number of square metres that were proposed and that a larger floor space was required. We then looked at what alternatives there were, given that we wanted to get this hospital built as quickly as possible. The health department came through with a proposal to have the new hospital face Winthrop Avenue. But, again, that created secondary headaches, because it would be right next to the smokestack of the existing power plant. Also, the power plant was ageing, and at some stage over the next 10 years it would have needed renewal.

Another issue was that in moving to that location, we would require considerably more car parking space. We already have significant parking issues around that hospital. So we have now agreed that we will move the power plant to a position at the rear of the hospital. Obviously the timing to get all these things done is critical if we are to achieve our target time frame. The power plant will need to be moved. We will need to build a new multistorey car park for the new hospital. So far, everything is going according to plan. It is a very tight time frame. We have gone out for expressions of interest this week for the construction of the multistorey car park. The car park will be either 4 600 bays or 5 000 bays depending on the outcome of discussions with the planning department. We have also had meetings, just yesterday, and previously, with the City of Nedlands about the temporary use of Rosalie Park as an offset for parking while the construction of that car park occurs. As I have said, it is critical that all these things move in conjunction.

We also have issues with the TICHR—Telethon Institute for Child Health Research—building. TICHR is very committed to being next to the hospital to take advantage of research opportunities and to be in close association with the hospital. Ronald McDonald House will also need to be moved to that area. So we have a lot of balls in the air at the moment. But everything is being pressed by our department, the Department of Treasury and Finance and the department of strategic projects with great enthusiasm to make sure that we maintain those timings.

The bed numbers of 240 have been criticised in the past, but I have to say that that is a significant increase in the number of beds that were proposed by the previous government. If we go back to this document that has been provided, under the first yellow column, under specialist tertiary hospitals, PMH, by 2015–16, which is the date for the construction of the new hospital, the number of beds was proposed to be reduced to 178. So, as members can see, with 250 beds, we will have 72 beds more than was proposed under the former government.

Mr I.C. BLAYNEY: Can the minister give an estimate of the cost of the new hospital, and an update on the planning for that hospital? Also, is this new hospital being considered as a public–private partnership?

Dr K.D. HAMES: Yes, that is correct. We said when we came into government that this would be done under a public–private partnership, and that is currently the intention. The cost will be in the order of $1 billion when we add all those other components. The car park is also being proposed as a public–private partnership. I understand that groups like the City of Perth are interested in putting up a proposal to fund, construct and manage that car park. We need to remember that the whole site is managed by the Queen Elizabeth II Medical Centre Trust, which has responsibility for that land. This is being done in close cooperation with the trust and with its continued blessing on the direction that we intend to take. The whole QE II site will be extremely busy, given that we are still in the process of constructing the mental health dwellings, the pathology buildings, the cancer centre and the WA Institute of Medical Research centre. I know that Professor Bryant Stokes is also still talking about a neuroscience research building. So it will be an extremely busy site.

That is why we are talking about Rosalie Park, to see whether we can have some temporary parking on that site for about two years. We are about to undertake a process of putting forward a proposal to Subiaco council and talking to the community about what is proposed, to try to get acceptance from the community and, of course, those who are currently using that recreational facility, because it is fairly well recognised that we will need to have some sort of compensation package for the present users of that facility. Again, that is an essential component.

[10.00 am]

Mr A.J. WADDELL: I refer to page 198 of the *Budget Statements* and "Works in Progress" under "Asset Investment Program". I refer specifically to the line item "Hospital Nurses Support Fund". Can the minister explain why his election commitment promised $28 million over four years for the nurses' support fund, which was about $7 million for each of the four years, but only $1.441 million has been budgeted, short-changing nurses by about $26.5 million? What support will nurses miss out on due to this reduction, now that their funding has been slashed? Why has the minister left our nurses without this support?

Dr K.D. HAMES: That would be an excellent assumption if it were true. I have to say that I also went immediately to that line item and asked where the money was. The money has been rolled into the general budget. This component is just the capital component of the budget. The member should remember that when we came into government, the former Minister for Health had allocated approximately $6 million to childcare facilities. We increased that total to $28 million, with the money still available for childcare facilities and the rest going to provide assistance to nurses, as the member has described. It is an excellent policy, if I may say so, that recognises the great contribution nurses make. That project has been very well received; the nurses have made an amazing range of choices in terms of the things they want, including things such as childcare services, while a vast number of them are actually improving the care of their own patients, which I thought was fantastic. That money is still there, and I will hand over to the director general, who I think will hand over to the director of finance, who will explain exactly where that money is.

Mr K. Snowball: Director of finance?

Mr W. Salvage: The answer is correct. What we are looking at in the assets table is the capital component only, and this relates to the residual amount that was transferred across when the $28 million fund was created; it specifically relates to the provision of child care. The balance of the hospital nurses' support fund is in the Department of Health's recurrent budget.

Dr K.D. HAMES: We have done that in some of the other services also, such as the Friend in Need Emergency scheme funding, for the reason that we want to make sure that it continues into the future and is not just a four-year fund that suddenly gets wiped out at the end of four years. That is now part of our normal recurrent budget and will continue. To explain the split-up of funding that went to those services: in 2009–10, $1.6 million went to the North Metropolitan Health Service; $2 million to the South Metropolitan Health Service; $464 000 to the Child and Adolescent Health Service; $1.26 million to Country Health Services; and $45 000 to other health services scattered between those areas. Those funds were distributed last year, hopefully to the great benefit of the nurses who provide such fantastic service.

Mr A.J. WADDELL: If it has moved into the recurrent budget, whereabouts can we find it? Is it masking a cut somewhere else in the recurrent budget?

Mr K. Snowball: What has occurred here is that instead of having specific funds for the hospital nurses' support fund as an election commitment over the term of the government, this has now been converted into a recurrent fund as part of hospital and health service provision. The North Metropolitan Health Service, for example, now has provision of funds that allows it to provide the sort of support we would like to see. It is not substituting any other funds in those hospital budgets. It is basically in addition to the normal recurrent funds; these funds are now also available to support nurses.

Mr R.H. COOK: Are we to just take the minister's word for that?

Dr K.D. HAMES: I guess so; I am happy to give my word that that funding will continue through our time in government. What I cannot give the member a commitment for is that it will continue through the opposition's time in government. If and when the opposition gets back into government, it will need to make a specific decision —

Mr R.H. COOK: In 2013.

Dr K.D. HAMES: Yes. We are not doing Indigenous Affairs and the Dreamtime at present!

I give my commitment to everyone who is listening that we will continue through our term of government to make sure that nurses' funds are available and that it is within the budget of each of those divisions. When the opposition gets into government, it can make a decision as to whether it continues that, or whether it will be absorbed into other services.

Mr A.J. WADDELL: Could the minister point out which line item relating to the North Metropolitan Health Service is increased by $1.6 million? Is that seen as an expense blow-out in that line item, or is there a note somewhere to indicate that there is growth for that particular purpose in that line item?

Dr K.D. HAMES: I will hand over to the director of finance.

Mr W. Salvage: The $28 million was specified in last year's *Budget Statements* as an election commitment. All bar $6.672 million of that was recurrent; it was part of the recurrent budget and remains part of the recurrent budget. The $6.672 million related to childcare costs, which were shown as a capital item. In this year's *Budget Statements*, that has been reduced to $1.4 million. The balance of that $6.672 million has been transferred back into the recurrent budget to be allocated back to area health services. We will not see the transparency in the line

item in this year's *Budget Statements*; it was made clear in last year's *Budget Statements* that that funding remains part of health funding.

Dr K.D. HAMES: Can I give a further explanation? It is important. It can happen that a government will make an election commitment leading up to the election, but can only make that commitment for a four-year period. The member for Kwinana will find the same when he gets there. An election commitment is made for a four-year period, but it then drops off at the end of the four years. Four years down the track, Treasury stops including it because only a four-year election commitment has been made. If we want that election commitment to continue forever, it has to be included in the recurrent budget component. That does not take away from anything else. When we add up the total budget for last year, it includes that election commitment. When we ask by how much the budget has grown, the answer is that it has grown by 6.7 per cent, which again includes that bit, so it does not substitute or camouflage some other bit; it just becomes a commitment that continues. The same needs to happen for the FINE scheme and the Royal Flying Doctor Service. We want to make sure that those things continue into the future, so they become part of the annual budget for each of those divisions, with our direction as a government that this is our election commitment, and it will continue.

Mr A.J. WADDELL: Is this reported in the annual reports?

[10.10 am]

Dr K.D. HAMES: I will ask Wayne Salvage to answer the question.

Mr W. Salvage: It will be when we come to report our 2009–10 performance.

Mr D.A. TEMPLEMAN: Minister, I will refer to the items in the budget relating to the Peel Health Campus. The second dot point on page 196 refers to the major infrastructure-related projects and activities in the South Metropolitan Area Health Service. One of its activities is to finalise planning and commence the Peel Health Campus stage 1 development. I refer also to the table on page 119 of the budget papers. Under the heading, "Completed Works" is a line item for the Peel paediatric ward. Does the minister and/or the health department have concerns about how the contract with Health Solutions is being delivered to the people of Peel through the Peel Health Campus?

Dr K.D. HAMES: I have said previously in this place that I have concerns about an issue the member specifically referred to; that is, the wages being paid to the lowest income group within that hospital. I have also said previously that I do not have concerns about the actual delivery of the service. When one goes through the categories of provision of service and the contract requirements for the standard of service and compare that with other hospitals, the Peel Health Campus is providing a top-level service.

As I stated in Parliament the other day I had a meeting with Mr John Fogarty, one of the directors of the company managing that hospital. My understanding is that that company has put an offer to lower paid staff and is waiting for a decision by those staff members on whether that offer is acceptable.

Mr D.A. TEMPLEMAN: At the meeting with Mr Fogarty was the issue of the recent departure of the chief executive officer after only four months in the position discussed and the reasons given for his departure? Is the minister able to share those reasons with the committee?

Dr K.D. HAMES: I regard discussions that I have had regarding the former CEO as confidential.

Mr D.A. TEMPLEMAN: They have been made public.

Dr K.D. HAMES: Mr Chairman, I have not finished my answer.

Mr D.A. TEMPLEMAN: The former CEO's comments were made public in the local newspaper.

The CHAIRMAN: Member for Mandurah.

Mr D.A. TEMPLEMAN: Does the minister have any comment about his comments in the local newspaper?

Dr K.D. HAMES: Member for Mandurah, the Chair is calling for your attention.

The CHAIRMAN: Member for Mandurah, can we hear the answer and then you can ask a further question?

Mr D.A. TEMPLEMAN: I do not think the minister is answering the question.

Dr K.D. HAMES: That is because the member for Mandurah is talking while I am trying to talk.

Mr D.A. TEMPLEMAN: The minister said that he was not prepared to answer.

The CHAIRMAN: I will call both members to order if we cannot have only one person speaking.

Dr K.D. HAMES: Those discussions are confidential and I have spoken to the chairman and got his point of view. I have spoken to a number of staff within the hospital and got their point of view. I have to say that there are conflicting points of view. However, the issue of the employment of that particular staff member is not the responsibility of government.

Mr D.A. TEMPLEMAN: Minister, being the local member, you would have seen the comments by the former CEO in the local newspaper. He made a number of comments about his relationship with the directors of the board, which are cause for concern. Does the minister have any comments to make about those comments? I am assuming the minister has read those comments that appeared in the local press in Mandurah a couple of weeks ago.

Dr K.D. HAMES: Indeed I did. As I said, I had conversations with the person concerned. I am not prepared to discuss my discussions with him publicly. I reiterate my previous comments that the contract requirements of the company providing the service are being met fully and the service is top level. The staff at that hospital are exceptionally good staff. They work extremely hard and they do a fantastic job. I have nothing but praise for the standard of service provided by that hospital. I have fewer complaints from patients about that hospital than about other hospitals.

Mr D.A. TEMPLEMAN: The minister mentioned that he had met with the Director of Health Solutions. The staff who are currently involved in industrial action at the hospital have been requesting to meet with the minister. If the minister has not read today's newspaper I inform him that it is stated in that newspaper that they have again asked to meet with him. Has the minister met with them or is the minister intending to meet with them; and, if so, when? If not, why not?

Dr K.D. HAMES: I do not have any recollection of a written or verbal request for me to meet with them.

Mr D.A. TEMPLEMAN: Why does the minister not do it off his own bat? This has been going on for 18 months.

Dr K.D. HAMES: Even if I had, Mr Chair, those issues relating —

Mr D.A. TEMPLEMAN: Why does the minister not get off his bottom and actually meet them down there, just like I have been doing?

The CHAIRMAN: Member for Mandurah.

Mr D.A. TEMPLEMAN: I have been going there every week to meet with these people. Why can the minister not do that? He is the local member and he should be saying, "We'll sort this out. I've met the director of Peel Health Campus and now I'll talk to the staff". I cannot see why the minister cannot do that.

The CHAIRMAN: Member for Mandurah.

Dr K.D. HAMES: Mr Chair, the member's behaviour is totally inappropriate.

The CHAIRMAN: Member for Mandurah, I know you are passionate about this, but you do need to keep it in check.

Mr D.A. TEMPLEMAN: It is my hospital, Mr Chairman.

The CHAIRMAN: I know.

Mr D.A. TEMPLEMAN: The minister, who also represents the area, should be taking a deep interest in the operation of the Peel Health Campus, as I am. Can I ask a further question? I reflect to page 199 —

The CHAIRMAN: Member for Mandurah, you have had four further questions. I can put you on the list again for later. Other members are seeking to ask questions. You have had your initial question and four further questions. I will put you on the list again.

Mr D.A. TEMPLEMAN: Thank you.

The CHAIRMAN: Member for Kwinana, you can ask your question.

Mr R.H. COOK: I refer the minister to page 198. Under "Works in Progress" reference is made to the new children's hospital. The minister's expansive response to the question about Princess Margaret Hospital and some follow-up questions—for some reason we are not allowed to ask follow-up questions.

In 2007 the minister described Princess Margaret Hospital for Children as suffering from severe infrastructure problems. A 2008 election promise by the Liberal Party was to rebuild the hospital by 2014. In addition to the $28.4 million already spent on Princess Margaret Hospital since the announcement, what extra costs has the government incurred because of the delays in maintaining the severe infrastructure problems?

Dr K.D. HAMES: I remind the member that our commitment to rebuild that hospital by 2014 made when in opposition was based on inadequate information.

Mr R.H. COOK: It was the government's election promise; not ours.

Dr K.D. HAMES: The opposition's election commitment was to have it completed by 2015, based on full advice.

Mr R.H. COOK: The Labor Party's commitment was for construction to begin by 2012. Would the government be able to match that?

Dr K.D. HAMES: Mr Chairman, this is not how estimates work and the member has been here long enough to understand that.

The CHAIRMAN: Members, I will outline how the questions go. I take the list and I work down the list. As each member's name comes up, that member gets the call. In this case it is the member for Kwinana. He can ask a number of further questions after that, but only he can ask them and not any other member.

Mr R.H. COOK: Why is that, Mr Chair?

The CHAIRMAN: That is the ruling that has been given to us by the Speaker and it is how it has worked for many years.

Mr R.H. COOK: It is not the case, Mr Chair.

The CHAIRMAN: It is the case.

Mr R.H. COOK: It was not like that last year.

The CHAIRMAN: Members, if you need to take it up, take it up with the Speaker. That is what we have been told to advise members and that is what I am doing.

Mr A.J. WADDELL: The people of Western Australia are putting an enormous amount of money into this budget and they have a right to properly scrutinise it.

The CHAIRMAN: Member for Forrestfield, you can take it up with the Speaker. I am under instructions from the Speaker to do it this way. It worked this way all day yesterday and that is the way —

Ms J.M. FREEMAN: No, it did not.

The CHAIRMAN: Yes it did for every committee I chaired, because they were the instructions I was given. If members do not like it, take it up with the Speaker. That is the only option open to them. If members keep arguing with me, I will call them to order and if they are called to order a number of times they will be out of here and will not get to ask any questions. I am advising members how it will work. The member for Kwinana has the call and he can ask follow-up questions. There will be no follow-up questions from other members. The questions are directed to the minister and that is it. Sorry, the minister was answering.

Dr K.D. HAMES: Thank you, Mr Chairman. I appreciate that. I am trying to answer the question. The commitment was made by the Labor Party based on the full advice that the hospital would be completed by 2015. As I explained, there have been some reasons for the government not being able to do that sooner. Originally, two buildings were to be moved. We do not have to move those buildings, because we have moved the location. That, too, has added to the difficulty. Because we need more space we now have to move the power generation plant to the back of the hospital. It is an excellent effort on behalf of the staff. Despite those constraints, we are still able to deliver a new hospital, which is 70 beds more than the number proposed by the Labor Party on the same date that was proposed by the Labor Party—one year later than my original estimate. However, we are still spending money to ensure that Princess Margaret Hospital for Children maintains a high standard of service. Under either scenario, it is still a long way off before the new hospital is completed. I will ask Phil Aylward to provide details of any extra expenditure at Princess Margaret Hospital for Children and what is proposed to keep that facility up to standard.

[10.20 am]

Mr P. Aylward: The additional expenditure relates primarily to repairs and maintenance, which is normal operating expenditure that we would incur anyway to keep the building operating and in a safe condition. The other components are listed in general and specific terms in the *Budget Statements* that relate to holding funds and specific upgrades that we are already committed to undertake. For example, I refer to power generation, which we were committed to upgrade irrespective of whether the building was to last a further two or four years.

Mr R.H. COOK: In terms of the power unit and the multi-level car park, issues need to be resolved before the government can put shovel to sand. What are the current time lines for those developments? In particular, can the minister advise at what stage the planning approvals and applications are at for those developments?

Dr K.D. HAMES: As I said earlier, we asked for expressions of interest for the provision of the car parking bays just this week. For a more detailed answer, I refer to Dr Russell-Weisz.

Dr D.J. Russell-Weiz: As the minister said, we have gone out for EOIs. The closing date for submissions is in three to four weeks. They will be evaluated, after which time there will be a request for proposal phase.

Mr R.H. COOK: For clarification, the car park for which the government has asked for expressions of interest this week is associated with the medical research facility, not with the developments that are required for the children's hospital.

Dr K.D. HAMES: That is not the case. The car park relates to the provision of extra bays for Princess Margaret Hospital for Children, plus better catering for the existing demands at Sir Charles Gairdner Hospital. We have done the modelling. As the member is aware, there were lots of issues with the local council because people were parking in residential streets. Staff are couriered by bus from Graylands. That car park covers all the needs of that site. I ask Dr David Russell-Weisz to provide further comment.

Dr D.J. Russell-Weiz: The release of the RFP will be at the end July, early August. The closing date is October 2010. We aim to start construction of the car park at QEII in the first quarter of 2011.

Mr R.H. COOK: What is the time line for the application and construction of the power unit?

Dr D.J. Russell-Weiz: Currently, strategic projects is considering whether the central plant will be constructed at the western end of the site or within the new children's hospital. A decision on that is due in the next couple of months. The upgrade to the Western Power substation is in train. Currently, we are working with Western Power; it will be upgraded in time for the opening of the new children's hospital in 2015.

Mr R.H. COOK: I refer to the site for the new children's hospital. What does the state need to do to in terms of providing title for the land and the amount of pre-prepared groundwork that needs to be put in place to get a private sector partner to participate? I will repeat a question I asked in relation to Midland health campus. What is the modelling showing; will there be annual savings to taxpayers by virtue of doing a PPP model? What is the outcome of the public–private comparator?

Dr K.D. HAMES: All the land is under the ownership of the QEII trust. Whatever goes on that land requires leasing arrangements for the land. The land remains under the QEII trust ownership. The buildings and car park constructed on the land will become part of the contract. I will ask Dr Russell-Weisz to provide further comment.

Dr D.J. Russell-Weiz: In relation to Midland health campus?

Dr K.D. HAMES: Can the member repeat his question?

Mr R.H. COOK: Can the minister provide details of the private–public comparator for the development of the children's hospital? In that context, what will the annual savings be to taxpayers by going private rather than providing a public facility?

Mr P. Aylward: The public sector comparator analysis has not been completed. It will be undertaken over the next three to five months. It will be completed prior to the government going to the market in, we hope, January 2011. That work is underway, but not yet completed.

Mr R.H. COOK: Can I confirm that in addition to not having the evidence to suggest that it is cheaper to go the private model at Midland, the government also does not have evidence to suggest that taxpayers will save money if the government uses a private model for the new children's hospital?

Dr K.D. HAMES: There are two components to that. The first is the construction of the hospital and the second is the provision of additional services within the hospital. We are committed to a public–private partnership model, based on the experience of governments in other parts of Australia—Labor governments, I might add—that have used a public–private partnership model. We will construct the hospital under a public–private partnership model. A final decision on the provision of services, such as catering and cleaning, has not been made. Both options are still available. As I said to Mr Kelly, we are looking at —

Mr R.H. COOK: Mr Kelly?

Dr K.D. HAMES: Dave Kelly. I thought I had better call him Mr Kelly.

Mr R.H. COOK: It was a bit out of context.

Dr K.D. HAMES: In discussions with the union, concerns were expressed—as I said earlier, we must compare apples with apples—that a private sector group would be able to come in, which is attested to have happened under the model for Royal Perth Hospital. A direct comparison was not made between the number of orderlies required. We will make sure that a direct comparison is done. Frankly, if private sector proposals for catering, cleaning and the like do not stack up, we will not proceed down that path. The hospital will be constructed under a public–private partnership model.

Mr R.H. COOK: Can the minister confirm that there is no model, but that the hospital will be built on a PPP model? There is no evidence to suggest that it will be cheaper and more efficient other than anecdotal evidence from the eastern states. The minister mentioned what Labor governments in other states have done. When the government developed the PPP for the children's hospital in Victoria, the hospital was announced and the funding for the hospital hit the forward estimates. After it had done the public–private comparator and decided to use the PPP model, the numbers then left the forward estimates. The government is not even at the point of deciding whether to use a PPP model. It certainly has not done a public–private comparator. Where is the funding for the new children's hospital in the forward estimates?

[10.30 am]

Dr K.D. HAMES: The funding is not in the forward estimates. There is money in the forward estimates for the hospital to get to the stage of developing the public–private partnership. The model we are following requires funding by the private sector. We have based that on comparators with other states. I will point out the other states that have used similar models. In Victoria, the Royal Women's Hospital has done a design–build–fund–maintain model. There is also the new Royal Children's Hospital, the Parkville comprehensive cancer centre, Casey Hospital and Mildura hospital. In South Australia, Royal Adelaide Hospital is following that model. In New South Wales, there is the Royal North Shore Hospital stage 2 redevelopment, the Orange Base Hospital redevelopment, and the Newcastle Mater hospital development. In Queensland, the Sunshine Coast University Hospital has a parking model. All of the new construction that has occurred over recent years in the United Kingdom has been done under similar models. There is ample evidence around the world, which is why other states have followed that public–private partnership model for the construction and also, mostly, the maintenance of hospitals. It is an extremely successful and cost-efficient model. Let us look, as an alternative, at what the former government did with Fiona Stanley Hospital. It started with a budget of $400 million, which built up over a period to $800 million, and finally had a budget of $1.76 billion—that is, $2.7 million per bed, which was one of the highest, and remains one of the highest, costs of construction for a hospital bed in Australia.

Mr R.H. COOK: I know that other jurisdictions have done public–private comparators and I know that, on the basis of that specific modelling, they have made decisions in those specific instances to go down the PPP route. Can the minister confirm that he has not done any specific modelling for the new children's hospital under a public–private comparator?

Dr K.D. HAMES: The director general will answer this question.

Mr K. Snowball: As part of looking at the construction of all of these projects —

Mr R.H. COOK: Has the minister done a public–private comparator—yes or no?

Dr K.D. HAMES: This is the director general's answer, and he is not to be directed by the member as to how he answers the question.

Mr K. Snowball: In terms of the development of all of these projects, for both the construction and procurement component and the delivery of services, each will be judged on its merits. Each will be a case-by-case examination of the public sector comparator to private sector provision. The initial decision to explore the extent of PPPs in each of these projects was based on previous evidence from other states going into those markets, as well as our own experience in this state in a number of areas in which we are already providing a PPP model.

Mr R.H. COOK: So the answer is no.

Mr A.P. JACOB: I refer the minister to page 183 of the *Budget Statements* and to the third dot point under the heading "Infrastructure", which refers to Royal Perth Hospital. What progress is being made towards the retention of Royal Perth Hospital?

Dr K.D. HAMES: Royal Perth Hospital is proceeding according to the planned schedule. The commitment that we made in opposition was that Royal Perth Hospital would be retained as a 400-bed tertiary hospital. That has now been locked away in the clinical services framework. By 2014, when Fiona Stanley Hospital opens, Royal Perth Hospital will reduce from its current 680 beds to 410 beds under the new model. We have appointed a

committee, chaired by Greg Joyce, the former director general of the then Department of Housing and Works, to develop that model. The member for Ocean Reef, with his architectural expertise, is also a member of that committee. We are getting advice from the state architect. We also have on that committee representatives from the City of Perth. We have a great opportunity with the future development of Royal Perth Hospital. We have five inner city blocks that largely contain old buildings that are little used. Some of them are heritage buildings that were retained by the former government with our strong support. The committee is now looking at options for the five inner city blocks that can be redeveloped. I also said that my preference was to build a new west wing and that conforms to what had been planned by the former minister, which was to demolish the old building on the south side of Wellington Street. However, we are looking at other options. One option that I am reasonably supportive of is building a new emergency department and about 100-odd beds to take the north-side component up to about 300 beds and retaining the component of the old building along Wellington Street for a 100-bed waitlist surgery centre. We are modelling this somewhat on Royal Prince Alfred Hospital, which is a 400-bed major trauma centre and which has a separate waitlist surgery centre. That is something that has been very strongly supported by the current federal Minister for Health and Ageing. We think that is a cost-effective model. To do this, though, we need to be able to generate funds from within those blocks to fund the construction of the hospital; hence, there is no funding as yet in the budget. We made the commitment that this development would start in our second term of government, provided that we achieved that. That will be the best time, because it is no good starting changes to construction when we are about to downsize that hospital from 680 beds to just over 400 beds. We will be ready; we will have all our designs in place and we will have our costings worked out. What we will need to do, probably starting next year, is have in the forward estimates those initial funds for construction because, as members know, land sales do not translate directly into construction costs. We will need to have that offset of funds in the forward estimates from next year and the out years to make sure that we can meet that timetable.

The committee is in the process of talking to builders, universities and the council to work out the options for development of the whole site. My view is that there is a strong opportunity for development of the eastern end of the total Royal Perth Hospital precinct, perhaps for hotels or residential accommodation. At the other end, closer to the Central Law Courts, there are opportunities for multistorey office buildings or new car parks. There are a lot of potential development changes. We are interested in working very closely with the council to make sure that we have a precinct that is very supportive of what the local community wants in that area. With the sinking of the railway line, there will be a big boost in population in the city of something in the order of 30 000 or 40 000 people. Obviously, retaining the hospital at that site will be a great bonus for them. I am excited by what is happening. I have great confidence that at the start of our next term in government, construction will commence on a new west wing, the size of which is obviously yet to be determined.

Mr A.P. JACOB: The minister earlier touched on how the retention of the hospital will impact on other hospitals, and probably more so on the South Metropolitan Area Health Service. Can the minister go into a little more detail about how it may impact on Joondalup Health Campus?

Dr K.D. HAMES: Obviously, local members are concerned that this might have an impact on Joondalup Health Campus. Members must remember that under the 2005 clinical services framework—it is on the sheets that I handed out—there was still going to be 1 000 tertiary beds within the city, even though there are currently 680 and 630 beds in the city. There are more than 1 200 beds currently at Sir Charles Gairdner and Royal Perth Hospitals.

[10.40 am]

The 2005 framework had—I forget the exact number—more than 1 046 tertiary beds still at Sir Charles Gairdner Hospital. Now, with the retention of Royal Perth Hospital at 400 beds, it will still have 1 000 tertiary beds. The number of tertiary beds in the inner city precinct has not changed under those models. Therefore, that does not have an effect on Joondalup hospital and when it will become a tertiary hospital. It was proposed in documents of the former government that Joondalup might reach the stage of being a tertiary hospital in around 2020. I think that that will depend on demand and growth. Therefore, as the new hospital currently under construction reaches completion, Joondalup hospital will benefit from research facilities and student training facilities, because we have had to increase the number of student training places with our expansion. As a tertiary hospital, the only thing Joondalup will miss out on being is a state referral centre, which Fremantle, Royal Perth and Sir Charles Gairdner Hospitals currently are. Obviously, patients come from all over the state to access those state referral centre hospitals' higher level tertiary facilities. When Joondalup will reach the stage of patients from other parts of the state attending its facilities is yet to be determined, and it will, in my view, be determined by demand. However, I reiterate my point: the same number of tertiary beds is in the central city precinct now as was the case under the former government's plan and the current existing structure.

Ms J.M. FREEMAN: I want to go back to page 198 of the *Budget Statements* and the line items "Fiona Stanley Hospital — Development" and "Equipment Replacement Program"—both points are on that page.

Dr K.D. HAMES: Sorry; can the member talk a touch slower? It is hard to —

Ms J.M. FREEMAN: Can the minister just listen a touch quicker!

Dr K.D. HAMES: I am trying.

Ms J.M. FREEMAN: Given the minister's excitement before, I would have thought that he would want that sort of pace of life!

I refer to page 198 and I will ask very slowly about Fiona Stanley Hospital and the "Equipment Replacement Program" line items.

Dr K.D. HAMES: I will respond very slowly.

Ms J.M. FREEMAN: Sorry, I am teasing the minister now.

Two things came out of a question I previously asked upon which I would now like further clarification. One aspect is the facilities management at Fiona Stanley Hospital. The minister previously spoke about the construction of one of the new hospitals—I do not think that it was Midland; I think it was the new children's hospital—saying that an apples with apples comparison would be done in terms of the privatisation of services such as catering. I understand from the advice given by the minister's advisers that the tenders have gone out for catering, cleaning and other services. I would like to know the dates when the tenders went out, when the tender process will close, and what the tenders are for in terms of service delivery—that is, are they for catering, are they for cleaning, are they for orderlies or are they for other services, and will they include staffing? That is the first part of my first question. The second part —

Dr K.D. HAMES: Can I respond to one part at a time?

Ms J.M. FREEMAN: Yes, if the minister is happy for me to come back to my other one.

Dr K.D. HAMES: I just point out in relation to the member for Nollamara's question that her use of the word "privatisation" is not a correct interpretation of that word. Privatisation means selling something off to the private sector for the provision of a service. This has not been privatised. It has been contracted out to the private sector—exactly, I might point out, as the member's former health minister contracted out the management of diabetic services. If the former government privatised services, we can also —

Ms J.M. FREEMAN: Minister, can I clarify that point? When I worked with the orderlies at Sir Charles Gairdner Hospital whose service was privatised out under the previous Liberal government, they lost their jobs because the then government contracted the service out.

Dr K.D. HAMES: Contracted out—yes, that is what we did.

Ms J.M. FREEMAN: Those orderlies saw it as privatisation.

Dr K.D. HAMES: They may well have done.

Ms J.M. FREEMAN: They are the people on the ground. They are the ones who suffer from it. They know what they feel.

Dr K.D. HAMES: Whatever they feel —

Mr R.H. COOK: It is called privatisation minister; just call it what it is!

Dr K.D. HAMES: No, it is not. The government is contracting out those services to the private sector.

Ms J.M. FREEMAN: Can the minister answer my question?

Dr K.D. HAMES: I will ask Nicole Feely to respond to the member's specific question.

Ms N.M. Feely: The tender process closed on Monday and the bids were in on Monday. Under the guidance of probity, they will be evaluated over the next three months and —

Ms J.M. FREEMAN: Sorry; through the minister, the tender process closed on Monday and the tenders are in.

Ms N.M. Feely: Yes.

Ms J.M. FREEMAN: Through the minister, and now the tenders will be looked at over the next three months.

Ms N.M. Feely: Yes.

Dr K.D. HAMES: Yes. I do not specifically look at them, but the staff will and they will make a recommendation to me.

Ms J.M. FREEMAN: I understand. I am sorry, but Ms Feely is going a bit fast for me!

Dr K.D. HAMES: Mr Chair, I need a short comfort break.

Ms J.M. FREEMAN: Can we do it after my question or does the minister need a break right now?

Dr K.D. HAMES: Sure; I am not that desperate.

Ms J.M. FREEMAN: Can I just say, Tuck managed three questions between the short and the long break.

Dr K.D. HAMES: Keep going.

Ms J.M. FREEMAN: You are the health minister!

Dr K.D. HAMES: Keep going; we are all good.

The CHAIRMAN: It is entirely up to the committee. If the committee decides to take a comfort break, we will stop proceedings.

Dr K.D. HAMES: We will finish answering the member's questions. Ms Feely was still answering the previous question.

Ms N.M. Feely: Yes; the bids were all in on Monday and, for probity reasons, I have of course been advised that it is not appropriate to discuss the bids. However, in general, the bids sought were for non-clinical services across a range of areas, such as catering, imaging and security. A raft of issues has been requested and I can take the question on notice and come back with a list for the minister, but I do not have an extensive list before me. However, no clinical services were involved in this tender process.

Ms J.M. FREEMAN: My question was about whether the minister compared apples with apples before going through this process.

Dr K.D. HAMES: The bids have to be in first in order to do that comparison.

Ms J.M. FREEMAN: Is it the minister's intention to now compare apples with apples?

Dr K.D. HAMES: They will do that as part of the assessment of those proposals.

Ms J.M. FREEMAN: Where are the other apples from? How will that be done, and on what basis will it be done?

Dr K.D. HAMES: I am not doing it; the staff will do it. Ms Feely.

Ms N.M. Feely: Each of the bids put in will be compared internally both between other bids and we will look at current public sector costs. A decision will then be made as to whether the tender bids are appropriate.

Dr K.D. HAMES: The director general would like to add to that answer.

Mr K. Snowball: These of course are new services; it is not really a case of looking at the provision of existing services in existing facilities. A lot of work has been done to absolutely define each of the service areas—the function areas—and to give comparisons by way of other similar sized facilities in other states to arrive at what is a reasonable cost to deliver these services. That is then tested against the private market.

Ms J.M. FREEMAN: Is that being done on the basis of other hospitals delivering those services?

Mr K. Snowball As a comparison, yes, and as a build up to the total service. Obviously, Western Australia does business in a particular way. In those cases in which we do not have a direct comparison in, for example, the eastern states, we will do our own cost assessment to arrive at a reasonable price to deliver that service.

Ms J.M. FREEMAN: I have a further question that goes to the other issue of the "Equipment Replacement Program" on page 198 of the *Budget Statements.* The Fiona Stanley Hospital development will, as I understand, come on line in 2014. The minister outlined that there were provisions for equipment in the equipment replacement program, but that there was no provision for Fiona Stanley Hospital. My question is: given that the forward estimate for 2013–14 contains nothing, and that the 2012–13 provision has a very minimal amount, where will the costs for theatre equipment for Fiona Stanley Hospital come from?

Dr K.D. HAMES: Those figures for 2012–13 are yet to be determined, which is why the budget contains a zero figure. Those figures will be determined as we move forward. We committed to put in an extra $120 million over the short term, which we have done, to boost those funds. We are looking at alternative options for the provision of equipment, such as leasing, to see whether outright purchase is the best available model for the provision of

services. Those figures in the budget do not mean that they will necessarily remain at that level. When we get to the provision of equipment for Fiona Stanley Hospital, an assessment will be made of what we will provide from other hospitals that will be significantly reduced in size. There will be an evaluation of the funding required to fully equip that hospital, which will be done in the context of what is left in the $1.76 billion budget. Remember that the $1.76 billion budget was pitched at a time when construction costs were significantly higher than they are at present, but it has yet to be determined whether there will be growth in demand as a result of the current escalation of costs across the system. Therefore, that has yet to be determined. Obviously, when we open the hospital, it has to be fully equipped. When we get to that stage, we, through either the $1.76 billion or additional funds, will need to provide the funding required to fully equip the hospital.

[10.50 am]

Ms J.M. FREEMAN: I go back to the original question I asked: given that the government will take only 20 per cent of the equipment from Royal Perth Hospital for Fiona Stanley Hospital, will it take any of the theatre equipment and what impact will that have on costs?

Dr K.D. HAMES: Generally the equipment required in theatres is not huge; most of it is built in, particularly, obviously, things like the lighting systems and equipment built into the walls for the provision of gas service and so on. Therefore, not a lot of additional equipment is required for a theatre; most of it is trolleys, anaesthetic care and the like. Those things will be provided.

Ms J.M. FREEMAN: What about the machine that goes ping?

Dr K.D. HAMES: Ping?

Ms J.M. FREEMAN: It is a joke.

Mr R.H. COOK: It is a Monty Python reference.

Dr K.D. HAMES: Sorry, yes!

The CHAIRMAN: There was agreement for a five-minute break.

Mr R.H. COOK: If I may, Mr Chair—only if Parliament House can guarantee we get a good coffee.

The CHAIRMAN: I am not concerned about your coffee. It is a comfort break. You have five minutes and I will be back in the chair at five to 11 and we will start whether you are here or not.

Meeting suspended from 10.51 to 10.57 am

The CHAIRMAN: A quorum is present. The member for Forrestfield has the call.

Mr A.J. WADDELL: I refer to the chronic disease management program on page 195 of the *Budget Statements*. I note that the average cost per client in a chronic disease management program totalled $2.622 million in 2009–10. Can the minister tell me what the cost would be for the average emergency department admission for a person suffering from a chronic disease and what percentage of emergency department admissions would be patients suffering with chronic diseases?

Dr K.D. HAMES: Some aspects of the chronic disease management program were discontinued, in particular the diabetes management program. The advice I received from the health department was that, based on an assessment of costs across the system, the program was not successful. Although the member is right in that the costs of managing patients in a hospital are generally far higher, we needed to do an assessment of what percentage of people with diabetes were treated through the program and what difference that made to their presentation rate. It is true that the program, particularly for diabetes management, resulted in a reduction of those people's admissions to hospital. However, it initially started as a trial program, and to work properly it would have had to have been significantly increased in size to get to all those patients who have diabetes. The percentage of patients with diabetes seen through the program was a very small component of the total number of people with diabetes. Therefore, the program needed either a significant injection of funds to make it work properly across the whole system or, given that we were having financial difficulties at the time as a result of the global financial crisis, to be stopped. In our ongoing discussions with the commonwealth government about the role of the commonwealth and state government in provision of services, it is well recognised by the commonwealth government, and Nicola Roxon in particular, that the chronic disease management space is rightly the province of the commonwealth government. In fact, general practitioners asked why we were funding chronic disease management when they are funded through Medicare for that exact same service. The General Practice Divisions of WA said that it could provide that chronic disease management program just as well. The member will note that part of the federal government proposal from Mr Rudd is a significant increase in funding

by the commonwealth to deal with chronic disease management. Therefore, the commonwealth government is in effect taking over that space. I ask Dr Lawrence to provide further information on that subject.

Dr R. Lawrence: I think the key thing that the minister has already alluded to is that the cost per patient across the whole program was in excess of the bed days saved. In fact, the cost per patient across the whole program was very expensive. When we looked at a specific cohort, yes, it was effective but the efficiency of size and the need to have this program out in the community pushed up the overhead cost for the program. There is no doubt that such programs in the right patient populations are valuable, but they have to be set up on a size and scale of magnitude that makes them efficient and we must get the right patients involved. This program could not be put into the scale or size to do that with the funding that was available.

[11.00 am]

[Mr P.B. Watson took the chair.]

Mr A.J. WADDELL: Was the program unsuccessful because it was a pilot project? Would it have been successful if it had been a full-scale project?

Dr K.D. HAMES: That is perhaps a good point. If the funds were there right at the start, it would have been more successful. There would not have been such high costs per patient to try to reduce it. However, the reality is that we did not have the money and we were in a space that, as all our discussions with the federal Minister for Health and Ageing would suggest, was the space of the federal government and general practitioners and not of state governments, which have the prime role of looking after public hospitals. We have gone into that space to try to reduce the number of people coming into the public system from private hospitals. The member knows that aged care is a good example. There has been a big cost shift from the commonwealth to the state while inadequate aged-care services were provided. That is another example of the state getting into the private sector and commonwealth government space to reduce the pressure on our hospitals.

Mr A.J. WADDELL: We do not want to get into the blame game of whether the state government or the federal government is responsible; we just want the best health outcomes for the community. If the minister is saying that the program would have been successful if it had been run properly, and I assume that success is measured by fewer hospital bed admissions, surely funding it properly would have saved us money in the long run?

Dr K.D. HAMES: If we had the funds, yes. I am pleased to say that the commonwealth government has recognised our good advice on this matter and has put significant funds into continuing those chronic disease management programs, which will do what the commonwealth government is supposed to do—treat patients at a primary level and focus more on preventive health care to reduce the burden on the state, which is largely responsible for funding public hospitals.

Mr A.J. WADDELL: Is it a general policy to move out of the preventive area? I note that, under the prevention, promotion and protection line item on page 193 of the *Budget Statements*, we are dropping down from a budget of $61 million to $39 million, with a note that it has something to do with Gardasil, but that seems to be only about $7 million. Is there a general withdrawal of money from that area?

Dr K.D. HAMES: We have had significant discussions with the Prime Minister about how we can better manage our health service. As the member can appreciate, each Minister for Health has a view on which areas of responsibility they would like to keep and which they would like the commonwealth to have more responsibility for. The commonwealth has said that it intends to increase funding for preventive health care and chronic disease management. There are some responsibilities that we want to keep for ourselves. The Hospital in the Home program is a very good example. All the state health ministers are very happy with their Hospital in the Home programs because they provide direct links between doctors and hospitals outside the hospital for the provision of better managed care. My understanding is that Western Australia provides more funding for preventive health care than the other states. I do not think that necessarily suggests that we are spending enough. Preventive health is a critical area. Not all the preventive health care aspects get picked up. For example, a lot of the Close the Gap funding is going to Aboriginal communities to improve preventive health programs. The Ernie Bridge program for diabetes management in the Kimberley is critical. Some of those funds are in other budgets as well.

Mr P. ABETZ: The second dot point on page 182 of the *Budget Statements* relates to emergency ambulance services. The government has given a commitment to provide an additional $150.6 million over five years. Can the minister elaborate on how this injection of additional funds will improve the responsiveness of the ambulance service, how many additional full-time equivalents will be employed in the metropolitan area and country areas, and how many extra ambulances that might involve?

Dr K.D. HAMES: As the member knows, a *Four Corners* program on the provision of ambulance services in this state showed that, particularly in recent years, there had been a deterioration in the response times and the

level of service provided by the ambulance service. The program expressed particular concern about the efficiency of the call centres in this state. We engaged Greg Joyce, the former director general officer of the then Department of Housing and Works, to make recommendations about what changes needed to be made. After an intensive consultation process, a certain level of funding with St John Ambulance was recommended. I am pleased to say that all that funding was provided for the three years of the contract. That funding will provide a huge boost to ambulance services in the state. There are two components to that funding. The first component was funded from consolidated revenue and the second component was an additional $26 million that was funded for the country component through the royalties for regions funding. That will fund the St John Ambulance Service in the areas where it provides a service and the WA Country Health Service in the areas where it provides the service, which is throughout the Kimberley at Derby, Broome and Kununurra. As a result, we will have an additional 184 paramedics in the metropolitan area over the three-year agreement. There will be 42 extra patient transport officers to decrease the time taken by qualified paramedics to transport patients between different locations, and 40 extra communications officers, just about doubling the number of communications officers on duty at any one time, which will make a huge difference. The member for Mandurah will be pleased to know that there will be 10 extra paramedics for Mandurah. Mandurah was identified in the report as an area of significant need. There will also be five operational team leaders, six clinical team leaders and five training staff. That is in the metropolitan area.

[11.10 am]

Ms J.M. FREEMAN: Is the minister able to give us a copy of that list?

Dr K.D. HAMES: I am happy to provide that. I think I gave it to the media when I put it out—perhaps I did not, because I have not put out the 10 paramedics for Mandurah. But it is on the public record now, because I am reading it out.

As I say, Mandurah is part of the metropolitan ambulance service system, but it is in the country. I notice that the Chairman is shaking his head, member for Mandurah, but my definition of being in the country is when it takes longer than 10 minutes to drive from one side of our electorate to the other—and in our electorates it obviously does!

Mr D.A. TEMPLEMAN: That is where the member for Dawesville and I share very common ground!

The CHAIRMAN: Members, I would like to say that the distance from one end of my electorate to the other is 100 kilometres. That is country!

Dr K.D. HAMES: There are two final components. There will be 28 career paramedics for the regional centres. That is particularly important for the improvement of ambulance services in country regions. There will also be 17 community paramedics for 17 volunteer subcentres. There will also be a significant number of new ambulances. This capital investment of $55 million has been provided by St John Ambulance itself. There will be six additional ambulance depots in the metropolitan area, and four in the country; and 25 additional ambulances. I think everyone will agree that this will significantly improve the service. The service will still be provided at a cost of $48 per person. The public system that operates in Queensland runs at virtually double that cost.

Mr P. ABETZ: Has a new contract been signed with St John Ambulance, and is the minister in a position to advise me whether one of those new ambulance stations will be located in Southern River?

Dr K.D. HAMES: No, I am not in a position to advise the member on that, because I do not know the details of where those services will be going. But I am sure the member—as a member of the Education and Health Standing Committee— would have read the report by Greg Joyce into ambulance services in this state. That report identifies very clearly where the gaps are. So, if Southern River is listed as one of the gaps, everything that has been recommended in that report has been funded —

Ms J.M. FREEMAN: Everything that has been recommended in that report has been funded?

Dr K.D. HAMES: For the three years of the contract, yes, that is correct. So, if the member is getting anything extra in his area, so it shall be. The reason that the fourth year was not funded is that we are doing three-year contracts. The amount put in the fourth year was slightly less than was asked for. But by the time we do the next three-year contract for that service, I will be strongly pressing for that to be the full amount that was recommended, if not more, depending on what we find the needs are between now and then.

Mr R.H. COOK: Is the department amending the way it does the contracts?

Dr K.D. HAMES: We are amending the way we do the contracts, particularly, again, as per the recommendations in that report. One of the key components is that reporting of sentinel events is now a

requirement of those contracts. We are getting St John to do assessments of what work the paramedics should actually do, and a team of people is making recommendations on what services they should perform. I add that I am very keen to have paramedics included as a registered body providing services. I have raised that at a ministerial level with other states, and even though that is not their highest priority, I think it is essential that we have one standard of service across the whole of Australia, with agreed training and services that St John will provide. If the other ministers do not agree to include that, I will look at having that registration just in this state. I think I still have the ability to do that without that becoming part of a national registration process. I will ask Dr Towler to provide more information on that, because he has been involved in the negotiations on the contract.

Dr S.C.B. Towler: I just want to bring members up to date on the progress since the release of the report and on some of the issues that have been raised. The contract is being negotiated and finalised at the moment. There will be substantial commitments to include performance indicators that relate to quality and safety and governance outcomes for the provision of service. Mr Joyce and I have been working with the ambulance service. We have five implementation committees covering communications centres, clinical governance, inter-hospital patient transfer, rural services and education and training. They are all progressing well. We expect to complete the preliminary implementation work within the next few months and report back to the minister. The activities around the minister's request to explore the registration of paramedics have been referred through the national Health Workforce Principal Committee and have been endorsed for Western Australia to come back to all ministers with further advice. We are continuing to look at the other key outcomes from the report to ensure that in our partnership with the ambulance service, the contract can be finalised and the ambitions raised in the report can be met.

Mr R.H. COOK: At the time of that report, there was discussion about the poisonous relationship that existed between the institution of St John Ambulance and the paramedics. Does the reform process go towards addressing some of those very serious industrial relations issues?

Dr K.D. HAMES: I think so. I have to say that I have always found—this will not do anything for his career—John Thomas extremely good to deal with. He in particular has been intimately involved with all the negotiations about what is to happen. The member is right. The relationship was deteriorating. Part of the progress that we have made is to improve that communication, and in fact to require St John to make some changes in the way it is managing things. One of those changes is to who decides what paramedics can and cannot do. It was an individual person, and that was causing some angst. Now it is a team of doctors who have a much wider range of expertise.

The CHAIRMAN: Minister, there was a supplementary question from the member for Nollamara.

Ms J.M. FREEMAN: Yes. The minister said that he would provide as supplementary information that table that he was reading from.

Dr K.D. HAMES: No, I did not, because I said that I have now put it on the public record.

Ms J.M. FREEMAN: The minister said he was going to provide it.

Dr K.D. HAMES: I said that I have no problem with giving it to the member, but it is not supplementary information, because I have already provided it.

The CHAIRMAN: So the minister is not going to provide it?

Dr K.D. HAMES: Not as supplementary information, no, because I have already provided it on the record. I am happy to give the member a printed copy, privately, of that list.

Mr D.A. TEMPLEMAN: I refer to page 196 and the issues regarding Peel Health Campus. The minister told me earlier, before I was savagely silenced, that he has not had any contact with staff who are currently in dispute with Peel Health Campus.

Dr K.D. HAMES: I am sorry. I meant to check that with my staff during the break, and I forgot to do that. I am not aware that those staff have asked me to meet with them. The question is whether I should meet with them when there is a dispute going on about wages. I have been trying to assist in recent times. The member says that dispute has been going for 18 months, and I know that is true. I have expressed to the managers of Peel Health Campus my concern about the inability to come to a conclusion. I have, in fact, offered the services of the health department as a mediator to try to resolve those issues. At the time I made that offer, it was put to me that progress had been made and that an offer was being put to the staff—in fact, on the day of our meeting. I gather there is a requirement for a 30-day response time to that offer. I understand that is where the situation is now. Our contract is for the provision of a standard of service, and that standard of service is being provided. I have

made it clear that I am not happy that the staff at Peel Health campus are paid significantly less than staff elsewhere. I am very hopeful that that offer will address that concern.

[11.20 am]

Mr D.A. TEMPLEMAN: I think it is important for the minister to check his electorate office, because the information I have is that for three weeks members, including members who are constituents of the minister in his electorate of Dawesville, have been trying to secure a meeting with him. If that is true and those people are seeking a meeting, I again ask the minister whether he will give them a meeting.

Dr K.D. HAMES: I am happy for people within my electorate to meet me at any time on any issue, but I will not interfere in a matter that is a component of an industrial dispute between employers and employees. That is not my role. In fact, I do not see people in my electorate office about issues to do with health unless they are people from within my electorate. I will check requests for meetings, but only with individuals who wish to discuss something with me as an individual. I point out to those who may be thinking of doing that that I am aware that there are a significant number of staff involved and it is obviously not practical for me to see everyone who wants to see me on the same issue, particularly when we are waiting for a determination by the members on whether the offer is acceptable.

Mr D.A. TEMPLEMAN: Has the minister or his staff at any time reviewed the contract between Peel Health Campus and the current provider regarding any concerns about breaches of that contract over the past 12 months?

Dr K.D. HAMES: Yes, I have.

Mr D.A. TEMPLEMAN: What was the outcome?

Dr K.D. HAMES: The outcome was that the standard of service being provided by the hospital met all the contractual requirements and in fact, in many instances, exceeded them.

Mr D.A. TEMPLEMAN: I refer to page 199 of the *Budget Statements* and the line item "Peel Paediatric Ward". I note that that will open on 12 June; I have not yet received my invitation, but I hope it is in the mail!

Dr K.D. HAMES: I hope so, too. I am not doing the invitations, of course; the local team and Arthur Marshall are sending those invitations, but I am certainly aware that they intend to invite the member for Mandurah and other local members.

Mr D.A. TEMPLEMAN: How does the establishment of the paediatric ward relate to the overall contracted bed numbers at Peel Health Campus? Will the beds for the paediatric ward be additional to the contract, or will they be absorbed or included as the current contracted number? Is it true that if, for example, there are no children in the hospital at any one time, those beds would then operate as a general ward? I am wondering whether there has been a separation of the ward and how that relates to the current bed numbers of Peel Health Campus. What if, in the future, we do not get the expected numbers of children having overnight or extended stays within that ward? What will then happen to those beds and the staffing of those beds?

Dr K.D. HAMES: That is a good question, and at one stage I would have been able to give the answer off the top of my head because I was involved in all those discussions. I know that there is a lot of flexibility within the system. Currently the children are in the main wards, as the member knows, so they will be moved out. That will provide an opportunity for additional use of beds, including by the private sector. Can someone expand a little? My answers seem a bit short!

Ms N.M. Feely: That is the correct answer.

Dr K.D. HAMES: Ms South has more details of the specifics. The member is asking for more detail about what happens if those beds are not properly full—what can they then be used for, and what is the total number of beds.

Mr D.A. TEMPLEMAN: How does that relate to the number of beds that Peel Health Campus is currently contracted to provide from the hospital overall?

Ms J.E. South: The paediatric ward is a private development, despite the fact that the government has provided $500 000 towards it. It is a private development. At this stage there is no commitment by the Department of Health to purchase paediatric beds from Peel Health Campus. The decision about whether we purchase those will be part of the annual negotiations with Peel Health Campus, so there is no set agreement at this stage to purchase public paediatric beds. That needs to be decided.

Mr D.A. TEMPLEMAN: This is actually quite critical because, as the minister knows, the establishment of the paediatric ward at Peel Health Campus has had wide and very strong local community support through

fundraisers. Individuals, businesses, groups and organisations have invested heavily in this particular ward. I am concerned that it will open on 12 June without agreement between the Department of Health and the contractor on the actual operation of those beds. The minister is telling me that there is no formal agreement at this stage about who will pay for those beds to be occupied. From what the minister has said, it will not be the Department of Health; it will be the responsibility of a private operator. Does that mean that any child going into a hospital bed within the paediatric ward will have to go in as a private patient rather than as a public patient? When is it expected that the arrangement will be established? I do not want the community to assume that it has put all this effort into creating a children's ward and for there to possibly be a contractual dispute about who actually is responsible for operating the ward and who will pay for it. The assumption by the community is that it is its children's ward; it helped pay for it, and it would expect that if a child falls ill and needs to be accommodated in that ward, the child would be accommodated as a public patient. Is the minister telling me that that has not been finalised?

Dr K.D. HAMES: I will ask Dr Lawrence to give a more detailed answer, but the member's assumption of what should happen is what will happen. I might say that I have also made a significant contribution to that unit, and there is certainly a requirement that it will be used as a paediatric unit within the total bed numbers available under contract to the government. Whether those beds are where they currently are, or out in the ward, there is obviously agreement that when that ward is built, that is where the children will be housed. I ask whether Dr Lawrence has anything further to add to that.

Dr R. Lawrence: There is a fundamental difference between beds and activity, and that is where some of this confusion arises. The number of beds that Peel Health Campus and its management put on site is kind of irrelevant; what we purchase via contracts with these providers is levels of activity. The paediatric ward is obviously a much safer, better designed place for paediatric patients to be, rather than inpatient wards. The ongoing level of capacity to treat patients and the volumes are negotiated by the contract. Those patients are there already, and the demand feeds into the modelling that feeds into the contract negotiations, which are updated annually on the basis of what volumes of service should occur through the site. Where they are located in the hospital and how the hospital runs them is, at the end of the day, their business. But I expect that all the patients who are covered by the existing contract will move to the appropriate place to be cared for.

[11.30 am]

Mr D.A. TEMPLEMAN: Minister —

The CHAIRMAN: This is the member for Mandurah's last additional question.

Mr D.A. TEMPLEMAN: This question is actually very important. I refer to the ownership of the constructed building. The contract currently with Health Solutions has another four years to run. Irrespective of who continues after that contract date expires and the new contract date becomes operational, who actually owns the building known as the paediatric ward at the Peel Health Campus? Is it the owner, the private contractor, the state or the foundation?

Dr K.D. HAMES: It is the government, and the foundation is in agreement. Having constructed that building, the foundation agreed that the building would become a government asset that is managed by Peel Health Campus.

Mr D.A. TEMPLEMAN: Therefore, it becomes part of the overall asset of the campus.

Dr K.D. HAMES: It is definitely not owned by the current contractor. The current contractor did not build it. I am not sure what money the contractor put into it, but it was not a significant sum. Had I been minister at the time, I would have done the contract differently. It would have been a contract between me, as Minister for Health, and the trust, which constructed the building. The former government required that the current operator be tied up in all the legal agreements pertaining to the paediatric unit. The downside of that was that the negotiations about the legal requirements were quite protracted, particularly about who would pay for whatever might go wrong with that unit. I would have done it between me, as minister, and the trust, because at the end of the day it is a government-owned asset. It was the decision that was made at the time, but at the end of the day the building is handed over to the government. I do not know on what date that will occur. It will probably be at the end of the contract.

Mr D.A. TEMPLEMAN: Just to clarify something, Mr Chair —

The CHAIRMAN: This is not the Peel show. All members have a crack at asking questions, member for Mandurah. The member for Armadale.

Ms A.J.G. MacTIERNAN: I would like to ask some questions about the Armadale hospital. What is happening with the expressions of interest process for the Galliers wing.

Dr K.D. HAMES: Sorry, member, I was obtaining information and did not hear the question.

Ms A.J.G. MacTIERNAN: A couple of months ago the department went out for a brief expression of interest period for off-loading the Galliers wing to a private sector entity. What has happened to that EOI process, which closed in April.

Dr K.D. HAMES: As members may be aware, the Galliers wing was initially proposed with the extension and reconstruction of Armadale hospital to be operated by the private sector. A contract was awarded and a private operator commenced managing private maternity facilities in that wing. It had a contractual dispute with the government because, as part of that contract, the contractor was to provide high-dependency unit beds at that hospital, but that was not forthcoming. As a result the contractor won the court case. The court ruled that the contractor be refunded its contribution to the construction of that wing. I think it was in the order of $12 million as well as some additional fees. The state government took over managing that private wing. Members will be aware that there are no other private obstetric services in the eastern corridor through to Midland and Ellenbrook. We went out for expressions of interest. We were looking for two things. Firstly, to see whether there was a private sector operator who wanted to manage just that wing as a private maternity service to provide the private service that was originally proposed for that wing; and, secondly, to see whether the private sector was interested in putting up additional private service facilities on that site. I understand that no expressions of interest of any significance were received. I will ask Nicole Feely to provide the exact detail on whether there were any expressions of interest. Certainly nothing has come before me. The state government will continue to operate that private wing for obstetric services.

Ms N.M. Feely: The minister is correct. The tender process has been assessed and a probity guidance brief is currently being prepared for the acting director general's attention and finally for the minister. I hope it will be finalised by the end of the week with recommendations on the outcome of the tender process.

Ms A.J.G. MacTIERNAN: I understand from the minister that basically there is no significant —

Dr K.D. HAMES: Ms Feely gave a conservative answer and a correct one, but my answer is also correct, my understanding is that there are no providers of service that wish to fit in with that model. I am very sad, because we had a private sector operator in the past.

Ms A.J.G. MacTIERNAN: Members know the history. If the minister really wants to know the history and really wants to talk about the fact that the government was going to privatise it, at the time Helen Morton was given the opportunity to save face by having this mickey mouse private wing that was never going to work because it was too small —

The CHAIRMAN: Member for Armadale.

Mr T.R. BUSWELL: Knock it off.

Ms A.J.G. MacTIERNAN: My question, if I can continue —

The CHAIRMAN: Member for Vasse, if you want to take this over, do so; otherwise, I will ask you to walk outside. The member for Armadale.

Ms A.J.G. MacTIERNAN: A plan B has been developed by the hospital, which involves bringing together the private and public maternity wards at Armadale in Galliers. This is a very important proposal for a number of reasons. I wonder whether the minister can give us any figures on the increase in the births that have been recorded at Armadale hospital. At the moment we have a dysfunctional system. The private and public wards are separated, and because of the staffing difficulties, including losing applications in drawers when people go on holidays, I am constantly having people tell me their horror stories. They are halfway through delivery and have been made to walk over —

Dr K.D. HAMES: Mr Chair, I have lost track of the question.

Ms A.J.G. MacTIERNAN: I am trying to describe the problem to the minister.

Dr K.D. HAMES: I know the problem; just ask the question.

Ms A.J.G. MacTIERNAN: Now that the EOI process seems to be at a dead end, are we going to now consider the proper configuration of Galliers as a mother–baby unit under a proposal that has been developed by hospital staff?

Dr K.D. HAMES: I have seen aspects of that proposal, which I gather is still being fully developed. I have an open mind on that. When the final proposal comes to me, I will make the decision. With regards to the member's request for figures, I will need to provide that by way of supplementary information, but I need to know the exact information the member is seeking.

Ms A.J.G. MacTIERNAN: I would like the figures indicating the growth in the number of deliveries at the hospital for the past five years in both the private and public sectors.

Dr K.D. HAMES: We will provide details of all births at the Armadale hospital, distinguishing between public and private for the past five years.

[*Supplementary Information No A26.*]

Ms A.J.G. MacTIERNAN: On the same topic, I know that plan B was finalised some time last year; I know that from answers I have had on questions on notice. I am wondering whether the minister can table plan B by way of supplementary information.

[11.40 am]

Dr K.D. HAMES: I am not prepared to do that. We were waiting for the outcome from the expressions of interest. We will now proceed to make a decision on that proposal.

Ms A.J.G. MacTIERNAN: Why would the minister not let the public see plan B? I understand that the minister may not have made a decision; but what is the point of not allowing us to see plan B?

Dr K.D. HAMES: That is not the way proposals that are put before government work. Proposals are developed and put before government. Costings are done, comparisons are made and then the government makes a decision. A proposal has been put forward with the support of staff and it provides the input we need as a government. If I need further community input, I will seek that community input and provide the proposal. I am not saying that I will not do it—rather, I am saying that I will not do it now.

The CHAIRMAN: I would like to ask a question as the member for Albany.

Dr K.D. HAMES: I gather that the Chairman is allowed to do that.

The CHAIRMAN: I am allowed to do that. It is frowned upon, but I still do it.

I refer the minister to outcome 2 on page 188 of the *Budget Statements* that refers to improving the health of the people of Western Australia by reducing the incidence of preventable disease, specified injury, disability and premature death. In the metropolitan area, there are 668 deaths per 100 000 people, with a 75.3 per cent higher mortality rate in males than in females. In rural areas, there are 708 deaths per 100 000 people, with a 74.3 per cent higher mortality rate in males than in females. In remote areas there are 767 deaths per 100 000, with a 59.7 per cent higher mortality rate in males than in females. In rural–remote areas there are 1 475 deaths per 100 000 people, with a 66.4 per cent higher mortality rate in males than in females. Does the government have a policy for men's health in rural and remote areas? Has funding been put aside specifically for prostate cancer and other men's illnesses? A lot of money is put aside for women's health issues. Albany has a good men's resource centre, which the government funded. The people of Albany appreciate that. There is also one in the Wheatbelt. Are there any plans to look after men in regional Western Australia?

Dr K.D. HAMES: This is an issue of which the government is fully aware. It is fully supportive of the provision of men's services in the community. As the member knows, the Department of Agriculture and Food funds two centres. The Department of Health funded the Albany and Derby centres.

The CHAIRMAN: There is one in the Wheatbelt. It was funded by the Department of Agriculture and Food.

Dr K.D. HAMES: There has been discussion among ministers about the need to expand services. In fact, there was a tongue-in-cheek suggestion that since there is a Minister for Women's Interests, there should be also be a minister for men's interests. Interestingly, those who volunteered to be such a minister were women.

Ms J.M. FREEMAN: There is a minister for men's interests. There is the Premier, the Treasurer —

The CHAIRMAN: The member for Nollamara has many opportunities to ask questions. This is my one opportunity for a question. I ask her to sit and listen.

Dr K.D. HAMES: We are seriously looking at expanding men's health services in this state. I cannot say specifically what those plans are, but they will be further developed by the Minister for Agriculture and Food and the Minister for Regional Development. There is the view that men's health should probably be moved from

the agriculture portfolio. It has not been determined whether it should come under the Department of Health or the Department of Regional Development and Lands. There is a strong focus on that issue.

The CHAIRMAN: A great job has been done in Albany, Derby and the Wheatbelt. If anywhere else in the world had the morbidity rates our regional areas have, we would say that they were disgraceful. I have been a member of Parliament for 10 years and nothing has been done by either the Labor or Liberal–National governments. The men's resource centre in Albany was set up by local people. The government did not set it up, but it did provide the funding. I am not sure about the centres in the Wheatbelt and Derby. Men in regional areas are sick of hearing people say that they are looking at the issue. We want to know what is going to happen.

Dr K.D. HAMES: I am not in a position to say because —

The CHAIRMAN: But the member is the Minister for Health!

Dr K.D. HAMES: I know what is happening; but other ministers are responsible. I am not sure whether those ministers have made announcements. If not, I am sure they will make announcements in the near future.

Mr R.H. COOK: I refer to the line item "Prevention, Promotion and Protection" on page 193 of the *Budget Statements* and to the average cost of breast screening. What is the current waiting period for a breast screen recipient who has been recommended follow-up treatment? By that I refer to a woman who has had a breast screening and who has been identified as needing follow-up treatment. What is the national accreditation benchmark for the waiting time for follow-up treatment? Can the minister confirm whether BreastScreen WA is in danger of losing its accreditation because of the delays experienced in Western Australia?

Dr K.D. HAMES: We will have to take that question on notice and provide the response as supplementary information. In the south west areas, particularly in the Bunbury region, there have been problems with the ability to provide a breast screening service. As an election commitment, we had funding in the budget of just under $5 million to provide an upgraded breast screening service. We delayed those upgrades because St John of God Health Care proposed its own breast screening service. I am pleased to say that the commonwealth government has provided additional funds of more than $20 million to enable St John of God to establish a breast screening centre in Bunbury. We are continuing the funding of just under $5 million to improve the breast screening service in the meantime with an additional bus and additional staff to reduce the waiting times in the Bunbury region. I do not have specific details for the other questions. We will provide that as supplementary information.

Mr R.H. COOK: Do any of the minister's advisers have that information?

Dr K.D. HAMES: No; none of them has those specific details. The supplementary advice will be the wait times for breast cancer screening in this state and a wait time comparison with other states. We will also address the member's concern that our service's accreditation has been placed at risk because of alleged delays.

Mr R.H. COOK: That is for women who have had a breast screening and who have been identified as needing follow-up treatment.

[*Supplementary Information No A27.*]

Dr K.D. HAMES: One of the downsides to having fewer advisers present is that we sometimes lose that lower level of detail that the former Minister for Health had. That is a sacrifice that I am prepared to make.

Mr R.H. COOK: The sacrifice is overwhelming. Actually, it is quite underwhelming.

Some time back there was debate about women who fall outside the age range of eligibility for breast screening services. What are the screening options available and recommended for women who fall outside the free age range for BreastScreen WA mammograms? Has a decision been made nationally about restricting the free age range? If so, will Western Australia enforce the restrictions or maintain free access for existing age ranges?

[11.50 am]

Dr K.D. HAMES: These issues have been discussed frequently at the ministerial council with varying views by individual health ministers from other states. I am very reluctant to discontinue screening patients for breast cancer, and quite a few other health ministers share that view. We have not yet made a decision on that subject but I expect that we will over the next few meetings. As I said, I am very reluctant to discontinue screening for any particular age group.

Ms J.M. FREEMAN: I refer to page 181 of the budget papers and to the line item for the "Friend in Need — Emergency (FINE) Scheme".

Dr K.D. HAMES: Which line is the member referring to?

Ms J.M. FREEMAN: The "Friend in Need — Emergency … Scheme" is under the heading "Significant Issues Impacting the Agency". Shall I count down the number of dot points for the minister?

Dr K.D. HAMES: Yes, because I still do not have the spot.

Ms J.M. FREEMAN: At page 181, the "Friend in Need — Emergency … Scheme" —

Dr K.D. HAMES: Yes. Which dot point?

Ms J.M. FREEMAN: I have two dot points. I also refer to page 180. The second line item in the service summary table indicates that the allocation for the home-based hospital programs increased to $60 million from 2009–10 to 2010–11. The "Friend in Need Emergency/Silver Chain (Public Hospital Admittance)" line item in the table of major policy decisions listed on page 161 of the 2009–10 budget papers indicates that there is $27 million for both the budget estimate and the forward estimate. That was an election commitment. According to pages E536 to E582 of the *Hansard*, only $6.2 million was allocated to the FINE scheme in last year's budget. The minister said that the make-up to the rest of the $27 million came from not new commitments, but existing funding to Silver Chain. There was an undertaking that there would be a formal procurement process for the remainder of the funds up to $27 million. Has that occurred? By my reckoning, from looking at the service summary for the home-based hospital programs, the FINE program still has not reached the $27 million that was committed. That is my second question. It looks as though it has gone up to only $20 million. My third question is: given what we were talking about with the hospital nurses support fund, why is this still in this budget and not part of the general revenue budget that the minister's adviser was speaking about earlier in terms of the recurrent funding; or, is it just a contained commitment for those four years and the intention then is not to continue it?

The CHAIRMAN: That is the longest question I have ever heard, member!

Dr K.D. HAMES: Yes, I think I get it. The scheme is still being rolled out. We now have a contract with Silver Chain. I met with the chief executive officer a couple of days ago. The CEO is extremely happy that he has significantly increased staffing levels.

Mr R.H. COOK: Was that put out to tender?

Dr K.D. HAMES: Yes, it was.

It is not something that can be rolled out 100 per cent right at the very start. There is a matter of increasing staffing levels, but we also have to react to demand. I am advised that Silver Chain has developed very strong relationships with general practitioners and is getting a big increase in referrals from general practitioners who have patients who would otherwise go. It also prevents nursing home patients being sent to hospitals. I also gather that there has been considerable success in that area. Part of it is about getting to patients who are sent to hospital before they need to be sent to hospital or sending patients home early. That requires considerable commitment by the doctors in hospitals, and that is a matter of developing the process and developing trust within the hospital system to provide that service. As the member can see, the home-based hospital programs include Hospital in the Home, which is a pre-existing program that was started by the previous health minister, and other similar programs. The member will note that the funding goes from $40 million up to $60 million, $64 million, $68 million and $71 million. That obviously means that that program will be continued in the out years beyond our four-year election commitment; hence the $71 million in 2013–14. It incorporates the continuation of that program. I now need to ask Wayne Salvage to give any further details about the budget that he might care to provide.

Mr W. Salvage: I can confirm that the original FINE commitment expenditure over four years has been rolled into the budget, so in the final year of the original commitment, there is now an additional $24 million, and that will be indexed forward.

Ms J.M. FREEMAN: The original FINE commitment was $24 million, not $27 million, as outlined in the election commitment.

Dr K.D. HAMES: I think $3 million is for additional services, and partly for the Hospital in the Home program. It was $84 million over four years, so it is the equivalent of roughly $21 million dollars a year, not $24 million. Those additional amounts were changing over the years. The original was $3 million in 2008–09, $21.5 million in 2009–10, $32.5 million in 2010–11, and $27 million in 2011–12. If we compare the figure for 2008–09 with the figure for 2013–14, the member will see that there is an additional $31 million in the 2013–14 budget.

Ms J.M. FREEMAN: I want to confirm that the minister has said that it was put out to tender.

Dr K.D. HAMES: Yes.

Ms J.M. FREEMAN: Is it possible for the minister to provide by way of supplementary information a breakdown of the Friend in Need — Emergency Scheme funding for the home-based hospital programs and the hospital-based programs that are run in-house, as I understand it? They are two different programs.

Dr K.D. HAMES: The question is: is there a breakdown of any funds that go from the election commitment to the hospital-based programs?

Ms J.M. FREEMAN: If we look at the service summary for the $60 million, can I have a breakdown of the funding towards the Friend in Need — Emergency Scheme, the home-based hospital programs and the full-time equivalents associated with the current directly employed home-based hospital programs, as well as a comparison from 2009–10?

Dr K.D. HAMES: Yes, I am happy to provide that supplementary information. The member will need to restate the information she wants so that it is in *Hansard*.

Ms J.M. FREEMAN: As supplementary information, I am asking for a breakdown of the home-based hospital programs in 2009–10, including the actual budget and the estimate for 2010–11 for the FINE scheme—that is, what went to Silver Chain and what went to the home-based hospital programs, and the FTEs employed under both, if possible.

[*Supplementary Information No A28.*]

Mr T.R. BUSWELL: I refer to page 181 of the budget papers and to the very excellent plan A for child development services. An amount of $49.7 million has been allocated over four years. Firstly, what is planned for delivery in the first year? Secondly, how many FTEs will be employed in the metropolitan area? What does the minister anticipate will be the impact of this increased resource on existing waiting times?

[12 noon]

Dr K.D. HAMES: I am particularly pleased with funding of just under $50 million over four years for child health services. I congratulate the former Treasurer for being focused on this area. This area has been deficient for a long period. I have to say that when I was the Deputy Chairman of the Education and Health Standing Committee, all our investigations were into issues relating to Indigenous affairs because that was the preferred area of the Chairman, the member for Pilbara, and me. When we decided to do something different, the member for Bassendean was very keen for us to do a review of this particular space. He was very concerned that the numbers of full-time equivalents were not being provided. In fact, prior to that our former member in the upper house, Hon Barbara Scott, was a very strong advocate for improving child development services. In the early part of our term in government these services did deteriorate; demand increased, staffing levels were difficult to maintain and, therefore, waiting times extended.

Child development services will require a significant increase in the number of staff and that is where this funding will be focused. There will be an additional 17 speech pathologists, which is a 33 per cent increase in staffing and which is expected to reduce waiting times from just under 19 months to eight months—by more than half. In occupational therapy there will be an additional nine staff, which is a 43 per cent increase, to reduce waiting times from 15 months to seven months. In physiotherapy there will be an additional five staff, which is a 52 per cent increase in physiotherapists, to reduce waiting times from 12.2 months to five months. There will be two additional clinical psychologists, which is a 15 per cent increase, and two additional social workers, which is a 13 per cent increase. It is recognised that these services are critical in helping children in those early stages of development who have potential significant adverse outcomes if their disability is not diagnosed and treated early. I must say that we were very pleased when we were recently at the clinic and the paediatrician involved said that it was the best increase in funding they had had for 40 years. We are very strongly committed to this program.

In the longer term the Education and Health Standing Committee recommended significant further funding for that, particularly in the area of school nurses and child health clinics. In our discussion with the federal government about the total federal health package—again, that is the space that the commonwealth government says it should be involved in—I asked the federal health minister to fund the program for the child health nurses. The commonwealth government said it would rather fund this program than the child health nurse program, but we will continue to have those discussions. As we move forward I hope that the federal government will make a contribution to improving child health services along the lines of those recommended by the committee. However, I think this is a great first step in an area that has not been addressed before.

Ms J.M. FREEMAN: Can the minister outline where the money is going for speech pathologists, occupational therapists, physiotherapists, clinical psychologists and social workers?

Dr K.D. HAMES: I have given the numbers for those particular areas. Where they are located is based on demand, where the need is and where the waiting times are most difficult. That will be managed by Phil Aylward, who will give us some indication of what his plans are.

Mr P. Aylward: The minister outlined that in the first year there will be an increase of 45 allied health professionals in the metropolitan area, which is a substantial uplift that will dramatically reduce waiting times for children. The rollout of the program will probably incorporate a further 50 full-time equivalents in the metropolitan area over the following five years, and a large number of staff will be employed in the country areas as well. We are working out the detailed plans at the moment, but the first year is a significant instalment to fast-track the reduction in waiting times.

Dr K.D. HAMES: We are looking at different options for how we can better provide that service in country areas. It is not always best, for example, to have a speech pathologist located in the bush. Six months or so, or perhaps a year, ago we went to Newman where there was a significant deficiency in speech pathologists. Having a speech pathologist go to Newman, live in the community and provide that service had been tried in the past. However, sadly, people who do not necessarily come from those rural and remote areas do not always stay. We can spend a lot of money in getting a house and moving people there, and they stay for the term of their contract, which might be one year, and then they leave again. There is a very good alternative model that we are now trialling in Newman. There are women who are trained nurses whose husbands work in the mining industry who have decided that they are raising their children and do not want to work in the hospital but are available for part-time employment. We will employ those nurses part-time to work with the mothers they meet at the schools with their children to have a direct tele-link to a speech pathologist elsewhere. Currently, speech pathologists fly in to Newman once a month, I think it is, from Port Hedland and spend in effect one day there. It is simply not possible to provide proper treatment for a child with a speech disability, for example, in one day. Under our proposed model, the mother, the child and the trainer, who will be someone who has a nursing background and the capacity to pick up those extra services easily with a little additional training, will have a direct tele-link once or twice a week. I think that is an extremely prospective model for the country, particularly now that this government is rolling out funding to upgrade the telephone connection system, the radio masts, throughout the whole of Western Australia.

Mr R.H. COOK: I have a point of order. The narrative is entertaining but I think we have enough information now.

The CHAIRMAN: Thank you, I will not take a point of order. I think the minister is completing his answer.

Dr K.D. HAMES: I try to keep answers to a minimum but the answer is mine and there are no restrictions on answers in estimates.

Mr R.H. COOK: I have a follow-up question on child health services. Is the minister aware that Bassendean community health nurses have had their number of days a week chopped from four to three days because of funding cuts to the child community health program? Is that a formulaic, across-the-board cut or is it specifically for the Bassendean community health nurses?

Dr K.D. HAMES: These throwaway lines are fairly common but often not accurate. The fact is that this additional level of service will be provided in the area of greatest need. Bassendean has a need, as I am sure Armadale does; there will be an increase in those services. This is a massive increase in funding and full-time equivalents—something the former government probably dreamed about.

Mr A.P. JACOB: I refer to the four-hour rule program, which is listed on page 181 of the *Budget Statements* as a significant issue that impacts the agency. I note that the program commenced more than 12 months ago and that it was recently extended to regional centres. Can the minister advise what progress has been made towards achieving the 98 per cent target?

[12.10 pm]

Dr K.D. HAMES: The four-hour rule program has been going exceptionally well. We set very difficult targets; 85 per cent was the target for the three tertiary hospitals in May, moving to 95 per cent and then 98 per cent. We deliberately made them very tough targets to meet, but we have teams of people working through the hospitals who have made significant inroads towards those targets. As we expected, they are having some significant additional benefits. The ambulance ramping times have significantly reduced. For example, in the weekend ending Sunday, 3 May 2009, the average waiting hours per week was 48.5 and at the end of May 2010 that was down to 24.9 waiting hours. Not all hospitals have been as successful in reducing those times. There also have been significant reductions in access block in those hospitals. Those figures are for the beginning of May this year. There are still significant improvements to be made. Interestingly, mortality rates decreased in those

hospitals. That goes well with the report by Dr Sprivulis on the increase in adverse events in emergency departments as a result of people waiting for a bed for longer than is reasonable. I will ask some Department of Health staff to provide more detail about that.

We also have seen improvements in bed occupancies. When in opposition, we were long critical of the occupancy rate of between 95 per cent and 105 per cent in our tertiary hospitals, which is not good for proper patient management. Surges through emergency departments have a direct effect on waiting lists and the ability to find beds for elective surgery patients. The anecdotal evidence from hospitals is that they are starting to have an increased number of empty beds. We should always have some empty beds to properly manage our hospitals. The number of empty beds is now increasing and occupancy rates are getting back towards 90 per cent.

Mr K. Snowball: Before I ask Dr Lawrence, who has responsibility for our four-hour rule program, to respond, I will advise members that every hospital in Western Australia is operating under the four-hour rule program. We have just spoken to the staff at the regional country hospitals about implementing the program. The momentum that has been gathered as a consequence of this approach is quite phenomenal. It is changing our hospitals significantly for the better. A lot of people believe that this is about emergency departments; it is actually about the flow of patients who come into the hospital and the discharge processes. Every aspect of the hospital is examined as part of this process to arrive at ways of improving not only the service, but also the time people wait. If I have not stolen all of what Dr Lawrence was going to say, I invite her to add to what has been said.

Dr R. Lawrence: All the hospitals are now involved in the program. The minister has given the key indicators for the stage 1 sites and their progress towards the target. We are continuing towards the next target for the stage 1 and 2 sites, which is to achieve a rate of 95 per cent and 85 per cent respectively by October. All those improvements have been done in the background of ongoing increases of attendances to emergency departments, which in itself is remarkable. As a consequence, we are seeing significant interest in the program from the eastern states about how our program is working now that the pressure is being put on them. Stage 3 is interesting. Questions are being asked about why some of the hospitals are being included in the program, given that the raw data appears to show that some of those hospitals do not need to undertake this program. However, they are facing challenges such as the huge growth in the populations of the surrounding areas and the increased expectation in the demand for their services. The only way that the system will be able to meet the local demand and the demand on the entire system is to reform the whole system at the same time.

Dr K.D. HAMES: It is not all good news. Although I do not want to be the promoter of not-so-good news, we have not quite met our first target. I ask Dr Lawrence to advise how the hospitals are going and what continued progress they are making.

Dr R. Lawrence: The minister has reported the most recent monthly figures.

Mr R.H. COOK: They are not on the website either. I was going to ask a follow-up question about that. We want to know why they have not been published. All the previous reports are on the website.

Dr R. Lawrence: The quarterly reports are on the website. I can follow up the April report. It should be on the website. It has been signed off and was handed out yesterday at the steering committee.

Dr K.D. HAMES: We will follow that up and make sure that it is on the website.

Mr R.H. COOK: Given that the report is not published on the website, what are the figures for Royal Perth Hospital, Sir Charles Gairdner Hospital and Fremantle Hospital? I am sure that the minister will want to tell me about Princess Margaret Hospital for Children because I think that is the only hospital that is getting within cooee of meeting its target.

Dr K.D. HAMES: We would all be very happy to know that Princess Margaret Hospital for Children has, on a few occasions, reached 98 per cent. It has always been at a very high level. Sir Charles Gairdner Hospital has been struggling to meet the target. Can someone remind me of the percentages? I think the last figure I quoted was 79 per cent for Fremantle Hospital and 76 per cent for Royal Perth Hospital. Is that close?

Dr R. Lawrence: Reliable figures that can be replicated and measured against show that Royal Perth Hospital reached 75.8 per cent, Sir Charles Gairdner Hospital reached 65.7 per cent and Fremantle Hospital reached 74.6 per cent. These averages are calculated on a weekly basis. The percentages are different, depending on from where the average is drawn. On a daily basis, the hospitals have a much greater variation. There are many days when they are close to the 85 per cent target.

Dr K.D. HAMES: The point to be made is that when we look at the daily figures, we can see days when the hospitals get a huge surge in patients, particularly on a Monday, and those percentages go down, whereas on other days the percentages are right up there. Taking an average is not necessarily a great way to do it, but it

shows that we have not hit the 85 per cent target. It is interesting to look at the graph. A lot of changes were put in place early on and some significant changes are still being put in place. The program has not been operating for very long. The graph has shown a significant curve upwards as the hospitals have improved. It is interesting to note that the federal government is requiring all states to follow our lead on the four-hour rule. However, rather than doing it across the presentation range of patients, the federal government is doing it on a category-by-category basis and over a much longer time. I think that it is doing it over four years rather than two years and it is setting a maximum of 95 per cent rather than 98 per cent. In the first 18 months, the category 1 hospitals have to meet that target and in the next 12 months the category 2 hospitals have to meet that target, followed by the category 3 and 4 hospitals. I have advised all health ministers that that is not the best way to do it to get the best outcome. The hospitals in the United Kingdom said that it is not about the emergency departments and dealing with category 1 patients; it is about a change in attitude in the whole hospital. It has been difficult to achieve that. There has been some degree of resistance to this program in some hospitals because we are requiring people to change the way that they do things. A good example is that the peak time when beds are needed is about 10.00 am and the peak times when beds become available is about 5.00 pm. The four-hour rule works by moving the times when beds become available from 5.00 pm to 10.00 am when the beds are actually needed. The saving of half a day in bed time significantly increases the number of beds available. That is how it works. Previously, a surgeon would not discharge a patient until the surgeon had seen the patient for a follow-up examination. The surgeon would operate all day and not see the patient until late in the afternoon, and then the surgeon would discharge the patient. It does not work like that. Surgeons now have to find alternative ways of seeing their patients at a time when it is best to discharge the patient. Alternatively, a surgeon can sign discharge rights to other people, including senior nursing staff, according to certain criteria. Those things are critical to get the outcome that is needed. All the teams that are working on this are extremely dedicated and are working exceptionally hard to achieve those targets.

[12.20 pm]

The CHAIRMAN: Before we continue, I draw to members' attention that it is now 12.20 pm, so we have only 40 minutes left to cover another three divisions.

Dr K.D. HAMES: No. We have until 5.00 pm.

The CHAIRMAN: Yes, the minister is correct. I stand corrected on that. But I do want to remind members and the minister that the intention of the Chair is to ensure that as many questions as possible are asked, and that answers to questions are short and to the point. The member for Ocean Reef had a further question on this matter.

Mr A.P. JACOB: Given that Joondalup Health Campus is, I believe, the busiest emergency department in the state, can the minister give us an update on where that hospital is with regard to the four-hour rule, and also the other stage 2 hospitals?

Dr K.D. HAMES: Yes. Joondalup hospital will be included in the four-hour rule requirement. Obviously that is the busiest hospital in the state. It has more ED presentations than Royal Perth has. Consequently, currently it has the longest ambulance ramping time of any hospital, and it is more often on bypass than any other hospital. The hospital was never designed to deal with such a large number of patients, hence the huge investment by the former government and this government in expanding the capacity of that hospital. Someone else might have a better answer about the specifics. Dr Lawrence.

Dr R. Lawrence: Before I start, to be fair to Joondalup, it has not actually started to make changes as a result of the four-hour rule. It is really only one month into that change process. It spent six months on diagnosing what it needed to do, and it has had only three or four weeks to start implementing it. So we would not expect it to move from its base line. What I can tell the member, though, is that in the week ending 30 May—so this week just gone by—the average for its four-hour target was 71 per cent.

Mr A.P. JACOB: That is not bad.

Dr K.D. HAMES: Joondalup hospital is in my view extremely well managed and is providing great outcomes. As we expand the number of beds at that hospital to 471, that will obviously make a huge difference to the ability of that hospital to cope with not only the four-hour rule but also the huge and growing demands of the member's developing electorate.

The CHAIRMAN: If there are no further questions on this issue, the member for Forrestfield.

Mr A.J. WADDELL: I refer to page 179, item 39, net amount appropriated to deliver services, for want of a better line item. I would like to follow on to some extent from the work that is happening with the four-hour

target and the idea of moving people through the system more quickly. I am concerned that there is a bottleneck after that. I am anecdotally getting stories from people in my electorate about long waiting times to get into diagnostic services, in particular for CT scans. I am getting stories that the Shenton Park outpatient clinic has been shut down for two days a week, and people are experiencing increasingly long waiting times to get the diagnostic tests that they need for the early detection of cancer and a range of other things. Can the minister provide some information about the waiting periods for access to diagnostic services such as CT scans and MRIs through the various hospitals?

Dr K.D. HAMES: Some of that relates to the availability of CT scanners, obviously. We are increasing the number of CT scanners. Outside the metropolitan area, we have committed to new CT scanners in Esperance, Carnarvon and Narrogin. There is also one at Nickol Bay Hospital in Karratha. We currently have one PET CT scanner at Sir Charles Gairdner Hospital. We are replacing that PET scanner with a new PET CT scanner. The people here will be pleased to know that I have agreed to that now. An additional private PET CT scanner will be going in just down the road at Hollywood Hospital, and one will also be going into the new Fiona Stanley Hospital. The last one is going into Bunbury Hospital. For the more specific details of the member's question, I will need assistance.

Ms J.M. FREEMAN: Can the minister give us the line item?

Dr K.D. HAMES: The member for Forrestfield is just using this to raise a general matter. Any new equipment will be in the line item that deals with new equipment, such as scanners and ultrasound machines. What also comes under that line item that the member mentioned is the normal cost of running hospitals such as Osborne Park or Joondalup, or whichever it might be. These things are part of the total cost of running the hospital, so they come as a global allocation rather than as a specific allocation. Mr Snowball may be able to respond to the member's question about the waiting times.

Mr K. Snowball: I was just going to suggest, through the minister, that if the member has some particular issues, he should please ask his constituents to raise them with the relevant health service or hospital to make sure that they are dealt with in a reasonable time. I have had no reports of a broad increase in waiting times that can be attributed to the four-hour rule. In fact, the four-hour rule has sped up a lot of our processes. We have had issues with the implementation of a particular piece of software at Sir Charles Gairdner Hospital for imaging. We are working through those problems. That has slowed things down for us in terms of reading the results.

Dr K.D. HAMES: I think the question related more to places like Osborne Park Hospital, which are outside the EDs. It is outpatient-type services that the member is inquiring about, such as the opportunity to get an ultrasound or an X-ray or a scan. The member needs to understand that as the Minister for Health, people do complain to me about things, and I get letters from individuals or from members of Parliament. I have not had any complaints that I can recall about the waiting times for these services. However, it is very important, if people do have concerns, that they, through the member, let us know.

Mr A.J. WADDELL: We will do that. However, I am wondering about the caps for utilisation. This equipment is extraordinarily expensive. Are we running it to its full capacity, or is it sitting idle for a percentage of the time?

Dr K.D. HAMES: I will seek assistance on that answer. But it is important to remember that we provide a service for public hospital care. Most of the services that we provide in our hospitals to have tests done are generated by the hospitals themselves in treating inpatients, or by outpatient clinics, where the doctors working in those clinics request that a particular procedure be done. Of course people who see their general practitioner would go to the private sector for access—funded in part by Medicare—to have those tests done. Mr Snowball may be able to add to that.

Mr K. Snowball: I will ask Dr Russell-Weisz from north metropolitan to add to that.

Dr D.J. Russell-Weisz: From a north metropolitan perspective, we usually have two MRI scanners running at all times. They are at Sir Charles Gairdner Hospital. One of those scanners was damaged in the storm and is not functioning at the moment, so the other one is being run for very long hours. There is no downtime on those scanners when they are up and running. The minister mentioned our PET CT scanner. That is already running from 6.30 am to 5.30 pm. It requires something called cyclotron, which is produced at Sir Charles Gairdner Hospital, and that team starts at 4.00 am. The addition of the second PET CT scanner will assist in those waiting times. I cannot think any of any times when our imaging facilities are idle.

Dr K.D. HAMES: What about at Osborne Park?

Dr D.J. Russell-Weisz: At Osborne Park, the contract has just changed over from a previous private provider to be provided through the Royal Perth Hospital imaging radiologists, and Osborne Park is again at reasonably full capacity. I can get the member the exact waiting times.

Mr A.J. WADDELL: Can I get some of that information by way of supplementary information?

Dr K.D. HAMES: Is that the waiting times for scanning?

Mr A.J. WADDELL: Yes, please.

Dr K.D. HAMES: For any particular scanners?

Mr A.J. WADDELL: My concern is about the scanners at the Wellington Street annexe of Shenton Park, and Shenton Park itself. I also have a more general interest in the whole of the metropolitan area, if that is not a problem.

Dr K.D. HAMES: That will require a lot of additional work. I am prepared to provide as supplementary information the areas of the member's particular concern.

Mr A.J. WADDELL: If the minister can provide it for Shenton Park, that would be good.

Dr K.D. HAMES: Yes.

The CHAIRMAN: The minister agrees to provide supplementary information about the waiting times for PET scans at Shenton Park.

[*Supplementary Information No A29.*]

[12.30 pm]

Mr M.J. COWPER: I refer to "New Works" on page 200. Having lived most of my life in regional Western Australia and having a very good affiliation with the Nickol Bay Hospital, I am interested to see that $150 million has been allocated to Nickol Bay. I would like the minister to clarify whether the $150 million is on top of the $10 million that was part of the election campaign, and what other areas in regional Western Australia are receiving funds from the current budget. Of course, we could not go much further than the Harvey District Hospital.

Dr K.D. HAMES: I thought the member might add Harvey District Hospital in there. That $10 million was provided as part of our election commitment to do a number of things, including obstetric services and accommodation issues at Nickol Bay. It was also to look at planning for what was required to properly address the health needs of that region. The former government funded the new hospital at Port Hedland, and it was generally seen that that would be the major regional hospital. We believe that Karratha needs an equivalent hospital to provide for what we see as significant growth and expansion in both of those towns in the future. It has been estimated that the cost of a new hospital of a similar size to that at Port Hedland will be required in the longer term for Karratha, so an amount from the royalties for regions scheme of $150 million has been put into the budget to cover that expected cost, with the main funds peaking in 2012–13 and 2013–14, so it is a fantastic outcome for Karratha that we were able to get that money and properly deal with what we expect to be significant growth in that region. Of course, we have had additional funds for other parts of the state. As the member knows, we are building the new hospital in Albany that is due for completion in early 2013. There is currently $77 million for Busselton Hospital, and as the member for Vasse happened to mention in his breakfast speech, additional funding might be needed to provide a higher standard of service. There is also funding for Carnarvon Regional Hospital. When we came to government and there was an international funding crisis, we needed to significantly reduce expenditure—both recurrent expenditure and capital expenditure—in our budget and sadly, some projects had to be pushed backwards. Busselton Hospital was one of those, as was Carnarvon Regional Hospital and Harvey District Hospital. We now have the funds in place for Carnarvon Regional Hospital: $20 million from the royalties for regions scheme. There will be an additional $6 million on top of that out of the WA Country Health Service capital fund. That covers the full cost of Carnarvon Regional Hospital. There is a health clinic going into Exmouth, an upgrade of the Esperance District Hospital and a continuation of the upgrade of Kalgoorlie Regional Hospital. The member for Murray-Wellington will also be very pleased to know that on page 198 there is an allocation for the redevelopment of Harvey District Hospital. The original budget allocated about $7 million, and it is now about $13.9 million in total. We are looking at sorting out some issues with aged accommodation, and that money has now been put into the budget, with construction over the next three years. There is a significant boost in funding to the capital works program, giving us a total capital works project in health of more than $800 million, which is a record total sum. Exmouth District Hospital will have a new ambulatory care facility worth $8.075 million.

Mr M.J. COWPER: I refer to page 197. There will be redevelopment of the Harvey District Hospital, including a new emergency unit, refurbished inpatient care, ambulatory services and a GP clinic, with a possible transfer of aged care facilities to the private sector. Do I take that to mean that we are looking at negotiating some activities with Hocart Lodge Aged Centre?

Dr K.D. HAMES: That is the case; there are discussions going on about transferring those beds to that organisation. It has not yet been decided; that is part of the negotiations, but as part of the budget process, we put funds in to allow us to deal with those issues as well.

Mr M.J. COWPER: Coincidently, the federal member for Forrest, Ms Nola Marino, and I will be meeting with Hocart on 9 June, and I wondered whether someone from the minister's office might participate in that meeting.

Dr K.D. HAMES: I am sure that if the member sends an invitation, we will be able to provide someone to attend that meeting.

Mr R.H. COOK: I am genuinely perplexed, so I am looking for some guidance in relation to the role of the royalties for regions scheme in the West Australian health budget. We were told that royalties for regions was a top-up fund for those things that would otherwise be met. The redevelopment of the Carnarvon Regional Hospital was clearly part of the Department of Health's scope of services; it was in the forward estimates, although the government had delayed it. The redevelopment of Nickol Bay Hospital came out of nowhere; it was not mentioned before, but suddenly $150 million hit the books. One hospital project is fairly and squarely within health's core business, but it was not funded; it had to be funded by the royalties for regions scheme. Another project seemed to come out of thin air. Development of the Harvey District Hospital was delayed, but the royalties for regions scheme did not touch that. We have already discussed the shortfall in funding for Busselton Hospital. What is it about the hospitals at Busselton and Harvey that do not make them eligible for royalties for regions funding, while the Carnarvon hospital is? Does the minister just sit there while Brendon Grylls comes in and cherry picks whatever he likes out of the budget?

Dr K.D. HAMES: No, that is not the case. There was something in the order of $6 million in the budget for the hospital in Carnarvon; that was all, and that limited the scope of works that were proposed at that hospital. That is what we, as a health department, could afford to fund. We are still putting in that same amount of money from the state government's original budget for the health service. We are reinstating the previous funds we had. The great benefit of royalties for regions is that I have the option to go to the Minister for Regional Development, who is responsible for the royalties for regions scheme, to ask him whether he is prepared to provide additional funding for additional works that I might like to do. That was the case for the hospital in Carnarvon. It is not necessarily the case that royalties for regions will not provide additional funds for Busselton Hospital. As we go through the process of developing Busselton Hospital, what I can afford to spend in Busselton is $77 million. That is what I have and that is all I intend to spend, except that additional proposals have come about for improving the service further. Under my normal budget I would not be able to do that, but it may well be that I am able to seek additional funds through royalties for regions. That money is available to fund things in the regions that otherwise would not have been funded by the health department.

[12.40 pm]

Mr R.H. COOK: Therefore, the government was not going to fund the Carnarvon hospital redevelopment?

Dr K.D. HAMES: We were going to fund the $6 million for the original upgrade that the Labor government proposed. Now this government is going to do it much better and spend a lot more money on it. We were going to do exactly what the former Minister for Health proposed with exactly the same amount of money, and that was one option. The second option is to use royalties for regions funding to put money into those regions to improve that standard of service that had been neglected for so long. Hence, we are funding those additional things. In the same way, we have gone to the commonwealth government and sought additional funding for things such as Midland hospital and the paediatric unit at Broome hospital. The commonwealth has agreed to fund those additional services that we might otherwise not be able to afford. All members have to do is look at the total capital works budget for health and compare it with capital expenditure under the Labor government. It has significantly increased in a way that we were unable to afford before. Putting additional funds back into the regions gives the government opportunities—particularly through health, given that the demand is so high—to have a much greater standard of service. The funds for Harvey hospital were reinstated.

Mr M.J. COWPER: It was after Yarloop hospital closed.

Dr K.D. HAMES: Yes, Harvey hospital was committed to because Yarloop hospital was closed by the former government. Those moneys have been returned, with interest.

Mr R.H. COOK: The minister is saying that there are two Ministers for Health.

Dr K.D. HAMES: No, there are not. I go to the minister seeking additional funds.

Mr R.H. COOK: Begging additional funds!

Dr K.D. HAMES: I do not beg; I ask.

Mr R.H. COOK: The member for Eyre is a bit vulnerable; why does the government not put some money into Esperance? Perhaps the government needs to prop up the member for North West.

Dr K.D. HAMES: I put up a business case for a new proposal —

Mr R.H. COOK: The government does not worry about the member for Murray–Wellington because he is safe.

Dr K.D. HAMES: When I put up a business case for a new proposal for additional services health requires, it goes to cabinet. It is a cabinet decision, not a specific decision by the Minister for Regional Development.

The CHAIRMAN: The member for Armadale is not here, so we move to the member for Nollamara.

Ms J.M. FREEMAN: I refer to "Workforce" on page 186. I am not sure about these line items. I also refer to page 202, line item —

Dr K.D. HAMES: What is the member referring to on page 186?

Ms J.M. FREEMAN: Workforce.

Dr K.D. HAMES: Yes, but what?

Ms J.M. FREEMAN: Okay, I will take the minister specifically to a line item. I refer to page 202 and under the heading "Expenses" is a line item "Employees benefits". I refer also to paragraph (b) at the bottom of that page, which refers to full-time equivalents. Can the minister give a breakdown of FTEs as outlined in paragraph (b)—that is, 31 112 in 2008–09; 31 311 in 2009–10; and 32 495 in 2010–11—into medical staff, such as doctors and nurses; ancillary staff; clerks, orderlies; PCAs; and cleaners? Do those figures include the additional 800 nurses?

Mr T.R. BUSWELL: Is the member asking for the number of miscellaneous workers' union members and others?

Ms J.M. FREEMAN: I was asking about nurses actually.

Mr R.H. COOK: It is not, member for Vasse, but the member has not been here all morning.

Ms J.M. FREEMAN: I advise the member for Vasse that if the minister wants to give me that information as well, I would be happy to hear it.

Has the department considered long service leave entitlements for nurses and other employees to bring them into line with other Western Australian public sector employees; and, if not, why not?

Dr K.D. HAMES: Can we deal with this in stages? The director general has carefully prepared for this question.

Mr K. Snowball: It would be helpful to give a breakdown of where we are right now in terms of employee groups, and then I will come back to a reconciliation of the member's request around 2010–11. The current position is that the estimated out turn for 2008–09 is 31 311. I will round the figures off. The figures are for nurses, 11 765; medical, 3 350; non-clinical—we can give a breakdown of these, but only into broader employment groups—admin and clerical, 6 300; hotel services is just under 4 000; and site services, 770. That is the breakdown. During the course of 2009–10, there were a few shifts, which we expect will continue. We have made major inroads into agency nurses. In percentage terms, we have halved the number of agency nurses the health system employs. We have converted those agency nurses into permanent nurses who are employed by the health system. We have increased nursing staff by about 330, and that includes enrolled nurses and registered nurses, while at the same time reducing the number of agency nurses. In fact one agency nurse costs us 1.3 FTE compared to one registered nurse. Making that move has been important to the department. In 2009–10 we have also had increases in medical support with just over a seven per cent increase, or 237 staff. At the same time, we have reduced admin and clerical staff by just under 3.5 per cent, which is a significant achievement in that 12-month period, and likewise in hotel services. We are able to demonstrate what has previously been talked about; that is, we have reduced admin and clerical staff within the health system while employing and investing in clinical services to meet the activity demands that have stretched us, and also made the shift from agency nurses to general registered nurses.

Dr K.D. HAMES: I will give more details of these exact numbers. The change in nursing staff from July 2008 to March 2009 compared with July 2009 to March 2010 was 539 additional nurses, with 177 fewer agency nurses; 237 additional doctors; and a specific reduction in non-clinical services of just under 400 staff.

Ms J.M. FREEMAN: My question actually was whether that figure includes the 800 nurses promised in the Liberal Party's election commitment? It appears that there have been only 539 additional nurses.

Dr K.D. HAMES: I do not recall an election commitment of 800 nurses in one year. Was that our commitment?

Ms J.M. FREEMAN: I do not know.

Dr K.D. HAMES: I am sure that we did not make an election commitment of 800 additional nurses in one year. I think we matched the Labor Party of the day's commitment, which was 800 additional nurses over four years. I do not have those election commitments with me. I know that we have matched the opposition's commitment, and that number is a significant increase.

Ms J.M. FREEMAN: Has the department made changes to long service leave entitlements for nurses and other hospital employees to bring them into line with other public sector employees; and, if not, why not? I also want to know the progress of flexible hours for nurses in terms of increasing their employment and the number of on-site childcare centres, and which hospitals have them?

The CHAIRMAN: I am not sure whether that is a specific item that relates to this division or a general question about policy. I will leave it to the minister's discretion.

Dr K.D. HAMES: Generally those detailed questions are asked in the normal fashion through questions on notice. Members put their questions on notice. I get questions like that from the member sitting to the left of the member for Nollamara.

Ms J.M. FREEMAN: I understand that, but many questions have been asked by government members that could have been put on notice. Perhaps the minister can tell me —

Dr K.D. HAMES: The difficulty is getting the details to answer the question for supplementary information. It is hard to write those down. I can get the answers quickly for the member if she puts those questions on notice.

[12.50 pm]

Ms J.M. FREEMAN: I will put them on notice, thank you.

Mr T.R. BUSWELL: Further to that point, can the minister provide some advice about the anticipated percentage increase in the wages component of the health budget this year, compared with last year. Last year, the wages growth was about 12 per cent. I do not know what it is this year.

Dr K.D. HAMES: That is a very good question. I do not have the information off the top of my head, but Mr Salvage will have it. It was about 12 per cent last year and I think that it is something in the order of three per cent to four per cent this year.

Mr W. Salvage: Final approved budget growth for 2009–10 is for growth of seven per cent over last year's actual expenditure and that compares with the growth of —

Dr K.D. HAMES: And wages growth?

Mr W. Salvage: I do not have the wages number with me.

Dr K.D. HAMES: The figure was 12 per cent last year and we have done exceptionally well to keep it in the range of three per cent to four per cent.

Mr T.R. BUSWELL: The point I was trying to make is that it is a fantastic outcome for good management.

Mr A.P. JACOB: I refer to page 181 of the *Budget Statements* and the third dot point under the line item "Friend in Need – Emergency (FINE) Scheme". Has the FINE scheme delivered on its key aims of delivering cost-effective community care and improved patient care coordination, and what is the total allocation to FINE in this year's budget?

Dr K.D. HAMES: Indeed, the FINE scheme is going exceptionally well. I have already dealt with this to some degree in previous answers. We have ascertained the funding split for the FINE scheme and how the funds will be spread. As I said before, that amount is now incorporated in the home services component of the budget. Silver Chain is working to a total full capacity of 500 places in terms of the support that it is able to provide for what it calls a hospital in the home program through FINE. Dr Lawrence will provide additional information.

Dr R. Lawrence: I cannot give a specific figure, but it is heading towards that 500 capacity. We always expected a ramp-up rate. The other components are also ramping up for the FINE scheme. There is the home hospital component, which is the hospital in the home scheme and a post-acute care support for patients in their home. In addition, emergency department care coordination teams are now pretty much in place on site and the complex care coordination teams are now in place and building their client base. The residential care line was

already in place and continues to grow. I think that we are well on track and that we expect 2010–11 to be the first full year of operation.

Dr K.D. HAMES: Further to that, I will ask Dr Russell-Weisz if he will advise how his division and, in particular, Sir Charles Gairdner Hospital are linking in with the FINE program.

Dr D.J. Russell-Weiz: At Sir Charles Gairdner Hospital, as Doctor Lawrence said, we have been ramping up our links with the FINE program to facilitate early discharge from the hospital wards and both emergency departments. In the early days, there were some problems getting enough buy-in to the FINE program; however, I can say that we have achieved most of what we set out to achieve in the past few months, but that there is more work to be done.

Dr K.D. HAMES: Thank you.

Mr A.J. WADDELL: I refer the minister to page 189 of the *Budget Statements*. The line item "Total Cost of Service" comes in at approximately $2.82 billion this year and approximately $2.98 billion next year, meaning that the net cost of service will go up $39 million. The Western Australian Department of Health receives $145 million in commonwealth funding, as mentioned in the second note point at the bottom of page 189. My question is: has the department used the commonwealth money to bolster the budget bottom line and does this mean that 87 per cent of the increase in the total cost of services is being met by the commonwealth government?

Dr K.D. HAMES: The commonwealth funding has always been difficult to merge into the budget, because—and it is a silly requirement in my view—when we get specific budget allocations from the commonwealth, we have to —

Ms J.M. FREEMAN: They do not want you to hide it!

Dr K.D. HAMES: Well, it is millions of dollars, but it should be a lot more. For example, we received in one year $70 million to help with emergency department management and we had to include it as recurrent income for that year, which in fact artificially inflates the amount of money we count as recurrent in a particular year. Treasury, in particular, looks at the budget and sees an X per cent increase, but a lot of that money is commonwealth money. That certainly was the case last year when we received a lot of commonwealth funding. I understand that there is not as much commonwealth funding this year as there was last year, but of course that may change if we reach agreement with the commonwealth government on the additional $100 million proposed for next year. But as I have said, it has the potential to push up the budget expenditure by two per cent. However, Mr Salvage will be able to provide more detail.

Mr W. Salvage: This relates to the receipt into the health budget of commonwealth revenue for capital programs. In each of the summary tables, we have a "Total Cost of Service" line, which is effectively the state budget for that item and a "Net Cost of Service" line that takes account of things such as own-source revenue. The income statement as a whole shows that we are trading on an operating surplus, and that reflects the fact that these capital amounts that come into the budget are not an expense and are not reflected in health expenditure; it is just the way that revenue from the commonwealth is receipted, which means that we have an imbalance between our revenue and our expenses.

Dr K.D. HAMES: And the reality is that that figure that was always meant to be spent over four years is recorded as recurrent income in one year. That is the case for many items, including the waitlist surgery funding that is recorded as one year's recurrent income. It makes understanding those numbers difficult.

Mr R.H. COOK: Minister, last week in the media, the Premier was quoted as saying that in the event the Western Australian government did not reach agreement with the federal government, the WA government would fund the full reform program proposed by the federal government, which I understand to be in the order of $350 million in 2010–11. Given those assurances, why has the minister not put forward the full program proposed by the federal government in this budget?

Dr K.D. HAMES: There are two issues and one is that the member for Kwinana's statement is not correct. The $350 million mentioned in the letter—of which I am sure the federal minister gave the member a copy—is $350 million over four years and not over one year. The breakdown of that over the four years includes the $100 million I have been talking about for this next year's budget that we still do not have. We are still negotiating with the commonwealth. Those negotiations have not ended.

Mr R.H. COOK: It is immaterial, is it not?

Dr K.D. HAMES: It is not immaterial, because if we come to an agreement with the commonwealth government, we will get that funding and the state government will not have to provide it. The issue is that there

are a number of requirements as part of that negotiation with the commonwealth: one is to adopt the four-hour rule—we are doing that; one is to bring in boards—we are doing that; and another is to deal with elective surgery. We have provided significant additional funds—contrary to what members may have seen in a report—for elective surgery and we are still getting money for elective surgery from the commonwealth. Therefore, a component of that money is additional money for the forthcoming year for elective surgery. If we do not come to an agreement with this federal government or an alternate government—should one be elected—we will have to look at seeking additional funding to maintain that level of surgery. Some of the components of that funding relate to things that we actually do, such as the funding for sub-acute care, which is something the commonwealth should provide and that is not related to what we currently spend. The additional funds for aged care were for replacement money to cover the fact that we are already funding aged-care places. About 74 people who should be in approved aged care are, at any one stage, in our hospitals. And that is not from a lack of state funding.

The CHAIRMAN: Thank you, minister. The time is 1.00 pm. The member for Kwinana is first on the list when we come back from lunch. The committee will adjourn until 2.00 pm and return to continue with this division. Thank you.

Meeting suspended from 1.00 to 2.00 pm

The CHAIRMAN: Member for Kwinana?

Mr R.H. COOK: I refer to the National Healthcare Agreement and the Closing the Gap programs on page 185. What is the breakdown between the federal and state funding for the Closing the Gap programs? What is the process for deciding which programs will be implemented?

Dr K.D. HAMES: I will have to get some advice on what the commonwealth funding is because I do not know exactly what the commonwealth funding is. I know what the state government funding is, and that is $117.4 million over the forward estimates. There is a range of areas where that funding is already being proposed to be expended. The first is tackling smoking and is $7 million over two years, which has increased access to smoking programs, community education and pharmaceutical support strategies, such as nicotine replacement therapy. Primary health care that can deliver is $35.4 million for increased access to primary care services, aimed at reducing the high burden of chronic disease in Indigenous families. Transition to adulthood is $44.8 million over four years, aimed at supporting Indigenous young people to adopt healthy lifestyle choices, with issues such as sexual and reproductive health, drug and alcohol and mental outcomes. The second last is making Aboriginal health everyone's business, and $9.8 million for services and programs aimed at improving health outcomes for Indigenous people in prison settings. The last is $20.6 million to help Indigenous patients go through the health system and get timely access to health care. So those are five key components. There are a couple of others. There is $17.1 million for element 2 of the early childhood development funding, which covers things like prepregnancy, antenatal, and sexual and reproductive health. There is $11.3 million over five years for element 3. A lot of these things are developed in consultation with the commonwealth government. As to the problem areas we have to tackle in Indigenous health, element 3 particularly focuses on maternal and child health strategies during pregnancy and for children up to eight years of age. That is the bulk of that funding. As I say, there was a lot of community consultation on that and consultation with commonwealth government agencies, working out strategies that integrated where our money went and where the commonwealth money went. Does the member want to know about commonwealth strategies? Ken Wyatt would be able to advise us, if the member wishes us to cover that. Remember, it is not our budget.

Mr R.H. COOK: I guess I am trying to get a feel for the division between state and commonwealth funds.

Professor K. Wyatt: The commonwealth budget comprises $805.5 million over four years. The first part of that is $161 million over that four-year period for tackling chronic disease risk factors. It includes providing 100 health professionals for both the Aboriginal community-controlled health sector and some of those positions going for divisions of general practitioners. The following year there will be a further 150 health professionals, with the third year being a rollout of a further 150 supported again by commonwealth arrangements. That will also include smoking coordinators within that process. The second part is $474 million over four years for improving chronic disease management and follow-up, which comprises better access to Medicare benefits scheme health checks and to pharmaceutical benefits scheme items. The third part is $171 million over four years for workforce expansion, training and support to increase opportunities for training for Aboriginal people employed within both the state divisions of general practitioners and the community-controlled health sector.

Dr K.D. HAMES: Can I just double check on that? Are those figures for Western Australia or all across Australia?

Professor K. Wyatt: Sorry, minister. It is nationally.

Dr K.D. HAMES: So, in effect, probably 10 per cent of those are coming to Western Australia, which is the usual rule.

Mr J.C. KOBELKE: Can the minister clarify that? Can he actually give figures for Western Australia rather than just an estimate, given that we have far more than 10 per cent of the Indigenous population of Australia?

Dr K.D. HAMES: Indeed, we have 26 per cent. Does Mr Wyatt know the answer?

Professor K. Wyatt: Those figures are still being broken down. There are some 20 positions allocated already to Aboriginal medical services, and my understanding is that there are a further nine to the divisions of GPs. These numbers will increase and are complementary to the work that the state is doing, and further, they complement the rollout of the commonwealth nurse visiting program in the home and Healthy for Life program. It is a coordinated approach between the commonwealth, the state and the community-controlled health sector and divisions of GPs. They are prioritising based on evidence-based approaches where the resources need to be allocated to and assigned, and there is an agreement between all four parties so that there is no duplication but in fact complementary work in the way that we address the health needs of Aboriginal people in the state.

Mr J.C. KOBELKE: Through the minister, we are trying to find out the amount of $800 million that is likely to come to Western Australia. Can we get any estimate at all? With basically 26 per cent of the Indigenous population, we should certainly be getting a quarter, should we not?

Dr K.D. HAMES: We should. The director general wants to add to the answer.

Mr K. Snowball: For the information of members, the way the commonwealth arrangements are constructed means that the commonwealth is relatively prescriptive about how it will allocate funds. The commonwealth generally does it by expressions of interest. It has not actually gone ahead and said that of the $800 million, this is the share state by state, but has gone out and asked issue by issue for expressions of interest from the Aboriginal medical services and GP divisions, and then made its decision about the distribution on those files on a program-by-program basis. We do not have a picture yet from the commonwealth about what our share looks like. We are certainly in there bidding for what we believe to be an appropriate share, given our higher degree of need.

Dr K.D. HAMES: The Aboriginal medical services are obviously trying to access those funds as well.

Mr R.H. COOK: I am trying to get a feeling for where this stuff is hitting the ground and trying to get a feeling for how it is decided where this stuff is hitting the ground, to get a picture of what some of these programs would look like. Will the minister talk me through the process? We have these allocations under these headings. What happens then in order to get the program moving forward?

Dr K.D. HAMES: The director general will answer that.

Mr K. Snowball: Through the minister, we actually ran a very significant consultation process with Aboriginal people on a region-by-region basis right throughout Western Australia. Nine regions have developed regional Aboriginal health plans. Those plans have been formed on the basis of consistent information about health issues for those regions, health risks and health service gaps. That information has been provided to Aboriginal regional health planning forums. Membership of those comes from the major health providers in those regions, by and large Aboriginal medical services, the area health services and GP networks.

[2.10 pm]

Others will attend also, such as the Royal Flying Doctor Service, which plays a significant role in the regions, and the commonwealth generally through its Department of Health and Ageing. Those planning forums have worked up and developed their planning approaches for that region in response to that information about health needs in those areas. They have consulted with communities themselves, as forums, in those regions. We went through a process involving the chairs of all those planning forums to consider the priorities across the state. There was a combination of regional specific responses to Aboriginal health needs through to statewide responses, where there are consistent issues across regions that make more sense to address on a statewide basis. The third group has been specialised services—for example, mental health in which we have specialist mental health services that we want to develop, or specialist women's and children's services—developing statewide initiatives in consultation with those planning forums. Every step of the way there has been good information about the gaps and issues. The total contribution relates to not only specific physical health issues; mental health issues are being dealt with as specialised health services, as are social and emotional wellbeing–type programs.

All those bids then came forward; they were assessed by the forum and recommendations were made. From that, the specific programs were approved.

Mr R.H. COOK: Is it the regional forum that makes that decision or the statewide forum?

Mr K. Snowball: Yes, the statewide forum. Each of the chairs of those regional planning forums comes together as a statewide group, and that is where the decisions on priorities et cetera on a statewide basis are made. We then have a process of allocating those funds, which is basically setting outputs, performance measures and so on for each of the agencies that is responsible for its part in delivering against the Closing the Gap programs. That is the process in broad terms.

Mr R.H. COOK: In the scheme of things, the chairs of the various regional health planning forums come together to make a decision. How does an anti-smoking program in the Pilbara compare with an anti-smoking program in the Mid West? How are the differences resolved if, for example, the GP network in the Pilbara says, "We've got the best program for this", and the AMS says, "No; we've got it."? How does the department resolve those differences?

Mr K. Snowball: There were agreed criteria for assessment of proposals that came forward. As a general principle, it was how the best return in health terms would be achieved. That was a key criterion. I do not have them all on me; this is from memory. The second one was achievability; in other words, how quickly a service could be up and running in those areas—what infrastructure was required. So it was a matter of building on services rather than trying to develop them from scratch, and making sure that every region got a share of funds to support its efforts to reduce the gap. It was a combination of those very specific three criteria. We worked through the epidemiology in deciding where we would get the best return in health outcomes. It was a combination of dealing with reducing risk—reducing tobacco consumption and the like—through to gaps in specific services that need to be filled.

Dr K.D. HAMES: My involvement in this has been relatively minimal. The COAG agreements were made before my time, under the Labor government's term. This initial process was set in place. Most of the discussions were between state and commonwealth offices in the agreed areas that would be focused on, and all that consultation process occurred. Those offices came back to me with areas in which that funding was proposed to be made. I did not interfere at all because it seemed to me they were targeting all those areas of need required, given the constraints of what was agreed with the commonwealth about what our areas of focus would be across the nation, not just Western Australia.

Mr R.H. COOK: Can I have a copy of the criteria?

Dr K.D. HAMES: I see no reason why not. A supplementary number is not necessary; we will provide a copy of the criteria.

Mr A.P. JACOB: I refer to Fiona Stanley Hospital under "Works in Progress" on page 198. I understand the minister has further information on medical equipment for the hospital. Can the minister update the committee on this?

Dr K.D. HAMES: During the break I sought some additional information from other staff about the equipment funding for Royal Perth Hospital and found that I had given some incorrect advice to the committee. I need to correct that advice. The equipment funding for Fiona Stanley Hospital was in two parts, set in place by the former government. I commented that there was no money in the budget when we came to government. That is not correct; there was. In the order of $145 million of the $1.76 billion was for furniture and equipment. That covered 80 per cent of the cost of the equipment required for those hospitals. The other 20 per cent was to be provided from the closure of Royal Perth Hospital as a tertiary hospital and significant downsizing of Fremantle Hospital. The issue I guess is what difference the retention of Royal Perth Hospital makes to that. We should remember that 20 per cent is not a large amount. If $145 million is the amount for 80 per cent of the equipment, we would expect about $30 million would make up the remaining 20 per cent. That was always a guesstimate because there was no way of knowing, as it turns out, 10 years down the track what equipment would be available from those two hospitals or, of course, the standard of the equipment. In my view, we do not want to put old equipment into a brand-new, state-of-the-art hospital. I guess the change from our keeping Royal Perth Hospital is that maybe less second-hand equipment will now go to Fiona Stanley Hospital and more new equipment will go there. Presumably people south of the river will see it as a positive benefit that they are more likely to get new equipment. Where will that funding come from? We are talking about $30 million total if we provide no equipment from the other hospitals. The answer, therefore, is that somewhere between zero and $3 million will be provided. My off-the-cuff assumptions that it may well be possible to provide the 20 per cent, given that 20 per cent of beds at Fiona Stanley Hospital represents about 120 beds. We will be moving 280 beds

from Royal Perth Hospital alone. I forget the exact number, but a significant number will be moved from Fremantle Hospital. The equipment may well still represent 20 per cent, but I want to make sure we have first-class equipment. We have just put $120 million into the budget for replacement of equipment. It may be that a lot of new equipment is available to move across, but we will deal with that issue when we get there, as the former government had originally planned to do, and make sure we have top-quality equipment. If we purchase a piece of equipment worth $1 million a year or two before moving—given that units such as the burns unit will be moved in total—so be it. In a $1.76 billion budget, I do not see a difficulty in finding $10 million or $15 million that we might need for additional equipment. I am sure the people south of the river will be very happy.

Mr A. KRSTICEVIC: I refer to service 6, "Patient Transport", under "Service Summary" on page 180. I note that $135 million for the 2010–11 year represents a substantial increase from the estimated actual of $113 million for 2009–10 year—an increase of about 16 per cent. What is included in the $135 million?

Dr K.D. HAMES: As the member can see, that is a significant increase. The 2008–09 actual was $100 million; the estimate this year is $135 million, rising to $148 million, $160 million and $178 million over the forward estimates. The final figure is a massive increase over the actual expenditure. That is broken down into three separate parts. One that I have already talked about is the St John Ambulance funding of $70 million in the first year and $150 million over four years. Additional funding for the RFDS amounted to $68 million. Members would remember that we made that commitment before the election, but that was a building amount. It is the same with the patient assisted travel scheme, which had a 50 per cent increase in funding, one that is the envy of all the other health ministers. It has received a significant increase in funding for people from the bush, especially those with cancer. All the rules, the funding and the regulations have significantly changed to provide better care for cancer patients who come to the city, increased funding for airfares in particular and also funding for people who accompany those who have cancer, the carers. There has been a massive increase in funding for transport, something that I think people in rural and regional Western Australia are extremely happy with.

[2.20 pm]

Mr M.J. COWPER: The minister mentioned that $150 million has been provided for St John Ambulance. Does the minister have any idea of the cost per head of delivery of the ambulance service these days?

Dr K.D. HAMES: Indeed, I do. Someone will need to remind me what the old figure was. We are moving to $48 per head. That compares to about $80 per head under the public system in Queensland and $65 to $70 in other states.

Mr M.J. COWPER: That does not include category 3 responses. Are hospital transfers included in that?

Dr K.D. HAMES: I think they are included in that. I will need to check afterwards and get back to the member. Part of the increase in the $153 million relates to a significant increase in transport officers.

Mr M.J. COWPER: I think the minister said that it was about $30 a head compared with, say, $60. It was nearly half of what it was in Victoria.

Dr K.D. HAMES: It was. Ours was around $30 and Victoria's was around $65.

Mr M.J. COWPER: It did not include category 3 responses, though.

The CHAIRMAN: Member for Murray–Wellington, it is nice that you are having a conversation but could you go through the chair?

Mr M.J. COWPER: I just wanted to clarify that point.

Mr R.H. COOK: Member for Murray–Wellington, the reason it is so much cheaper in WA is that the patient pays a higher proportion of the cost to St John.

The CHAIRMAN: Member for Balcatta.

Dr K.D. HAMES: It is true, but what is also true —

The CHAIRMAN: It is true that I have given the member for Balcatta the next question.

Mr J.C. KOBELKE: I am happy to pass over.

The CHAIRMAN: The member for Murray.

Mr M.J. COWPER: I refer to page 186. There was some talk about the meeting with the Council of Australian Governments. We are well aware of the situation in which this government has resisted jumping on the bandwagon with other states in relation to funding of our hospitals. Can the minister give us an update on where we are at with respect to that? I know there was a bit of an impasse. Have there been any developments since?

Dr K.D. HAMES: Things have reached a bit of a stalemate with the commonwealth government. I received a letter from the federal minister recently that goes through the details of what Western Australia will miss out on by not agreeing to that package. That is in the order of $350 million over four years. The year 1 component for Western Australia is about $100 million. A package was put forward from the commonwealth that had two components, one being the health component in which all states were required to do the four-hour rule, something that we are already doing, and the other is to have activity-based funding, something that some states are already doing. We had proposed it and we are starting from next month. We had to bring in boards. The commonwealth was talking about a board for a small collective group of hospitals—about five or six hospitals together. We have not supported that. By the end of the conversation, we were able to negotiate Western Australia having about six boards, those basically being north metropolitan, south metropolitan, one or two—probably two—country boards and perhaps a children's or a women's and children's board. It was agreed that Western Australia could do that. There was funding as part of the package for a range of incentives from the commonwealth, including increased funding for waitlist surgery and for aged care, recognising the fact that we have about 70-odd patients in our hospitals at any one time for aged care. The funding that we were going to get back was a long way short —

Mr R.H. COOK: I raise a point of order.

The CHAIRMAN: There are no points of order.

Mr R.H. COOK: Mr Chair, this substantially covers what we discussed before lunch.

Dr K.D. HAMES: The member has not heard the rest of it.

Mr R.H. COOK: I am sure the member could read *Hansard* and get the same information.

The CHAIRMAN: It is up to the minister to decide how he answers the question.

Dr K.D. HAMES: I did not cover all those areas earlier. I am providing information on additional things. Those additional areas of the funding that were to be provided, according to the letter from the minister, will not be provided. The Premier of Victoria put up a model that we strongly supported. That was the health component, a component from the commonwealth, saying that if we gave up 30 per cent of our GST, that would go into a common pool managed by the commonwealth. It would then say that despite the fact that it is still putting in only 42 per cent of the funds, with that money it would then be putting in 60 per cent of the funds. The commonwealth would then call it its own and because there were no majority funders, there was no incentive for it to push patients onto the public sector because it would be paying 60 per cent of the cost. We reached agreement with the Director General of Health, in particular, negotiating those things on all the health components of the package. We supported the Victorian Premier, supported, I might add, by the New South Wales Premier. We supported their proposal, which had all the rest the same. The difference is that we would put in the equivalent of that amount of money, 30 per cent, into a pool but not break the GST agreement. We would put up that money and preferably have it managed by the state, so the commonwealth would put in its matching money. We would have it in a pool and clearly account for how the money was spent on that activity-based funding. The reason the commonwealth wanted to do that is that in the past New South Wales in particular—this is its complaint—had been given significant amounts of money for health and had not necessarily spent it all and had not accounted for all the money. Its view was that it had reduced its own state contribution after getting those commonwealth funds.

Mr J.C. KOBELKE: Mr Chair, can I ask a supplementary question?

Dr K.D. HAMES: I have not finished answering this one yet.

Mr J.C. KOBELKE: The minister is just taking up time and avoiding scrutiny.

Dr K.D. HAMES: There is heaps of time.

Mr J.C. KOBELKE: This is general policy and the minister is saying things that he can say outside to the media.

Dr K.D. HAMES: There is lots of time left.

Mr J.C. KOBELKE: There is not; there are still another three portfolios.

The CHAIRMAN: Minister, could you tidy this up?

Dr K.D. HAMES: I will wind up. The answer to the member's question is that it is still in limbo. We wanted the Victorian model. The commonwealth said that we cannot have the Victorian model and either we are in or we are out. At present we are out.

Mr J.C. KOBELKE: The minister was referring in his very, very lengthy answer to the fact that he had a letter from the federal minister. If the minister has that letter from the federal government, is he willing to table it? If he does not have it, will he provide it as supplementary information?

Dr K.D. HAMES: I ask the Deputy Leader of the Opposition to correct me if I am wrong, but since he has been quoting those figures to me in the house, I presume he already has a copy.

Mr J.C. KOBELKE: That is not the issue. The minister has been quoting from it extensively.

Dr K.D. HAMES: I have not quoted from it at all.

Mr J.C. KOBELKE: The minister has been giving figures from it because that is what he said he was doing. Is he willing to make the full letter available to the estimates committee?

Dr K.D. HAMES: No, I am not. It is a letter from the federal Minister for Health and Ageing. If she gives permission to give the member the letter, I would be happy to give him a copy. I will seek her advice first.

Mrs C.A. MARTIN: I draw the minister's attention to "Works in Progress" on page 198. Halfway down the page is the line item "Kimberley — Various Health Project Developments". Can the minister explain what this is about? The estimated expenditure is $708 000. Just below it is the line item "Kimberley Renal Clinics — Kununurra and Derby". Can the minister also give us a bit of information about that?

Dr K.D. HAMES: I will do it in reverse order. We committed to expanding the regional renal clinics as part of the deal we did with the Kimberley Aboriginal Medical Services Council and the Broome Regional Aboriginal Medical Service. We said that we would expand that package of renal dialysis services. The $45 million is the commonwealth funding package. I am sure that someone here will have the break-up of those. We have done a whole range of different things, including the hospital that the member's federal minister was pleased to announce in Kununurra, and health accommodation packages in both Kununurra and Wyndham. However, I will leave the detail to Jeff Moffet.

[2.30 pm]

Mrs C.A. MARTIN: Further to the question, the Gelganyem Trust made available a certain amount as well for renal services. Is that a part of this?

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

Mr J.D. Moffet: Through the minister, the "Kimberley — Various" contained multiple programs across the Kimberley in terms of the $45 million. It included upgrades to Broome, Kununurra, Fitzroy and Halls Creek hospitals. There is some balance left in the program. Fundamentally, most of this program is complete. I am sorry; I missed the member's second question.

Mrs C.A. MARTIN: Just below that, can Mr Moffet tell us a bit more about what is happening with the renal clinics in Kununurra and Derby?

Dr K.D. HAMES: Can I just clarify? I have two positions. One of those was for projects we have already done—that is, the $45 million. Then there is an amount of $42 million, which is for projects to be done, and that is the commonwealth funding.

Mrs C.A. MARTIN: All the funds have not been expended as yet; is that what the minister as saying?

Dr K.D. HAMES: Mr Moffet?

Mr J.D. Moffet: There are various funds to come. Is the member referring to the "Kimberley — Various Health Project Developments" line?

Mrs C.A. MARTIN: I am only interested in the Kimberley.

Mr J.D. Moffet: Okay.

Dr K.D. HAMES: There are two. Where is the other one? I am sorry. If the member looks down the page, there are two lines. One is an east Kimberley development package, and the amount is $42.8 million. Further down the page, the other one is "Kimberley — Various Health Project Developments". That is the item to which the member referred.

Mrs C.A. MARTIN: Yes, that is correct.

Dr K.D. HAMES: They are the two items. Can Mr Moffet explain both of them?

Mr J.D. Moffet: Okay. The "Kimberley — Various" is a completed program that related to the major upgrade of infrastructure in the Kimberley. That included Derby, Broome, Fitzroy, Halls Creek and Kununurra. That was

the substantial program across those sites. That is complete. There is a new program funded essentially by the commonwealth around the east Kimberley development package. That is currently in train. That includes, for example, an upgrade to the Wyndham health facility of $3.4 million—that has occurred —

Dr K.D. HAMES: That was topping up our money.

Mr J.D. Moffet: Yes—to enhance the primary care capability of Wyndham. It includes a significant expansion to Kununurra hospital, which is primarily an ambulatory expansion, of $20 million. It includes the initiation of short-stay patient accommodation to support, for example, renal dialysis services in Kununurra, and that will be $4 million. It includes remote clinics and upgrades in Kalumburu and Warmun; that is $5.5 million.

Mrs C.A. MARTIN: Is anything happening at Oombulgurri?

Mr J.D. Moffet: There are environmental health measures in Kalumburu and Oombulgurri of $4.3 million; sobering-up centres in Kununurra and Wyndham of $600 000, which is an upgrade through non-government organisations; and health service provider housing in Kununurra, and some provider housing in Wyndham as well.

Mrs C.A. MARTIN: Is there more staff housing and upgrading of staff housing across the region?

Mr J.D. Moffet: There is in Kununurra for $5 million, and in Wyndham for $1.5 million.

Dr K.D. HAMES: But outside that, member, there is also the funding through the royalties for regions program of $22 million for Aboriginal health clinics. The first two of those will go into Mulan and Billiluna.

Mrs C.A. MARTIN: Mulan and Bililuna, where we used to have seatainers.

Dr K.D. HAMES: Having been to those places, I know that their health clinics are little boxes. There are no areas for men's and women's separation, which is critical in some of those areas.

Mrs C.A. MARTIN: But we are getting that, are we not?

Dr K.D. HAMES: The member is getting those too. We are looking at what we will do with the rest of the money. There is $6 million in the first year and $22 million in total over four years.

The CHAIRMAN: Members, we still have Indigenous Affairs, Fisheries and the Disability Services Commission to deal with.

Mr R.H. COOK: I am conscious of the time. Perhaps we could finish the discussion on Health and move forward to perhaps spend an hour on Indigenous Affairs to provide enough time to deal with the Disability Services Commission and Fisheries.

The CHAIRMAN: Is everyone happy with that?

Mr R.H. COOK: I am happy to get any feedback about that.

Mr D.A. TEMPLEMAN: We would need an hour for the Disability Services Commission.

Dr K.D. HAMES: I advised the Indigenous Affairs advisers to come at three o'clock, but we can chase them to get them here earlier. They are not far away. Perhaps we could just keep going until they arrive. Essentially, it is up to members opposite in terms of how much time they want to spend on each division. We have government members who want to ask questions, but estimates hearings are largely about opposition members having a chance to peruse budgets.

Mr R.H. COOK: Can we start Indigenous Affairs and defer topics on —

Dr K.D. HAMES: It is just that my advisers are not here yet. We are chasing them quickly.

Mr R.H. COOK: Do we need them?

Dr K.D. HAMES: It is always handy. If we have a couple more quick questions, there will still be two hours left.

Mr J.C. KOBELKE: No. There are three portfolios to deal with in those two hours.

Dr K.D. HAMES: When we were in opposition —

The CHAIRMAN: You are not in opposition now, minister.

Dr K.D. HAMES: — in the other chamber, we had 20 minutes on Indigenous Affairs, because the questions just kept going on the subject that was being dealt with before.

The CHAIRMAN: Estimates should not be held up because the minister's advisers are not here.

Dr K.D. HAMES: The chairman is right, but if other members have questions, presumably they are entitled to ask them.

Mr R.H. COOK: While we are discussing procedural matters, in the Health budget there is a range of mental health line items, and there are also line items to do with the Drug and Alcohol Office, as well as Mental Health capital project items. Am I able to ask those questions of the Minister for Mental Health?

Dr K.D. HAMES: Yes. The Minister for Mental Health will deal with all those questions.

Mr R.H. COOK: What about capital?

Dr K.D. HAMES: We can deal with Mental Health capital works, if the member wishes. I have outside the advisers for the Disability Services Commission. If anyone wanted to go to that immediately, we could.

Mrs C.A. MARTIN: We like that other minister. He is nicer!

The CHAIRMAN: Members, can we have a decision on this, please? Otherwise we are just sitting here doing nothing.

Dr K.D. HAMES: Why do members opposite not ask a question on Mental Health capital works and get that over with? Then we can switch to whichever division members would like to deal with.

Mr J.C. KOBELKE: I am willing to ask a question on that. The question goes to the Mental Health Commission. I am not talking about the general capital works. However, even just the setting up of the commission's office, I think, has been handled by Health, because there is certainly nothing in the Mental Health budget. To the extent that it is contained within the Health budget, can the minister advise what the establishment costs are for the commission?

Dr K.D. HAMES: I will hand that over to Wayne Salvage.

Mr W. Salvage: We have negotiated a budget separation between ourselves and the Mental Health Commission. In respect of the operations of the former mental health division, funding of $16.7 million was transferred from the Department of Health to the Mental Health Commission, and that is expected to cover its expenditure for the remainder of this year. That is funding that was budgeted for the former mental health division when it was a part of the Department of Health.

Mr J.C. KOBELKE: So this is just capital.

Mr W. Salvage: No. This is the operating budget for the remainder of 2009–10.

Dr K.D. HAMES: We particularly want to know about accommodation and the like. That was the intent of the member's question, was it not?

Mr J.C. KOBELKE: Minister, I am trying to comply with the standing order requirements and not ask something that is in another division. But we are aware that the Mental Health Commission does not have in its division any money for capital. That sits within the Health budget. Therefore, I think it is appropriate within the health portfolio to ask what capital expenditure is involved in actually setting up the new commission, as opposed to accommodation or new wards that may then deliver mental health services.

Dr K.D. HAMES: The funding for its accommodation and the like is part of its operating expenditure, because it is taken as a lease. I have a capital component paper that goes through some of the capital requirement budgets for the mental health components of lots of different hospitals—statewide, Broome, Graylands, Joondalup, Osborne Park and the like. There is a capital component in those. I suggest that I table this page that details those capital works components in mental health.

[2.40 pm]

The CHAIRMAN: The minister cannot table any document.

Mrs C.A. MARTIN: Just give him a copy.

The CHAIRMAN: The minister can provide supplementary information, but if the minister wants to give the member a copy, I am quite happy with that.

Dr K.D. HAMES: No, I do not want to provide it by way of supplementary information.

Mr J.C. KOBELKE: If the attendant could take a copy, that would be all right.

The CHAIRMAN: Members, if there are advisers from the Disability Services Commission here, why do we not have them in the chamber?

Mr D.A. TEMPLEMAN: Mr Chairman, I have a question. In relation to mental health and capital expenditure as it appears in the budget, I am interested to know what happened to the community-supported residential units that were planned for Peel. The original intention was that these units be built at the Peel Health Campus site, but there were some issues relating to the lease of that site. I want some clarification. Is there a capital works item that clearly determines that there will in fact be community-supported residential units built in the Peel region; or, if that decision has changed, what actually happened to that amount of money that I believe was in previous forward estimates?

Dr K.D. HAMES: Mr Chairman, I am not aware that we have the previous forward estimates here, and it is not possible to find the proposed works in the budget papers. I think we will provide that as supplementary information, Mr Chair.

The CHAIRMAN: Will the minister tell us what he will provide, please?

Dr K.D. HAMES: Perhaps the member for Mandurah could reiterate exactly what he would like.

Mr D.A. TEMPLEMAN: I ask the minister to clarify the status of the community-supported residential units that were proposed for Peel—they were originally proposed to be built on the Peel Health Campus site. I am after the status of those units; and, if they have been deleted, why?

The CHAIRMAN: Is the minister happy with that?

Dr K.D. HAMES: We agree to provide exactly the information in that request.

[*Supplementary Information No A30.*]

Mr R.H. COOK: I draw attention to Graylands Hospital redevelopment planning under works in progress on page 198. I am trying to find the budget documents from last year, but my understanding is that this was a development that was postponed in last year's budget. It was for the redevelopment of some of the most dilapidated and, quite frankly, depressing mental health wards in service. It would appear to me that there will be more planning and no construction at Graylands Hospital. I was just wondering what the government's intentions are for redevelopment of that facility.

Dr K.D. HAMES: This development is being managed by the Minister for Mental Health. My understanding is that he is developing a strategy to look at land availability at that site, and also at continuing the former minister's plan to move a great deal of those mental health services into the community, as occurred in Mt Hawthorn. The Minister for Mental Health over the next 12 months will develop a plan for the replacement of that extremely ageing building. The member is right: it is an extremely dilapidated building. It is not suitable, in my view, for its purpose, and we need a replacement for that building. It is not on our current capital works program. Obviously, it is something that we will need to commit to in the future.

Mr A. KRSTICEVIC: I refer the minister to page 194, service 9, on aged and continuing care. As we all know, aged care is the responsibility of the commonwealth government, but it impacts heavily on our public hospital system. What will the government do to address this issue in the coming years?

Dr K.D. HAMES: The former government funded beds referred to as CAP—care awaiting placement—beds and put a significant amount of money into holding patients in contracted beds in the aged sector while waiting for the construction of new beds, which is the responsibility of the commonwealth government. We had been hoping that the commonwealth government would find a way to increase the number of available aged-care beds. As I said earlier, more than 70 beds in our hospitals are occupied by patients who are eligible for commonwealth-funded aged care but who are currently sitting waiting for beds—this is the case in our tertiary hospitals in particular. The commonwealth government put up a new package as part of the national agreement on health. Some of that was to pay back state governments for the cost of caring for those patients in hospitals—although it was a very small amount compared with the actual cost for those patients in hospitals—and to fund a package to increase opportunities for aged-care associations to provide better accommodation. Sadly, the package did not do that. The commonwealth government gave a commitment to provide zero-interest loans, but it is not zero-interest loans that are the determinant of the ability of the private sector to provide those beds. The key problem is that the funding provided to look after patients in those hospitals is inadequate. Therefore, for those patients, particularly those in high care, the associations actually lose money. Low-care services are hanging in there all right, but high-care services are losing money. Often those associations prefer to have empty beds rather than lose money by having patients in there. It is therefore a dilemma. There is no easy outcome for the commonwealth government. It is easy enough to blame the commonwealth government—I have to say—but finding a solution is extremely difficult. Certainly the package that the commonwealth government has put forward now is not a solution. We will therefore continue to have, particularly in this state, significant problems.

The other issue is that the zero-interest loans were based on a cost per bed of $110 000. The cost in Western Australia is about $200 000, so the associations had to fund that additional money out of other sources that were not zero-interest-based loans. We have said that we are happy to work with the commonwealth government and the private sector, even looking at land that the state government owns, to find a way to improve the construction of aged care beds; but Western Australia in particular is miles behind the other states in the number of beds per head of population, and that will not improve.

The commonwealth government has provided additional home-care packages, particularly to Western Australia, which go part of the way to address the problem, but, sadly, it is not enough to resolve our issues.

Mr R.H. COOK: I return to the asset investment program. In 2009–10, the government opened the Fremantle community-supported residential units at Alma Street, the construction of which was criticised by the then opposition but, strangely, embraced by the now Minister for Mental Health. What other CSRUs are being planned for construction in the coming financial year, and what is the expenditure on developing these units in the out years?

Dr K.D. HAMES: I will ask the director general to answer that.

Mr K. Snowball: The usual approach with community residential services is that it is through housing and works, or what is now —

Mr R.H. COOK: Ah, different estimates!

Mr K. Snowball: However, obviously from the mental health service point of view and through the Mental Health Commission, it will be the commission's role to then commission and purchase services through those facilities. If I might add, the remainder of the capital program that sits within health represents a partnership between the commission and health; in other words health is here to administer and procure the infrastructure that supports the commission's investment in services.

[2.50 pm]

Dr K.D. HAMES: Now that I am reminded, that was always the case. As Minister for Health, I provide the accommodation for that sort of service and the same with disability services—we provide that accommodation to the Disability Services Commission. Our advisers from the Department of Indigenous Affairs are here now.

Mr R.H. COOK: The second part of my question was: what is planned for developing more community-supported residential units? Is the minister saying I need to talk to the Minister for Mental Health about that question?

Dr K.D. HAMES: The member does, because the Minister for Mental Health commissions those from the Department of Housing. The Department of Health does not play an active role in providing capital infrastructure for those services.

Mr R.H. COOK: The minister has no purchase order sitting on his desk from the Minister for Mental Health at the moment?

Dr K.D. HAMES: No.

The appropriation was recommended.