Division 8: WA Health, $4 123 267 000 —

Ms L.L. Baker, Chairman.

Dr K.D. Hames, Minister for Health.

Mr K. Snowball, Director General.

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

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

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

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

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

Ms J.E. South, Acting Executive Director, System Policy and Planning.

Dr A.G. Robertson, Acting Executive Director, Public Health and Clinical Services Division.

Ms J. Collard, Director, Aboriginal Health.

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

Dr R.M. Davidson, Chief Psychiatrist.

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

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

The minister may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. I ask the minister to clearly indicate what supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the committee clerk by Friday, 8 June 2012. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office.

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

[Witnesses introduced.]

The CHAIRMAN: The Deputy Leader of the Opposition had his hand up.

Mr R.H. COOK: My question relates to page 127 in budget paper No 2. I refer to $11.7 million in the line item "Savings Measure—Other Expenses Reduction" and $94.2 million in the line item "Efficiency Dividend". Can the minister provide a breakdown of the staff, services, programs, projects or capital works that have been cut, reduced or deferred to make these savings?

Dr K.D. HAMES: As I said in the previous hearing with Tourism, those decisions have not yet been made. The departments are working through opportunities that we have to recruit those funds. That will be made prior to the start of the new financial year.

Mr R.H. COOK: I appreciate that certainty. In relation to the efficiency dividend, it was perhaps last Thursday that the minister was told the department had to find savings of two per cent. The minister's department has already identified additional savings of $7.46 million this year and about another $25 million over the forward estimates. Surely the minister has had a closer look at that and understands where those savings will be found.

Dr K.D. HAMES: They are totally separate items.

Mr R.H. COOK: That is correct.

Dr K.D. HAMES: One has obviously just been posed; the other is something we have agreed to with Treasury previously. In fact, those savings measures have already been put in place. I will hand over to Mr Salvage to explain exactly where those savings have been made.

Mr W. Salvage: The $7.46 million expense reduction in 2012–13 relates to the decision the government made in the 2011–12 budget to apply a $300 million efficiency dividend to service delivery. That is Health's contribution to that overall savings target in the 2012–13 year. The breakdown of that number is as follows: the $60 000

relates to the abolition of the Physical Activity Task Force, and $42 000 relates to fleet savings through extension of leasing terms on government vehicles. There is a general appropriation reduction of $6.3 million yet to be allocated; there is $121 000 for fleet savings due to the refurbishment of government vehicles; $276 000 relates to a reduction in spending on external legal advice; $123 000 relates to reductions in travel; $4 000 relates to reductions in travel at PathWest specifically; and there is a $534 000 reduction for spending on administrative matters such as paper and printing and those sorts of things.

[10.40 am]

Mr R.H. COOK: Are any FTE reductions or operational staff associated with the $6.3 million that has been identified as general savings?

Mr W. Salvage: It is a general expense reduction, similar to the overall efficiency dividend of $94 million. The distribution of that expense reduction will be determined through the allocation process for 2012–13.

Dr K.D. HAMES: The director general wants to add to that.

Mr K. Snowball: The question was around FTEs. There is no specification for a reduction of FTEs associated with that particular reduction, so it is not specifically saying we should reduce FTEs in order to achieve it.

Mr R.H. COOK: But it does not exclude that.

Mr K. Snowball: Not directly, either way. We need to find an amount of money against those areas but a reduction in FTEs is not associated with it.

Dr K.D. HAMES: That $6 million represents 0.1 per cent of budgets. Most divisions will be able to find those reductions without needing to specifically resort to FTEs. In fact, our FTE demand is quite strong and our need for FTEs is strong, and I doubt very much that is what we will do to find those savings.

Mr R.H. COOK: I take up a point that Mr Salvage made previously. Am I to understand that the $11.7 million is a hangover from the previous efficiency dividend that the department was required to find?

Dr K.D. HAMES: Where is the $11 million? I do not see that.

Mr R.H. COOK: Sorry; it is $7.46 million. My apologies

Dr K.D. HAMES: The $7.4 million is from last year's budget.

Mr R.H. COOK: Sorry; $7.9 million. Is that as a result of the previous efficiency dividend drive?

Dr K.D. HAMES: No, not the efficiency dividend. There was a general amount across the whole of government in last year's budget. Rather than being allocated to specific areas, we were looking at opportunities to find savings across government. Some of those were identified and some were not. That was a $300 million reduction across government. In the end, it was divvied up and each department had to find that small amount of saving. As the member will see, $7 million is 0.1 per cent.

Mr R.H. COOK: That is spread over the forward estimates as well. Is that because the minister is anticipating not meeting future efficiency dividends?

Dr K.D. HAMES: It is not the case that we will have to do it again. Once we have made that saving, we do not have to do it again because we have that same saving for the following year unless we reintroduce whatever it is we stopped, to save. The forward amounts of $7.9 million and $8.5 million are not cumulative; they are a reflection of the original saving expanded in the dollars of the day and the expected increase in cost of whatever it is that has been cancelled.

Mr R.H. COOK: It depends where that cost is found. I accept that is over recurrent funding.

Dr K.D. HAMES: If we go to savings in fleet costs, for example, once we have made those changes, unless we suddenly have more vehicles or whatever, those fleet costs extrapolate into the forward estimates.

Ms J.M. FREEMAN: I refer to the major spending changes on page 127 of budget paper No 2. The savings measures and efficiency dividend included a freeze on all hiring of additional staff except operational staff within the Department of Health. Exactly what staff positions does the minister define as operational and non-operational? Does the minister consider, for example, all hospital staff to be operational or only doctors and nurses? Are managers operational? What about cleaners, who are keeping the environment clean and sanitised; catering staff, who prepare patient meals; personal care aides; and security staff, who keep the public safe? Are the administrative staff who process elective surgery applicants' paperwork operational or non-operational?

Dr K.D. HAMES: That is an excellent question. I will hand over to my director general to answer it.

Mr K. Snowball: In terms of the application of that efficiency dividend and the FTE cap, the FTE cap has essentially been applied to our public service positions within the Department of Health. As the member may be

aware, WA Health is made up of a public service agency, which is the department. Then we have area health services which are established under the Hospitals and Health Services Act. The definition under the Hospitals and Health Services Act relates to delivery of hospital and health services. The application of the freeze in WA Health will be to the Department of Health—that is, all administrative positions associated with policy, planning, legislative support and corporate support —

[10.50 am]

Dr K.D. HAMES: In effect, it is the Royal Street precinct and whatever buildings relate to that, but he is saying that it is largely Royal Street staff.

Mr K. Snowball: In respect of area health services, provided that there is a clear connection to hospital and health service activity and there is growth associated with that, services and full-time equivalents will be sought to match that activity growth. They are not subject to a freeze on FTEs.

Ms J.M. FREEMAN: Just to clarify that, is the director general saying that anyone who is employed under the provisions of the Hospitals and Health Services Act to deliver health services will not be subject to that freeze on staff?

Mr K. Snowball: The member might talk about individuals, but this is about a freeze on total FTEs—an FTE cap. That does not apply to hospital and health services. The member will see in the budget that there have been increases in certain areas, whether it be in child health or other areas. There is no freeze on FTEs to deliver on that increased activity or that increased commitment. The only freeze—that is, where we cannot increase the number of FTEs—is in the Department of Health.

Dr K.D. HAMES: To make that a little clearer still, under the new commonwealth–state arrangements whereby we provide a governance model for each region—we have the north metropolitan, south metropolitan, children's and two country services—they have a contract for service. We will provide contract funds for the provision of a service to that region. They employ whatever FTEs are required for them to deliver that service totally independent of the FTE cap. The people who do policy, write letters for me and study what health services need to provide—the Royal Street group in effect—have an FTE cap.

Ms J.M. FREEMAN: With regard to the FTE efficiency dividend and the answer to the member for Kwinana's question, the minister said that decisions have not yet been made about the two per cent cuts. Will the minister table in the future the cuts and the areas in which the cuts are made?

Dr K.D. HAMES: Again, as I said in a question on the previous portfolio, if members ask questions of the government about where the cuts will be made when the decision has been taken, we will certainly respond to those questions.

Mr A.P. JACOB: I refer to the table of appropriations, expenses and cash assets on page 127, particularly the total cost of services. I note that spending on health services is up $461.8 million this year from 2011–12. Can the minister please outline what this increase represents and what will be the overall effect on the Health budget?

Dr K.D. HAMES: The increase is a very good one for us when we consider that the increase in spend is after the efficiency dividend, so it means that we have a 7.3 per cent increase in our overall budget. Some of that increase is from state government funds and some is from commonwealth funds, but at the end of the day it is a significant increase. The increase in costs varies across the system. For example, we will increase the funding for non-government organisations by a certain amount, but in other areas in which demand is higher—for example, in emergency departments—a significant increase in funding is available. A good example can be seen on page 128, which shows that the estimated actual for emergency department funding is $430 million, increasing to $488 million. We have the flexibility and capacity to increase funding in those areas in which demand is higher. Across the whole budget, that is an excellent increase. We generally work on the fact that we have a consumer price index increase in the cost of running the health service. On top of that, we have another increase of about two per cent that is due to the ageing population and an increase of another couple of per cent that relates to the growth in the population from immigration. Those increases of course add up to larger growth in health demand than in other areas. It is good that we have been able to maintain that. It is good that the percentage of expenditure on health services as a matter of total state government expenditure has stayed at about 25 per cent for a significant number of years.

Mr R.H. COOK: I refer to the total cost of services on page 127. In relation to the 7.3 per cent increase, can the minister tell me what the current health service rate of inflation is in determining the current budget?

Dr K.D. HAMES: The director of finance will answer.

Mr W. Salvage: We would estimate the cost inflation rate for the whole of Health to be about 4.9 per cent. Cost growth in hospitals will typically be a little bit above that. Cost growth in areas of the budget such as the Department of Health—the department of state, if you like—will typically run a bit below that level.

Mr R.H. COOK: If the overall Health inflation rate is about 4.9 per cent, is it fair to say that this budget is looking at a 2.4 per cent increase on 2011–12 funding?

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

Mr K. Snowball: The Health budget is now essentially constructed around our clinical services framework, which predicts activity growth in the health system and in the hospital system. What the member is seeing in this growth of 7.3 per cent is a combination of recognition of cost growth in hospitals and health, plus recognition of the predicted increase in demand. That demand was built in in prior financial years, so that flow can be seen through our forward estimates. Each year we are allocated sufficient funds to cope with the activity that we are predicting in the hospital system, as well as funds to meet the increased cost of the provision of those services. That combination sees us provided with basically what we have predicted we will need to deliver against demand in this new financial year.

Dr K.D. HAMES: The system we have now is significantly better than the one we had previously. When Richard Court was Premier, I well remember him blowing his top one year when Royal Perth Hospital came in $100 million over budget. He put in place a system to change that, but it did not work all that well and the previous Labor government scrapped it. As I have said in the house before, when we came to government, the first thing Jim McGinty said to me was that we were $40 million over budget for the end of that year. We were over budget by much more than that at the end of my first year as minister. So we re-based the budget and, in our discussions with Treasury, we linked it directly to the predicted growth in demand, but it is flexible enough to take in the actual growth in demand on a year-by-year basis. After the midyear review, we got some additional funding in Health to reflect the actual growth in demands and costs. Twice a year we have upgrades of our budget to reflect exactly what comes through the doors.

Mr R.H. COOK: I draw the minister's attention to the fact that according to his own predictions, in the current year public inpatient services will increase by 4.6 per cent, emergency department services by 8.9 per cent and outpatient services by 7.3 per cent. The January to March figures already show an 8.3 per cent increase in separations in hospitals in the metropolitan area alone. If that is taken into account with the 4.9 per cent health service inflation rate, Health is essentially flatlining for the following year because demand is completely outstripping the rate of funding increase.

Dr K.D. HAMES: The member made that point during his speech.

Mr R.H. COOK: That was before I even knew the minister was looking at 4.9 per cent.

[11.00 am]

Dr K.D. HAMES: Yes, I know, but let me just point out, though, that the 7.3 per cent growth in budget is across the total budget—I made that point earlier—because some components, including the ones the member just listed, grow faster than 7.3 per cent and others do not. The cost of our public health services is significantly less than the $6.762 billion total budget that we have. Therefore, there is the capacity within the increase in the total budget to have increases in the areas that the member described, which have a faster rate of growth. The member said that we are flatlining. What we are doing is exactly matching our funds to areas of demand and to growth in demand. They do not all grow at that same even rate that the member just described; some go up faster than others. That is why we have this predictive model that is adjusted twice a year to reflect what actually comes through the door. If that $6.762 billion is not enough to pay for the services we need to provide for the number of people, on the figures the member has just given, who rock up at outpatient clinics or come through the door, our dollars will be adjusted midyear—increased midyear—to reflect what the actual demand is. This is our predicted cost as we see it now. Twice a year that is reviewed.

Mr R.H. COOK: Given that all the minister's demand indicators are well north of the 2.4 per cent real activity increase, the minister will have to put his foot on the hose on some sort of activity, will he not, in order to keep pace with this; or does he just expect Treasury to top it up?

Mr W. Salvage: Just picking up on the point that the minister made, there is movement in the budget every year. If we look at what was predicted expenditure in 2011–12 at this point—the budget point—last year compared with what we are looking at for 2012–13 at this point this year, we can see the figures from the appropriation table. If I refer the member to the total cost of service line, he will see that the actual planned growth at this point compared with the same period last year is 8.1 per cent. The difference between the 8.1 per cent and the 7.3 per cent is that approved budget adjustments came into the budget during the course of this year, and some of those

are detailed under the major spending changes table on that same page. The basic point is that there are adjustments to budget as we go through. If we are looking at planned spending for 2012–13 at this point, compared with planned spending for 2011–12 at this point last year, the actual growth is 8.1 per cent.

Mr R.H. COOK: But that is still short of the demand growth across a range of activities.

Dr K.D. HAMES: The director's comment responds to that additional comment.

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

Mr K. Snowball: Our activity predictions have proven to be extraordinarily accurate. In the last two years we have been within less than half a per cent of the actual demand that we have had to manage against the model predicting that demand. This year, what we have predicted we are seeing coming through, so this current financial year we will land pretty much right on that activity level. We are not expecting any sudden changes next financial year, but if there is a significant change, we have the opportunity to take that forward to government when that activity goes beyond what is predicted—the population grows faster and so on.

Mr R.H. COOK: On that point, the minister has admitted in this place on a number of occasions that demand is significantly higher than anticipated in the last budget. The department is already $50 million out between estimated expenditure this year and its budgeted expenditure last year, so I am not quite sure where the director general says the department is spot on. Given that some of those figures are around eight per cent—for instance, I think it was 7.3 per cent for emergency departments—my friend here the member for Joondalup will attest that in Joondalup alone we are looking at a 20 to 25 per cent increase in ED use. We are now looking at a 2.4 per cent real increase in health expenditure, with demand right across the service areas significantly higher than that. A figure of 4.6 per cent was the most modest one that the department has had. There was a figure of seven per cent; I saw eight per cent as well. As I said, separations at metropolitan hospitals alone were about 8.3 per cent in the last quarter, so I am not quite sure how there can be such a modest increase in budget, yet the department says that it thinks it will be on top of demand, which is clearly running well and truly beyond current budget measures.

Dr K.D. HAMES: That is just not accurate. I get back to the point that was just made about landing within the predicted estimates. The member has to remember that it is a $6.5 billion budget; it is not a $650 million budget. The member says $50 million as though it is a lot of money, and to the member and to me it clearly is, but $50 million is less than one per cent. If any major corporation, at the end of the year's spending, can end up with a figure that is within less than one per cent of the predicted budget, that is very, very close. I can tell the member that that is extremely well appreciated by Treasury, when we have had significant budget blow-outs in the past. The member said that we can just go to Treasury for that extra $50 million. Yes, we can, because we are so close to the prediction of what our budget should be. The member's former leader, who was Treasurer, would have died to get figures coming in that close to budget predictions. Last year we landed within less than one per cent of budget. This year we will do the same. We base it on the same sorts of predictions and the same sorts of growth. The member talked about the growth in Joondalup. We know about that growth in Joondalup. That growth in Joondalup is factored into our growth demands and our funding pressures. We are able to fund those additional services and hit the nail on the head again.

Mr M.P. WHITELY: Obviously, there are areas of activity that are much higher than —

Dr K.D. HAMES: I am sorry; we need a page and a line item.

Mr M.P. WHITELY: No. This is just a follow-up question on the same point. The minister must have a global activity percentage for the increase in the level of predicted case delivery. There has been mention of seven-point-something per cent in some areas and eight-point-something per cent in other areas, but the significant factor here is: what is the global figure for activity increases anticipated?

Dr K.D. HAMES: That is the figure that we have in front of us. We have gone to budget with the funds that we need to provide that —

Mr M.P. WHITELY: No. What is the global figure for case load?

Dr K.D. HAMES: That is it.

Mr M.P. WHITELY: I am not interested in a dollar figure. The minister has talked about 7.9 per cent in some areas and 8.3 per cent in other areas. What is the global activity figure?

Dr K.D. HAMES: I am sorry; I misunderstood the member's question, but the director understands it, so I will direct it to the director, who will further direct it.

Mr K. Snowball: I will introduce Dr Dorothy Jones. Before I do that, in terms of the way in which we predict the activity growth, Dorothy's area is the one that sets the activity levels using the global figure. When we have faster increases in growth in particular areas over others—that is, when we look at how we make the adjustment, respond to the growth in one area and manage the growth in other areas.

Mr M.P. WHITELY: In the end, the department must come up with a global figure.

Mr K. Snowball: That is the process. I introduce Dr Jones.

Dr D. Jones: As I understand the question, the member is seeking the actual number of activities that have increased year to year.

Mr M.P. WHITELY: Yes. Obviously, they have to be weighted for their importance. However, when they are summed altogether, what is the global percentage increase in anticipated activity, because that will illuminate the conversation that the minister and the shadow minister have been having?

Dr D. Jones: If we look at 2010–11 figures, we see that the inpatient activity was 560 602; in 2011–12, it went up to 586 428, and that was a percentage growth of 4.6 per cent. In 2010–11, emergency department activity was 784 183, and in 2011–12, emergency department activity was 853 890. The percentage growth was 8.9 per cent. In outpatient activity for public hospitals only, 2010–11 activity was 1 260 594, and 2011–12 activity was 1 351 953. The percentage growth was 7.3 per cent.

[11.10 am]

Dr K.D. HAMES: For example, large growth in emergency department demand, as we have heard, is not necessarily reflected in that size of increased cost for that ED. It has only resulted in a four-point-something per cent increase in demand in the hospitals, which is where most of our costs are incurred. That is why I get back to the point that the 7.3 per cent increase in total budget certainly gives the capacity to address those differences in growth.

Mr M.P. WHITELY: With respect, it does not. If there is a 4.9 per cent health price inflation—I think there was an average, but if we take a crude measure—the average of those figures quoted would be about seven per cent. The minister is about five per cent shy of being able to deliver. Obviously 4.9 per cent inflation is case related.

Dr K.D. HAMES: The member is using the word "inflation". Mr Salvage used the words "growth in cost". They are not the same. I will ask the director to address that difference in terminology.

Mr K. Snowball: In terms of increased activity, there is not a direct correlation between activity increases and a quantum increase in all services of the same size. In our system, where there is capacity and there are increasing numbers through an emergency department, if there is capacity in there, it is actually a lower unit cost for each subsequent activity that comes through the door. Alongside that, we have efficiency measures that prove their worth in terms of dealing with that extra demand without necessarily increasing resources to the same level. The four-hour rule —

Mr M.P. WHITELY: We are arguing economies of scale.

Mr K. Snowball: Exactly. The four-hour rule, for example, has meant we are able to deal with more patients coming through our emergency departments than we could prior to the four-hour rule—at a better per unit cost to the state. Yes, we have a recognition that there is cost growth but we also are managing our resources in a way that ensures we can meet this demand.

Mr M.P. WHITELY: So the 4.9 per cent is not a per unit cost inflation?

Mr K. Snowball: That is right. It is global. We are operating at two levels here—one is the allocation of funds to the system as a whole to meet what we see as predicted demand on our system. When we drill that down to ask, "Does that mean we can meet the activity coming through our hospitals?" the answer is, yes, we can, on the basis that we have both lower per unit cost in our system—it is actually a reduced cost per episode of service—plus we have our efficiency programs and productivity measures and reforms going on that, which also help us deal with increased demand. In fact our system has dealt with increased activity and at the same time improved quality and safety outcomes. We are delivering to the state, within our budget envelope, a better outcome. In fact last financial year we ended up delivering more activity than we were budgeted to provide because we were able to drive those reforms.

Mr M.P. WHITELY: What does the 4.9 per cent figure mean? That is what I am entirely confused about.

Dr K.D. HAMES: If I could give an example. Suppose we have to buy a $100 gizmo. The price goes up to $110 when we have to buy it next time. That is 10 per cent inflation. Instead of using it 10 times a day, we use it 15 times a day, so the cost per time it is used goes down. We are not saying that —

Mr R.H. COOK: We still pay 10 per cent.

Dr K.D. HAMES: The actual increase in the cost of providing a particular service is whatever that amount is.

Mr M.P. WHITELY: Does the minister have a specific per case inflation rate, and what is it? Obviously the minister is arguing it is not 4.9 per cent. What is the per case delivery inflation rate? We can then add that to the increase in case numbers. Again, I did not get a global figure; I only got several sub-global figures. If the minister is arguing it is not 4.9 per cent, what is it?

Mr R.H. COOK: It is not 4.9 per cent now that it is inconvenient to the minister!

Dr K.D. HAMES: No. The point he makes is a good one.

Mr R.H. COOK: I asked this specific question. The minister is now saying he did not answer that question. I asked: what is the health service rate of inflation? Is it 4.9 per cent or is that some other figure the minister has come up with?

The CHAIRMAN: Member for Kwinana, allow the minister to answer the question.

Dr K.D. HAMES: I heard the answer that was given to the member for Kwinana. He talked about costs. Both members are making very good points. We are not arguing with them. We are trying to work out what exactly the answer is.

Mr M.P. WHITELY: We want to know the per case rate of inflation.

Dr K.D. HAMES: We will have to provide that by way of supplementary information. We have there quite clearly what the growth in cost is but we do not have here now what the actual inflation rate per service is.

Mr R.H. COOK: The minister made specific reference to "health service inflation" on page 129 of the *Budget Statements* under "Significant Issues Impacting the Agency". If this is a significant issue impacting on the budget of the agency, surely the minister has a number and it should be foremost in his mind as to what this actually represents. This is in the first paragraph on page 129. It is also a concept referred to by a lot of health stakeholders. I would have thought it would be of acute interest when it comes to explaining the budget and the actual increase in funding. The minister said it is 7.3 per cent. If the inflation rate is at 4.9 per cent, that means we only have a 2.4 per cent real increase in funding.

Dr K.D. HAMES: That whole paragraph needs to be read. It surely talks about health service inflation using the inflation rate. It states it is —

> … an ongoing challenge in the face of activity and price pressures emanating from an ageing population and rising community standards, health service inflation …

That is a component of that cost. The answer given was that the cost of providing that service includes the inflation rate, if we like, of the cost of buying the gizmo. Evolving medical technologies, rural and remote service delivery and so on is also mentioned. There is a range of different things that contribute to the increase in cost growth. The point we make is that we have clearly predicted models of what that growth in cost will be. It incorporates all of those services. Our predictive modelling has been very accurate for the past two years. There is no reason whatsoever to suspect it will not be accurate in years to come.

The CHAIRMAN: I will give the member for Bassendean a further question, but before I do that, I want to confirm whether the minister has agreed to provide supplementary information. I have to be clear about this.

Dr K.D. HAMES: We can provide for the member as a supplementary answer the cost per weighted episode.

Mr M.P. WHITELY: If he can provide that, and the expected global case load increase.

Dr K.D. HAMES: Yes, we can provide that also.

Mr M.P. WHITELY: Then we can do the simple maths and figure out whether 7.3 per cent is adequate.

The CHAIRMAN: The minister is happy to provide that supplementary information and I am happy that he has stated exactly what that information is.

[*Supplementary Information No A23.*]

Mr P. ABETZ: I refer to the heading that is pretty close to the top of page 130, "Significant Expansion of Community Child Health Services". Three dot points follow that heading. There is an additional $58.5 million over four years. In the budget of 2010–11, $49.7 million was allocated to improve access to child development services. Could the minister inform us what progress has been made over the past two years in community child health, what areas the additional $58.5 million will be spent in and the anticipated outcome of that expenditure?

[11.20 am]

Dr K.D. HAMES: I will ask Phil Aylward to respond to that question.

Mr P. Aylward: I understand that there are two parts to the member's question. One related to child health, the other to child development services. In relation to child health, the extra uplift in funding will deliver a substantial increase in resources and investment, in both the metropolitan and country areas, of equivalent to about 100 extra staff. That is off the back of approximately 350 staff who are engaged in total across metropolitan and country areas. It is quite a substantial uplift in resources. We will continue to partner with a range of service providers, which will allow us to improve the screening rates across the seven screening points that we need to target. We do that in conjunction with other primary care providers, such as general practitioners and non-government organisations that might be working in rural and remote areas. In addition, we will commit to providing 100 per cent of those screening services to children at the highest need end—that is, children in care of the Director General of the Department for Child Protection. In our screening of women who are vulnerable from postnatal depression, this resource and investment will allow us to target those mothers and families in a far more comprehensive way. It is a substantial increase. It will make a profound difference in our ability to screen children who need the intervention of other service providers in a far more timely and accessible way. The feedback we have received from the community about this change and investment has been exceedingly supportive.

In relation to child development services, the earlier investment of two years ago has seen waiting time rates fall by approximately 50 per cent. That was a commitment that Health made in relation to that investment. It has changed slightly because we have also seen—as we predicted and wanted—a vast increase in the number of referrals. Referrals have increased by about seven per cent over the last two years. More people are aware of the services available in child development services. These are children with developmental delays who previously had to wait long periods before they could access services. In addition, the number of cases that we have seen over the last couple of years is approaching a 20 per cent increase—an uplift in services for children across the metropolitan area and in country areas as well. Again, it has had a profound increase. We are partnering with a lot of non-government service providers to deliver these services, because specialised assessment and treatment services are provided. That too has proven to be very successful. We anticipate that through the further rollout of those strategies we will be able to tackle the wait times even further. Basically, the objective is to get children ready for school and to be able to maximise their potential by going to school ready.

Mr A.P. O'GORMAN: In that answer Mr Aylward mentioned four areas of screening. Can the minister provide an idea of those four areas of screening?

Mr P. Aylward: We actually undertake seven points of screening. I am sorry if that was not communicated correctly in the first response. The first screening is a crucial one, a nought to 10-day child check. The final screening point that we identify is entry to school assessments. There are various categorisations based on the best available evidence that we have on milestones of child development, learning capacity, emotional wellbeing and play capacity.

Mr A.P. O'GORMAN: Is glue ear picked up in that screening? It is a detriment to learning. Do the Departments of Education and Health track the improvements in kids who have been picked up and who have received treatment?

Dr K.D. HAMES: Glue ear is picked up in the standard hearing test. They do a tympanometry test, which measures the pressure of the ear drums. For the last part of the question, I will hand over to Mr Aylward.

Mr P. Aylward: It is a very good question. It is something we know anecdotally in the very short uplift in the resource. The feedback we get from school principals and teachers is that there have been quite substantial differences. The gold measure is the developmental index that this state participants in. We will be able to measure what improvements this investment brings over time. That is clearly a goal we have in terms of educational outcomes.

Mr A.P. O'GORMAN: Reference was made to the Australian Early Development Index. Should those figures improve significantly in the next few years?

Mr P. Aylward: Yes, indeed. There are other factors that contribute to that index and improvement. But intervention in the early years of a child's development has demonstrated a causal impact in improvement in outcomes, including educational outcomes.

Mr A.P. O'GORMAN: I refer to vaccination rates in Indigenous communities. Obviously extra child development nurses will help pick that up. What improvements or increases are expected in the area of vaccinations?

Mr I. Smith: The outstanding regions for immunisation are the Kimberley and the Pilbara, where the vast majority are done by our community health staff. We run at statistics in excess of 90 per cent in those communities. Where we share the immunisation provision with GPs and other service providers in the southern area of the state, our figures range from 82 per cent to 85 per cent. Certainly in the northern areas we do an exceptional job with immunisation.

Ms J.M. FREEMAN: It has been said that the child health initiatives would be given 100 extra staff. Will they all be child health nurses or will they be other staff?

Dr K.D. HAMES: Of the $58 million, $40 million is additional funding for the contracting-out of services. Groups such as Silver Chain, for example, do a lot of those sorts of things with child health nurses. An $18 million component is coming through our growth funding. It will be used for direct employment to add to our additional staff numbers. They will be doing a combination of those two things to grow the numbers we need across the system. For example, some of those in remoter regions might have partnerships with the Aboriginal medical service. We will use that money on a variety of methods to deliver that service.

Ms J.M. FREEMAN: So the $58 million is not to employ 100 extra staff and $40 million will be used to contract out services. Are those services directly for the employment of child health nurses?

[11.30 am]

Dr K.D. HAMES: The member says that it will not cover the employment of 100 extra staff; it will. Not all of them will work for the public sector, so that will include the additional staff who we anticipate the private sector will also employ to deliver that service. It is all about delivery of service—the best and most appropriate place to do that and the best method of doing that. We anticipate 800 extra staff; I cannot tell the member at this stage what the $18 million will buy in additional staff compared with what the $40 million will provide in additional staff.

Ms J.M. FREEMAN: How many FTEs does the minister anticipate will be employed out of the $40 million by contracting or privatising-out the services to Silver Chain?

Dr K.D. HAMES: My answer is the one I just gave: we do not know; it depends on the market.

Ms J.M. FREEMAN: Will they be nurses?

Dr K.D. HAMES: Almost inevitably; I think, inevitably. There will be some administrative staff needed along the road to increase support for those members, but, by and large, yes, they will be nurses.

Ms J.M. FREEMAN: The minister said earlier that he currently contracts out to organisations like Silver Chain to supply child health nurses, or, if not to Silver Chain, to wherever else he contracts out to deliver child health nurses. What is the cost per FTE of those child health nurses the minister contracts out?

Dr K.D. HAMES: I do not think we contract any of the child health services at present. There are some school nurses through Silver Chain.

Mr K. Snowball: There is a combination of arrangements. For example, in some of our country centres where we might have a single clinic for a small community, it will do a range of things for the community, including first aid–type responses but also child health support for the community. There are examples, particularly in the country, where the same nurse will do a range of things in that community. The arrangement in those circumstances is quite different from a dedicated child health nurse in a clinic in the metropolitan area.

Ms J.M. FREEMAN: Can the minister not say what the cost per FTE will be to contract out for a child health nurse?

Dr K.D. HAMES: Not until we test the market is the answer. We do some already.

Mr K. Snowball: We do not have a precise number. We can certainly provide that information, but it will be an average. As the member knows, child health nurses are also across a scale, so there are different nurses at different levels and so on. We can give the member an average for a dedicated child health nurse in a clinic in the metropolitan area, which would then give the member a feel for the sorts of cost —

Ms J.M. FREEMAN: Contracted out?

Mr K. Snowball: No; I am saying our costs. When we go to the market, part of that market sounding is: what can the private sector or non-government organisations do to deliver that same service? It gives us a benchmark, if you like, to do that cost.

Ms J.M. FREEMAN: I am seeking the cost per FTE of a contracted-out child health nurse. My next question was to be: can the minister give me the cost per FTE of a directly employed nurse? The answer I have been

given, as I understand it, is that all the minister can give me is the cost for a directly employed nurse. If the minister is about to contract out to achieve 100 staff in an absolutely important and critical area of need that requires something like 250 staff, where is the business case to show that a contracted-out nurse is comparable with a directly employed nurse in terms of service and cost? The minister cannot deliver those cost figures to me. That is really my question: can the minister give me the cost of a directly employed FTE and the cost of an externally employed FTE, taking away things such as capital or administrative costs? I just want the cost of directly employed community nurses to deliver very important community child health in our community.

Dr K.D. HAMES: The member is right in her assumption that we cannot do that. We can give her only the cost of the existing service, but we have very good relations with organisations providing other services in the community. For example, Silver Chain provides the Hospital in the Home service to the community. The figure of 100 is predicted as if it were to cost the same as what it currently costs; that is roughly how many we would get. It is a service that we contract for, and we will go out to the market. We do not want to go to the market and say, "This is what we're going to pay you per service." We would not get any competition in the marketplace if we were to do that. It is a service that we require, and we will go to the market for the delivery of that service. That is how we will do it.

Mr A.P. JACOB: I refer to the seventh dot point on page 130, which refers to Royal Perth Hospital. There is an allocation of $22 million commencing in 2014–15, with a total commitment by the government of $180 million. Could the minister please explain what is happening with the allocation commencing in 2014–15, whether some further detail can be provided on the future of Royal Perth Hospital, and what is planned to address the government's commitment to retain the hospital?

Dr K.D. HAMES: I have covered that question to some degree in reply to a question that I had in Parliament not that long ago—a good dorothy dixer from the shadow minister! I will reiterate that the $22 million is the committed amount, because that is all we can do in the forward estimates. I remind members that it is not just the government that did that; I well recall Swan District Hospital Campus having $140 million allocated under the previous government, even though the total commitment was more than that because some was in the out years. We all do that; we cannot put that in the actual budget figures. This was the result of a very strong request on my part to ensure I got the words in the budget to say that we will provide $180 million. Members can imagine that that gives me far greater argumentative power in making sure that we get those funds in future budgets. It might not be exactly $180 million because we have to go through the final business case to get there; that is an estimate of funds based on the estimated cost of a total refurbishment on a floor-by-floor basis. When 280 beds move from Royal Perth Hospital to Fiona Stanley Hospital, it will give us capacity to have all patients in the north ward and the cathedral side of the H-shaped building, A block, so we can carry out refurbishment on the Wellington Street side. Maybe we will do it all at once or maybe we will do it floor by floor, but whichever way, we will have to work on that. It will be a total clean-out and refit on a ward-by-ward basis. That is the plan and I think it is a good one.

I would have liked to have built the west wing; members know that we committed to doing that, but I have had to go back on it for two reasons. Firstly, we are yet to build King Edward hospital, we are yet to expand Armadale Kelmscott District Memorial Hospital and we are yet to rebuild the Quadriplegic Centre. There are huge capital costs still coming in critical areas of health, and while we still have a good structure to the building at Royal Perth Hospital, it would not be responsible to bowl that over, even though I think the outcome would be better. Down the track some time, I think that may well happen, but for now this is the next-best option, which is the total fit-out of a structurally sound building. It will still retain Royal Perth as a major tertiary hospital in this state, and it will continue to see a significant number of patients through its emergency department, which is critical to its ongoing function.

[11.40 am]

Mr R.H. COOK: I have a follow-up question; the minister may have already done it. The member for Ocean Reef sat on a committee which had other associated stakeholders on it, and which provided a report to the minister in January 2011. I wonder whether the minister would be prepared to table a copy of that report.

Dr K.D. HAMES: I decided not to table it. I decided that—it is probably my own fault—because I was looking at how I could best sort out not just what needs to happen at that hospital but also how we could get there and how we could fund it. The committee looked at a range of different things, including what to do with the rest of the land at Royal Perth; whether there would be opportunities to move the people into the main hospital building when Royal Perth downsizes; what we would be able to get from selling that land; and what opportunities there would be for redevelopment. The committee talked to groups such as the universities and so on. At the end of the day, I realised that that is not what I should be doing as minister and that that is not what we should be doing in Health. We should not be sorting out what is going to happen to the land afterwards and trying to find a way to

fund it. I came back to the core issue: what do we need to do to the hospital? We have used part of the work for that, but instead of me trying to find the money, I have just gone to Treasury to get the money and then it is up to it and LandCorp to sort out what to do with the land that will be no longer required in the future to try to recoup some of those costs of the hospital. I realised that there was no way that we could generate enough money from that land to build the new west wing; it is just not worth enough money. It was my hope that I would be able to match one with the other and so not cost the Treasury or the taxpayer additional funds. It was just not possible. I am not releasing that report, because it is really not that relevant. The work was valuable to me, but as a public document it does not have value, because that is not what we are doing anymore.

Mr R.H. COOK: Nevertheless, some good policy would have gone into it, so it probably would be a useful document to have in the public domain, would it not?

Dr K.D. HAMES: I looked at it and I did not reach that conclusion. It was valuable to me and valuable to Health but of no value as a public document.

Mr R.H. COOK: On what basis does the minister think that the public should not have access to that document?

Dr K.D. HAMES: It was prepared at my request for me to help guide directions that we might want to follow.

Mr R.H. COOK: What is in that document that the minister is trying to hide?

Dr K.D. HAMES: Nothing.

Mr R.H. COOK: In which case, make it publicly available.

Dr K.D. HAMES: No.

Mr R.H. COOK: The minister talked up this report over the course of two years. The member for Ocean Reef never missed an opportunity to get up in Parliament and talk about the great work that was done on it. I assume a certain amount of expense was associated with it. There should not be any problem in making a copy available.

Dr K.D. HAMES: At the end of the day, the decision was made to not release that because it was not relevant to the direction that the government intended to take.

Mr R.H. COOK: Minister —

Dr K.D. HAMES: Is this an additional question?

Mr R.H. COOK: There is a mountain of public debate on how the minister will redevelop Royal Perth Hospital, and now he is saying that he will not make available the report that he is going to rely upon to make that decision.

Dr K.D. HAMES: That statement is not correct, because I am not going to rely on the report. It provided valuable advice.

Mr R.H. COOK: How much did the report cost to put together then?

Dr K.D. HAMES: Is this an additional question? Which page line item does it relate to?

Mr R.H. COOK: How much did the report cost?

Dr K.D. HAMES: The members who were on it were largely government and staff members, so obviously they did not cost anything.

Mr R.H. COOK: They did cost something, because you paid them to be there.

Dr K.D. HAMES: It did cost something. We had Greg Joyce do some work on that.

Mr M.P. WHITELY: The minister did not like it, so he is ignoring it and not making it public. That is obviously the case.

Dr K.D. HAMES: No. I do not know exactly what that cost was.

Mr R.H. COOK: Can I have that information as supplementary information?

Dr K.D. HAMES: Sure; I will provide as supplementary information the cost of the report. We might have it. We might be able to find it by the end the estimates, so why do we not just put that on hold and the member can ask me again?

Mr R.H. COOK: I have fallen for that trick before.

Dr K.D. HAMES: We will do it. If the member does not get it, we will provide it as supplementary information.

Ms J.M. FREEMAN: I want to stay for a moment on the subject of community health nurses and the new community child health initiatives on page 127 of *Budget Statements*. In the previous discussion on the anticipated 100 extra staff, it emerged that it is not known whether there will be 100 extra staff because the

health department is not employing 100 extra staff. How many will be school health nurses? Are they included in that 100 extra staff?

Dr K.D. HAMES: Sorry; I did forget to respond to a comment that the member made about the total number being 200-and-something. The Education and Health Standing Committee said there needed to be, I think, 150 additional child health nurses and 120 school health nurses. That was based on figures that we were given.

Ms J.M. FREEMAN: That is 230 if you add the two.

Dr K.D. HAMES: Yes, I know. That was based on figures by the health department. The health department has done a lot more work on that since and will be making a further submission to the committee on the actual number it believes it is, which is not that high. I made the statement in the house the other day that this money will be used for child health nurses, and there is a job still to do on school health nurses. That has yet to be budgeted for. We have now addressed two out of three parts of the committee's recommendation. One was the people who look after speech therapy and the like. That was just under $50 million over four years. The second component is this, which covers the issue of child health nurses. We have yet to address the issue of school health nurses. An additional number is needed—whatever that number may be. What the government has done, through the Minister for Education, at those 10 sites is make sure that those school health facilities will be on site, and we will support them by ensuring that they are properly staffed.

Ms J.M. FREEMAN: Of those 10 sites, obviously the minister is aware of the one that exists at Westminster Primary School in the electorate of Nollamara. Has the school health nurse at that site been taken out of a community centre and placed into the school?

Dr K.D. HAMES: I have no idea. Mr Aylward, do you know the answer?

Ms J.M. FREEMAN: At all those 10 sites, are they additional staff or have they come out of existing state child health clinics?

Dr K.D. HAMES: Mr Aylward will answer. But as part of that answer, for the benefit of those sitting around me, I remind everyone that we have a 7.3 per cent increase in the budget that accounts for growth in services. There will be growth of services required in school health as part of that, so I would strongly anticipate that additional funding will be provided by the people on either side of me to make sure that those school health services grow in line with the growth in demand, even though we do not have the capacity to build it to what it needs to be without supplementary government funding. I will go now to Phil Aylward for the specific answer.

Mr P. Aylward: Certainly, the initiative of the 10 child and parenting centres is very welcomed by the sector. It will involve using models that will be locally based. We anticipate that there will be a transfer of existing resources—that is, child health nurses that are based in the community so that they can be at the centre of the community at the school and provide better access to screening and referral opportunities. In addition, with the extra funding we have, we will be able to place additional staff in those centres. Again, we are working through the details, as we will do over the coming month, to find out exactly the additional numbers that will go into that area. But it is certainly anticipated that where there are gaps, they will become the community hub, if you like, or child and parenting centre for that community, and we will direct our effort and investment in those centres.

[11.50 am]

Dr K.D. HAMES: The short answer is "yes", but I will add more information. I do not know about the member for Nollamara's electorate, but in my electorate nurses in child health services also work in school health services; the one nurse does part-time in one and part-time in the other. There is flexibility across these things.

I certainly remember from when I was on Bayswater council that in most instances councils provide child health clinics and the government pays the rent. The problem with that is that councils always say that the rent is not adequate to properly maintain the buildings, so they get tired and rundown. Hence this proposal, which is really a trial, to move those services onto the school site, which is a good location because most parents go to school sites. We do not want to discourage those who might be at a private school and do not want to go to the other. We need to make sure that we cater for everyone in the community. That is the plan. Some staff may come from the local community that is old and rundown and move into the new centre, but total numbers will grow. That is why the answer is yes.

Ms J.M. FREEMAN: Has the department closed any state child health clinics with the opening of the 10, and how much has that saved the government in rent? Has the minister closed any?

Dr K.D. HAMES: I am advised that the answer is none.

Mr A.J. SIMPSON: My question relates to page 131 and the second last dot point under "Infrastructure", which refers to the southern inland health initiative. This year the initiative involves $565 million over five years going

into primary health care centres, small hospitals, nursing posts, telehealth and residential aged and dementia care. Can the minister tell me about the progress the department has made over the past years and plans to make in the coming years?

Dr K.D. HAMES: It is a massive investment as we know. An amount of $565 million has been allocated over five years for the southern inland health initiative. It is something we probably should not had to have done. The federal government has responsibility for the provision of primary health care services. In the past we have tended to contract out for doctors. A GP clinic has to provide coverage at our hospital. The problem and downside of that is if a GP is sitting in a surgery full of patients and someone has cut themselves—not as badly as Mr Snowball—and gone to the hospital, the GP has to leave his patients and go to the hospital. He was probably already running half an hour late and once he has gone to the hospital and come back, he is an hour and a half behind. That totally disrupts the practice.

A lot of country centres have trouble getting doctors because he or she would be the only one working on-call 24 hours a day in a little country town. They have trouble getting locums and doctors cannot go away for holidays. It is a huge burden. Doctors do not want to do that anymore. The package does a few key things. It upgrades the standards of the hospitals in those country towns, particularly in central hospitals such as those in Northam, Merredin, Katanning and Narrogin. The initiative upgrades those core hospitals. We fund the doctors to form a team, so someone is in the emergency department for part of the day and then on immediate call, which means they must be within 10 minutes of that ED after hours. That is all they do. Therefore, they do not have to run back and forth to the wards. We pay them sufficiently so it is not an economic loss for them to sit around in our EDs if patients do not turn up. Those doctors also provide outreach services to smaller towns. If a local smaller town does not have a doctor at all, we look to having a doctor go there for three days a week and a nurse practitioner go there for the other days. If that town is able to get a doctor of its own, we will provide support services for them. We will help cover things such as when doctors go on leave or on holidays. They can participate in the roster if they want. They have to be close on the night they are rostered on-call. That gives them freedom and provides coverage.

There is big funding in telehealth so that we can have telehealth linkages from all those little hospitals through to places such as Royal Perth. If a country town hospital has an emergency, the staff can ask someone for help. Telehealth also helps with outpatient clinic appointments so that people do not have to travel. A big component is training the doctors and nursing staff—all the allied health—to use telehealth so that it is used easily and efficiently. Telehealth can be used to help to set up clinics with the patient at one end and a service provider at the other. It also helps with the aged-care problem, which is, again, a commonwealth problem, but the funding packages are simply not working. That additional funding helps link with the private sector and supports the private sector in making a cost-efficient model to provide that extra care.

The southern inland health initiative is a comprehensive health package by which we are recruiting extra doctors. We were just down in Esperance with the member for Eyre recently. Already one or two additional doctors have been employed down there. While I was there, I met a husband-and-wife doctor team who were there on only a temporary basis and had been planning on leaving. They said they would now stay in the town because the model was so much better. We gained two extra doctors because the system is better.

I have given the long answer. I will ask for a very brief addition by Mr Smith from the WA Country Health Service because it is his baby and he is pretty proud of it.

Mr I. Smith: The minister spoke about the doctors. The other component of that is the capital. Clearly, we have been doing a lot of service planning with the communities, local government and staff around what we will do with all these sites for the future so that the infrastructure builds and changes reflect those needs. That includes a comprehensive condition audit of all the facilities to make sure that we prioritise the investment going forward. That work is occurring now and will occur over the forthcoming 12 months.

Dr K.D. HAMES: We have 45 doctors in the pipeline to come here. We will not get all of those, but there is a lot of interest in the package. That could solve our problem with the lack of doctors.

Ms J.M. FREEMAN: Is that doctors from overseas?

Dr K.D. HAMES: Yes—the UK in particular.

Mr R.H. COOK: My question relates to the southern inland health initiative. Recently in questions on notice the minister pointed to some pretty scary statistics on vacancy rates for midwives and obstetricians right across that southern area. I thought I would give the minister an opportunity to talk about how, for instance, he will fix up maternity services at Katanning District Hospital.

Dr K.D. HAMES: I thought the member misused those figures that I provided.

Mr R.H. COOK: I am sure the minister does!

Dr K.D. HAMES: I went through those figures afterwards. I have to say that I do not blame the member totally, because he is in the opposition and —

Mr R.H. COOK: I am sure they bore the minister's signature at some point.

Dr K.D. HAMES: It probably did, but I did not notice. It was not exactly clear that a lot of those obstetrician positions were for GP obstetricians. The member will notice that the statistics showed a deficiency in Collie, for example, but we do not provide them. It is not as though they are missing from our public hospitals. Collie is short two GP obstetricians. A lot of those things are things we do not have responsibility for as a government. The Deputy Leader of the Opposition extrapolated that to say that it was the case in Katanning. In fact, the deficiency reported in Katanning at that time was zero. The member could not say it was lack of staff in Katanning that led to what happened there. We developed problems in Katanning subsequent to the answer being given to the member.

Again, it is not government services. In fact, it is the member's federal government services that are lacking in provision of those —

[12 noon]

Mr R.H. COOK: It is not mine, minister.

Ms J.M. FREEMAN: It is every federal government.

Dr K.D. HAMES: It is a federal government responsibility. As I said previously, it did not just happen under the Labor Party; it happened previously with us. It is really an efficiency that the commonwealth should be addressing. Whether it is the Labor Party in government or our party, it should have been addressing this issue of country health services and it has not. The states had to take over that role. It is a shame but I do not see any change coming in the future. If the federal government had invested this $500 million instead of us having to do it, we would get the same outcomes we look like getting with the plan we put forward. The director general wants to make a quick comment.

Mr K. Snowball: While we have vacancies in the country, the vast majority of those vacancies are covered by locum arrangements in the short term, or agencies. Often it can be characterised as there being no doctor. In fact, there is a doctor but we are still trying to recruit a permanent one. We are able to keep those positions with doctors in them.

The second point of interest is that there has been a big effort through Health to get more of the interns and junior doctors spending time in the country. We have almost tripled the number of junior doctors now working in country settings. Unlike other states, WA has quite a high degree of GP proceduralists. Twenty-five per cent of our doctors in country areas can also practise as GPs or do other procedural work. The national average is about 12 per cent. Not only are we recruiting more GPs into the country but also we are trying to increase the skill levels of those GPs who are out there so we can continue to provide services such as obstetrics in places such as Katanning.

Dr K.D. HAMES: That was another deficiency in the answer I gave. We do have staff there but they are agency staff. They are FTE positions that are unfilled that we are advertising for. We do have someone there doing that work. Perhaps if the member asks the question again, I will get a better answer next time.

Mr D.A. TEMPLEMAN: I refer to the first dot point relating to the home and community care program under "Continuing Care" on page 141. I refer to concerns that have been raised by people working in the traditionally low-wage area of service delivery and the government's injection of funding to non-government sectors, including HACC services. The concern is that a lot of that new money has not flowed through to workers who are in those low-paid sectors. Can the minister tell me whether the health department is monitoring the flowthrough of moneys to non-government agencies to ensure that that money is flowing through to where it is needed—to low-paid workers? I know that the minister is aware of the wage and funding issues with Mandurah HACC. I would like the minister's comment on that.

Dr K.D. HAMES: With regard to the latter, I hope the member can resolve that. Mandurah HACC came to me the first time when I was in opposition and I sorted it out. I got its funding increased at the time. Hopefully, the member can do the same.

In relation to the NGO funding, this is a whole-of-government policy, not a health department policy, in terms of the position for NGOs. Mr Salvage has the answer to how that is organised. As a government, we decided not to direct that people specifically increase wages. We were largely leaving it up to NGOs, the services themselves. Their complaint to us all the time was that they did not have the funds to pay their staff adequate wages. They

had trouble attracting people or retaining people doing those jobs. A lot of the time people were doing it out of the love of doing it. We did not want to dictate because we knew that some people were virtually working in those organisations as volunteers because they wanted to be there. Those organisations might need those funds to get additional people who wanted to work and did not require the full level of wages that another agency would get if it was working for the public sector, for example. I will hand over to Mr Salvage, who will have a more definitive answer.

Mr W. Salvage: The value of the NGO uplift funding, if we can call it that, that came to Health in 2011–12 was $11 291 000. That is on page 127 of the *Budget Statements*. We went through a process with central agencies of government to define eligible bodies to receive the 15 per cent increase. Once that determination was made and announced by the Premier, the funds flowed to those agencies. Those funds form part of the contract between the Department of Health and the relevant agencies. As part of our management process, we ensure that there is full acquittal against the funds that have been received.

Mr D.A. TEMPLEMAN: I refer to Mandurah HACC as one example where concerns have been raised that pay rates have either not increased or declined slightly. Does the department not have some responsibility in monitoring the impact of what that money was originally given for? I am a little confused by the minister's answer to me at the beginning of his remarks in terms of me fixing it. I am not in a position to fix it; I do not have a chequebook like the minister. I am really keen to ensure that the quality services that Mandurah HACC has and continues to provide are provided. Those workers are on relatively low incomes, with many of them paying mortgages on wages of $30 000 to $40 000 a year. They are in my electorate and the minister's electorate. They have written to me and I am sure they have been in contact with the minister's office. I am seeking some commitment from the minister to ensure that their concerns are addressed, but, at the same time, to ensure that Mandurah HACC's functioning is not compromised.

Dr K.D. HAMES: I go back to what occurred when Mandurah HACC came to me when I was in opposition. The federal cabinet of the day, which I think was a Liberal government, put in a pay scale that people working in HACC needed to be paid to bring them up to a reasonable wage level. It was supposed to be phased in over three years. At the time, Mandurah HACC immediately increased wages to the final level that was recommended and as a result had significant funding difficulties because it was not funded to that extent at the time. That was partly due to its own management. I do not know what happened this time because it has not come to me this time; it went to the member.

Mr D.A. TEMPLEMAN: I have written to the minister specifically about this.

Dr K.D. HAMES: I am saying that Mandurah HACC did not come to me; it went to the member. I have not seen the letter from the member; it is with the department. I do not know how it is paying its staff this time. Last time I went to Jim McGinty, who organised a review of what it was doing, so the HACC staff went down to Mandurah and went through the books and worked out that it was paying more than is required under this regime, and it also affected the services it was providing. I think we found a mechanism for a temporary increase in funds to offset that, but by then it was reaching stage 3 anyway so the future funding levels were adequate. I do not recall what the member has written to say exactly how it got to this position this time, but I could ask my staff to ensure that whoever is responsible follows that through and investigates.

[12.10 pm]

Mr D.A. TEMPLEMAN: I am happy to leave it there on that particular aspect.

Can I raise one more question about Peel Health Campus? I note the completed works detailed on page 145. Peel Health Campus is mentioned twice in the table. One line item is for the completion of the emergency department expansion, which I think was over a year ago at least, and the other is for the theatre cooling system, which is under the heading "Metropolitan Plan Implementation". Are there any other outstanding maintenance issues to be resolved at Peel Health Campus; and, if so, what are they and when will they be resolved? Has the minister been approached about expansion plans by the private operator of Peel Health Campus in relation to its contract arrangements, and can he indicate its current contract time line?

Dr K.D. HAMES: I will deal with the last part of the question first and then I will hand over to Nicole Feely. In terms of approaching us for an extension, I had a meeting that included Mr Fogarty a fair while back largely about the payment rates for the support workers, and I expressed my point of view that that payment was inadequate. At that meeting, he raised the issue of a potential negotiation about the extension of the lease relating to an expansion of services that it would provide. My response was that we would consider that when he presented us with a proposal. To this stage, no proposal has been put forward. My understanding is that the existing contract goes to 2017 or 2018. No further action will be taken by us until he puts forward a proposal. I will ask Nicole Feely to respond to the other parts of the question.

Ms N. Feely: We meet with Peel on a monthly basis, so issues of maintenance form an ongoing discussion. I think $2.46 million has been set aside for maintaining Peel on a fit-for-purpose basis. At the moment, my corporate operations team is conducting with Peel an audit of the premises to properly identify what priority should be put on what issues moving forward.

Mr D.A. TEMPLEMAN: The cooling of the theatre was important. That was a major issue.

Ms N. Feely: That has been completed.

Mr D.A. TEMPLEMAN: I am interested in whether there are any major outstanding maintenance issues.

Ms N. Feely: Not to my knowledge, but I can take that on notice and I will come back to the member. It has not been raised with me.

Mr D.A. TEMPLEMAN: If the minister does not have it to hand, he could provide —

Dr K.D. HAMES: The answer is no, but if we find something, we will come back to the member. It is not supplementary information; it is personal information.

Mr P. ABETZ: I refer to the second dash point under the heading "Infrastructure" on page 131 about the $1.2 billion new children's hospital on the Queen Elizabeth II Medical Centre site. Construction was scheduled to commence in early 2012. When I drive past it, I note that there seems to be heaps of activity. Can the minister inform us how the work is progressing and what progress is being made towards the construction of the multideck car park, as car parking is one of the big issues that staff have raised as a concern?

Dr K.D. HAMES: I thank the member for that question. Certainly, it is going well. As he drives past, he will see that the cranes have arrived. The car park is well under construction. I will get Dr Russell-Weisz to talk about that progress in a moment. Construction of both the car park and the new hospital is going particularly well. I ask Dr Russell-Weisz to tell us how we are going.

Dr D.J. Russell-Weisz: Firstly, you mentioned the multideck car park. We have obviously had a lot of activity on site over the last six to nine months. We expect to get the first stage of the multideck car park back in mid-October, and there are plans for that. We will get 876 bays from the multideck car park back at that time. The next stage will come back in April next year when we will get further bays—probably an additional 800. Further stages, which will be built over the next two years, will come online when the new children's hospital comes online. We expect the whole multideck car pack to be functional by mid-2014. There has been some disruption to staff, as the member mentioned, and we have provided parking at Graylands Hospital and free shuttle buses to the site. I think the rapid erection of the car park has pleased most staff. We are slightly ahead of schedule and aim to have that first stage open in October this year.

Dr K.D. HAMES: I ask Dr Aylward to tell us about the children's hospital at the same location.

Mr P. Aylward: The basement structure is nearly complete, and very shortly a contract will be let for the steel superstructure. We anticipate that that will be issued to the market quite soon, along with the external facade—that is, how it will look and feel. The schematic design phase has concluded. We are now very advanced into the detailed design, so we are on track for its full completion in late 2015.

Mr R.H. COOK: My question also relates to the infrastructure investment program. Specifically, I refer to the item listed in the completed works on page 146 for the upgrade of the Health Corporate Network human resources information systems. Specifically, I want to get an appreciation of what the information and communication equipment upgrade will do in relation to that HCN system. The minister may or may not be aware that there is a great deal of anxiety amongst the workforce that HCN just cannot get it right. One particular study I looked at that was undertaken this financial year considered 129 pays over some time. It showed that in 43 per cent of cases, HCN actually got the pays wrong; so in only just over half of those cases, it got it right. The average error for those pay rates was $846, so the minister will understand that this is a substantial amount of money across the health workforce. How does HCN get it so wrong and for so long? I understand that this is of acute interest to the Australian Medical Association. What is being done to correct these problems? Will this investment mean that whoever is calculating these pay rates will, for instance, get a new calculator? How do we make sure that we are paying people what they are owed?

Dr K.D. HAMES: I was under the impression that HCN was a baby of the former government, but I am told by the director general that he thinks it is a fantastic service. I have been getting feedback from the member about all these problems, and particularly from the AMA about the payment of medical staff. However, I am told just now —

[12.20 pm]

Mr R.H. COOK: I spoke to one doctor who was about 20 grand out of pocket.

Dr K.D. HAMES: Yes, that was the case; I remember that particular case. I am told that it is now much better, so hopefully the answer back to the member will be —

Ms J.M. FREEMAN: It is from a low base.

Dr K.D. HAMES: — gang busters. The director will go first, and then Mr Aylward.

Mr K. Snowball: Perhaps I can clarify a couple of points about the Health Corporate Network, because it is not there just as a payroll service; it also does procurement for the entire system. It provides a range of services, and most of those it provides very, very well. On the payroll side —

Mr R.H. COOK: Are its hit rates as accurate in terms of procurement?

Mr K. Snowball: That is what we will go to. In procurement and the processes in procurement, it has done a terrific job. We have regular audits of our procurement processes—not only internal audits, but also audits by the Auditor General—and they have shown HCN, in particular, to be performing well. We also looked at comparisons against the wider shared services operations within the public sector, and HCN stacks up far better than those services.

Mr R.H. COOK: At 43 per cent?

Mr K. Snowball: On the payroll side, it is quite a difficult job to do, because there are 40 000 employees across the system, and those awards and enterprise bargaining agreements are quite complex in terms of getting it right. However, we have introduced processes to improve the performance and improve the error rates. I will perhaps ask Phil Aylward, who looks after HCN, to elaborate on that performance.

Mr P. Aylward: The ongoing savings to Health and to government are approximately $57 million per annum. That is a combination of both procurement savings across centralising our payroll service and very important accounting functions. We have done a lot of work on improvement of service provision, but it is a very complex payroll with multiple databases. We have an improvement exercise underway with a replacement payroll system, which has only partly commenced through the system. There is more work to be done, but on the efficiency and performance, as measured by a range of indicators, in comparison with other similar services in other jurisdictions in other states, HCN certainly is performing at a sound and reliable level. However, that does not take into account that from time to time there are errors in payrolls that need to be, and are, corrected when they are brought to HCN's attention.

Ms J.M. FREEMAN: Given that we are asking a question about completed works and the HCN human resources information system, which is the information and communication equipment and infrastructure upgrade that finishes in 2011–12, and Mr Aylward's comment that there is still more work to do and further upgrades are happening, where is that budgeted for in the rest of the budget?

Dr K.D. HAMES: Good question.

Mr P. Aylward: The transfer of this program has gone into the health infrastructure network, through the information and communications technology budget, and the final deliberations for the continuance of that program are yet to be determined. However, there is a live project that has the software already deployed. It is already deployed in my hospital, Princess Margaret Hospital for Children, and at King Edward Memorial Hospital, and we have a program to roll this out in subsequent years. However, it has been transferred—maybe the chief finance officer could explain this a bit better—out of that line item and rolled into the ICT infrastructure.

Dr K.D. HAMES: On the previous page, page 145, we see the amount of $60 million for information and communication technology.

Ms J.M. FREEMAN: Is it "Information and Communication Equipment and Infrastructure" on page 145, followed by "COAG Four Hour Rule Solutions—ABM/Decision Support System"?

Dr K.D. HAMES: At the top of page 145?

Ms J.M. FREEMAN: Yes. Is it the "COAG Four Hour Rule Solutions—ABM/Decision Support System" —

Dr K.D. HAMES: No.

Ms J.M. FREEMAN: — or the "Corporate and Shared Services Reform"?

Dr K.D. HAMES: It is that one and the one below. There are two line items.

Ms J.M. FREEMAN: Is it "Information and Communication Technology"?

Dr K.D. HAMES: Yes.

Ms J.M. FREEMAN: I see.

Mr R.H. COOK: I will come back to the issue. At the moment, according to my information, the department is looking at about a 43 per cent success rate in getting someone's pay right. What is the minister's key performance indicator? What does the minister think is a satisfactory number to hit?

Dr K.D. HAMES: Far less than that, and I am told that it is much better than that now. That percentage is not current. Mr Aylward?

Mr P. Aylward: I do not have the information that the member has available, but our performance is successful on most occasions in that the pays are correct. We would not accept an error rate of 40 per cent at all. However, the performance of getting the pays on time and accurate is a key requirement for HCN, and on most occasions we are successful, as demonstrated by the number of queries we get back from individuals at the end of each pay cycle.

Dr K.D. HAMES: I will just interrupt there and say that I think more needs to be done. The member's question has highlighted an issue that needs to be sorted out. We will get HCN to report specifically on percentage rates of successful management of wages. I am thinking that a default rate of less than five per cent would be acceptable, although we need to make comparisons. I am just plucking that figure out of the air really. We need to see what the rate is for other pay systems. Clearly, we need a system which reports that and which has those figures up to date and accurate. It should be in the budget.

Mr R.H. COOK: It should be in there, yes.

Dr K.D. HAMES: It is one of the KPIs, in fact. And we need to know the success rate in achieving those outcomes. I indicate to the committee that by next year's budget we will have that in place. Obviously, we will start that well before then, and I would be happy to report to the house in a few months to say what we have done with that item. It will be a good exercise.

Mr R.H. COOK: I thank the minister for that response. It is important that we get this right because, as the minister is acutely aware, we are competing with other states for a workforce, which, quite frankly, we will be less attractive to if we cannot get their pay rates right. What has also been put to me —

Dr K.D. HAMES: It depends. Are they overpaid or underpaid? It depends, does it not?

Mr R.H. COOK: What has also been put to me is that part of the problem at the Health Corporate Network is a cultural problem; that is, when staff question the accuracy of their pay cheques, they find that they are treated with disdain and the staff are rude. They cross-examine the staff member and question their motives, and there is a great deal of conflict. I am aware, for instance, that the Health Corporate Network sits at 5 St Georges Terrace. Perhaps the whole department needs to be brought back in-house to Royal Street so that this crew can be brought under control, because at the moment there is a very unhappy workforce that, quite frankly, is not being paid for the hours it is doing. Would the minister consider bringing the Health Corporate Network back into the Royal Street precinct?

Dr K.D. HAMES: The director would like to respond to that.

Mr K. Snowball: I think it is certainly true to say that HCN has an issue with reputation across the system. I do not think it is fair, though, to assign that to all the functions it does. A very significant number of staff are employed in that area, so I would hate to see our staff at HCN characterised as being rude and so on, because that is not the case.

Mr R.H. COOK: I can provide the director offline with some testimonials that would make his toes curl.

Mr K. Snowball: I agree that there are some areas that need to be improved. That is one of the reasons that, as a Health executive, I have assigned one of my chief executives to have clear oversight of HCN's improved performance; that is Mr Aylward, who spoke earlier. The focus of that is in systems to improve performance and client relationships as well. It has made some fundamental changes in the system. We now have only one payroll. I do not know whether the member is aware that in the past we had a multitude of payrolls, and different times of the week, and so on. It was a very difficult, complex system. It has brought that under one pay very successfully, and nobody missed out on their pay as a consequence of that change. So it is making those kinds of fundamental foundational changes without a lot of acknowledgement in the system. People would not know, in receiving their pay, what has gone into the work-up to change how that is being delivered. That has improved our performance, but there is room to improve. That is why I am certainly supportive and keen to make sure the Health Corporate Network is accountable for its performance to the broader system; that is, by doing it through Mr Aylward and by providing regular information in terms of performance against benchmarks around that. I

welcome seeing that happen. There is a management plan within HCN to improve those areas brought to our attention. I get a regular report. At state health executive, HCN reports to us on performance and on issues they are dealing with and addressing. It is not like it is down the line; it is something that is high on the agenda for Health. We agree that pay is important. We want to ensure people working in Health are paid well and paid right.

[12.30 pm]

Dr K.D. HAMES: Working out pays for health staff would have to be one of the most difficult areas of government to deal with. Not only do we have 40 000 staff and not only do we have a wide range of professions, but also there are very few fixed hours. Some staff work fixed hours; but it is very flexible. We need additional nursing staff and additional doctors to work extra hours, and some staff get called back. Some people in the private sector work in government; some are fully employed by government. There are as many scenarios as members can possibly think of in terms of what each week's pay might be. It is probably never the same one pay period to the next. That makes it extraordinarily difficult.

Mr R.H. COOK: Does the minister think that the Health Corporate Network would be more accountable if it was brought out of its luxurious offices in St Georges Terrace?

Dr K.D. HAMES: We do not have the room anymore for them to do that, but I am advised by the director that they report directly anyway. I think he is quite comfortable with where they are located.

Mr R.H. COOK: They are a law unto themselves!

Mr A.P. JACOB: I refer to the "Service Summary" table on page 128 and the sixth item, "Patient Transport". There is $180 million for 2012–13. That is a substantial increase from the allocation of $157.6 million for 2011–12. Could the minister outline what is included in $180 million and what increases in demand have been experienced within the patient assisted travel scheme over the past year?

Dr K.D. HAMES: This is one area in which all the staff behind me are probably not too happy with me about! When we were in opposition, we introduced some changes to PATS. It was an election commitment based on the Senate inquiry into patient assisted travel services. We put together all of the recommendations of that committee—something that has not happened in any other state. We had an anticipated cost of doing that. It is fair to say that the cost has been significantly in excess of that. I cannot say that I am unhappy because it provides a fantastic service for people outside the metropolitan area. I am sure the manager of Country Health Services is not unhappy either. It provides a fantastic service. We particularly focused on patients with cancer. Before, patients with cancer had to be more than 16 hours' drive away to be eligible to access a flight. We changed that to four hours. We included areas such as Esperance, Geraldton, Kalgoorlie and the like to enable people to be eligible to catch a plane. We also added the almost automatic ability to add a carer to travel with them. We increased petrol rates. Remember, petrol rates are never there to cover the full cost of petrol but as a subsidy to people driving. We did it at a level that was much higher than previously. We increased accommodation rates. Before, it had been at a rate that a person could not actually find any accommodation. We increased that fund as well. For example, previously, if a cancer patient requiring chemotherapy got sick and had to go into hospital, they stopped the funding for the carer who was waiting in an apartment. Suddenly, the carer had to start paying for accommodation because there was no accommodation allowance while the patient was in hospital. We added that back in so the carer would still get access to funding.

That $180 million is a significant increase. It also includes the increase for the ambulance service. Remember, we did an inquiry into St John Ambulance. We significantly increased funding in that area. Other transport costs have also been increased. There has been a huge increase in cost from $157 million in 2011–12 to $180 million in 2012–13. I have not got with me the figures before 2011–12, but they were significantly lower. Of course, I have left out the Royal Flying Doctor Service. We significantly increased funding for that service. Between those three areas, there has been a significant increase in funding. It comes under the heading "Transport" but they are actually critical areas of health service in this state.

Mr R.H. COOK: The figure we have here is obviously a global figure for St John Ambulance, the RFDS and PATS. Could we have that broken down across each service? By way of supplementary information is fine.

Dr K.D. HAMES: I do not need to do that. I have the information here. A figure of $136 million is for the ambulance service, the Royal Flying Doctor Service is $36.5 million, St John Ambulance is $94.9 million, and PATS is $42.2 million.

Mr R.H. COOK: In relation to the figure of $42.2 million for PATS, is it possible to get a breakdown of where these patients come from? If there is a range of co-morbidity issues, it would be difficult to identify what

services they are accessing, but could we identify the reason for their PATS application? Is it broken down to that level of detail?

Dr K.D. HAMES: We can provide that level of detail, but I am not sure we can do it by way of supplementary information. A supplementary question limits the time we have available. A question on notice will give us more time. Can we just assume that is a question on notice?

The CHAIRMAN: If it is a question on notice, it has to be put in writing. It cannot be assumed it is a question on notice.

Dr K.D. HAMES: How long have we got for supplementary answers?

The CHAIRMAN: Until Friday, 8 June.

Dr K.D. HAMES: That is only a week. I am told it will take one to two weeks to get it. Could the member put that on notice, because I would rather provide a more comprehensive answer? I will go back in figures to show what the change is and where the specific extra funding is. The member needs to put it in writing. He could send us that question.

Mr R.H. COOK: I am just confirming that is $42.2 million for PATS and $94.5 million for RFDS. Is that it?

Dr K.D. HAMES: Also, $36.5 million for the Royal Flying Doctor Service and $94.9 million for St John Ambulance.

Mr M.P. WHITELY: I refer to the third dot point on page 130 relating to $58.5 million to fund new early childhood services. The minister made an announcement by way of a press release in which he said that one of the aims of this money was to ensure all children in the care of the state receive a health assessment and those new to the care of the state receive one within 30 days. That is laudable; I am glad that will happen. One issue I have raised numerous times in this chamber, and in estimates forums and questions on notice with a range of ministers, is the number of kids in state care who are on a range of psychotropic drugs. We simply do not know how many kids are on antidepressants, amphetamines, antipsychotics et cetera. When I have asked for that information to be collected in the past, I have been told that it takes too much effort to do a file review. Now that there will be this system of all kids in state care receiving a comprehensive assessment and all new kids in care getting one within 30 days—I assume that covers foster care as well as direct institutional care—can the minister tell us if it will be possible to collect that sort of information? I am concerned because of not only the anecdotal evidence, but also the reviews in New South Wales and Queensland that have highlighted that it is common practice to put kids in care on a range of psychotropic drugs as a chemical straightjacket rather than deal with their underlying issues. I am concerned that the same thing is happening here. I simply have not been able to get the information to date. In light of the new system, will there be any attempt to collect that information?

[12.40 pm]

Dr K.D. HAMES: What age group of children is the member talking about?

Mr M.P. WHITELY: I am referring to all kids in state care. In other states the kids in state care, upon whom a review has been done to identify the proportion who are on psychotropics, range in age from zero to 18. That study revealed that it is up to 50 times more likely for kids in state care to be placed on a range of psychotropics than it is for kids who are not in state care. If the Department of Health is already doing the review—that is good; I applaud that—surely it would be possible to collect that information. I have been told in the past that it cannot be collected. It is a suggestion as much as anything.

Dr K.D. HAMES: I understand the question. It is something that I will need to explore in more detail. We need to discuss the pros and cons. I am not sure whether staff who are doing child healthcare checks would know if a particular child was in state care and I am not sure whether or not that question could be asked. I would be interested to find out what they do in other states and how they do it. That is something we will explore.

Mr P. ABETZ: Those checks are for kids up to three years of age.

Dr K.D. HAMES: That is right. We do preschool checks as well.

Mr M.P. WHITELY: I appreciate that the child healthcare checks are for children of a younger age range.

Dr K.D. HAMES: What the member for Bassendean would really like to see is the full spectrum.

Mr M.P. WHITELY: I would like to see the full gamut.

Dr K.D. HAMES: I am not sure that the child health clinic mechanism will capture the kids to whom the member is particularly referring.

Mr M.P. WHITELY: The minister is quite correct.

Dr K.D. HAMES: Those kids belong to a younger age group and are less likely to be on psychotropic drugs. I would have thought that that question might be better directed towards Hon Robyn McSweeney, the minister responsible for kids who are being managed by the state.

Mr M.P. WHITELY: The minister might assume that, but in other states it has been revealed that some very young children—children as young as 18 months—are being treated with these sorts of medications.

Dr K.D. HAMES: We will explore what is done in other states. We will need to talk to staff working in those areas. This issue does not need to be a question. Perhaps the member can write me a letter outlining his requests and I will get my staff to respond.

Mr M.P. WHITELY: Yes, I will.

Dr G.G. JACOBS: I refer to the fourth item under "Service Summary" on page 128 of the *Budget Statements,* which relates to the spend on emergency departments. There has been a significant increase from $430 million to $488 million. As a patient, that is a very good thing. What are the reasons for the increase?

Dr K.D. HAMES: It is a significant increase of $58-plus million, which is a more than 10 per cent increase in funding. That figure also includes some commonwealth funding as part of the national package. The reward funding deals with things specifically like the four-hour rule and gives us the capacity to increase funds in those areas. As we have heard, there has been a significant increase in demand. We have talked about what those costs mean. A 10 per cent increase in demand does not necessarily mean a 10 per cent increase in costs, although there has been a growth in costs. As part of the four-hour rule, and as part of trying to address issues such as ambulance ramping—the member has not asked me yet; I do not know whether he will later on—and in meeting the national targets for seeing patients in emergency departments in appropriate times, the ones that we are not doing well in are categories three and four. We need a different system in place. This funding will allow us to do that. We will use some funding to address ambulance ramping and to address the cluster of St John Ambulance staff who wait in the ED when ambulance ramping occurs and stop ambulances from getting out. Another area that needs to be addressed is the timeliness of doctors and nurse practitioners seeing patients in emergency departments. We are not doing well and it needs to improve. What is going really well is at the other end. The four-hour rule has significantly improved the eight-hour waits in EDs. Whereas we have been second, third, and, in some cases, the worst in the country, we are now best in the country by a country mile in every one of those categories. There are things to address and some of this financial funding will allow us to do that.

Mr K. Snowball: One of the key things around EDs—this related to a question asked earlier—is that we will hit close to 1 million ED presentations in the next 12 months, which is an extraordinary increase. At the same time, we have been able to improve the quality of that service and how quickly we deal with those patients. A study was undertaken about what it means going from overcrowded emergency departments to much better disciplined, organised and planned emergency departments and it estimated that up to 267 lives have been saved as a consequence of the introduction of the four-hour rule and the improvement of the quality of services in that area. That is really a tribute to the people in our hospitals who have been able to achieve that outcome, notwithstanding there are improvements to be made, which we are on to.

Dr G.G. JACOBS: What will that money do? How will the department improve its throughput? Will it put on more staff or pay more doctors? What will the money do to improve that efficiency?

Dr K.D. HAMES: I want to get back to the 267 lives that have been saved. I do not know whether members have read the report of Dr Sprivulis from Fremantle Hospital. He did a report on EDs, particularly the eight-hour rule. At the time he found that something like 120 patients are dying needlessly each year because of the eight-hour delays in EDs. Behind that was another 800 or 900 who had increased morbidity as a result of those delays. Someone who had cellulitis would end up losing a leg whereas it might have otherwise been saved. That report was backed up by another specialist in the Australian Capital Territory who arrived at similar results. When we put these measures in place, it is expected that that should improve. Dr Gary Geelhoed, former president of the Australian Medical Association, did research into that. We were getting evidence of reduced morbidity, but he put that into graphs to show what the morbidity and mortality would have been if it had continued on previous trends, particularly reflecting increased numbers coming through the EDs. It was coming down. That is where the 267 comes from. Part of the funding will go to increase full-time equivalents. For example, I have asked that each of our EDs addresses the time it takes to be seen by a doctor or a nurse practitioner. We will employ additional staff in EDs to fast-track patients. Those fast-track doctors and nurse practitioners will not be responsible for patients' ongoing care. They will see them, do a history and an assessment and send them off for an X-ray or blood test. If they are not that bad, patients will go back to the waiting room and wait for the normal team to come through to see them. That will address the category, for one. It will also mean, for the emergency

department doctor coming to see that patient, that the patient will already have had someone else give an opinion on what they think the diagnosis is. The patient will probably already have had X-rays done or a CT scan or blood test, so it will make it a lot easier for the doctors in the ED to manage that patient going forward if that initial work has already been done.

[12.50 pm]

Dr G.G. JACOBS: Does the nurse practitioner qualify in the four-hour rule? If the minister will excuse the expression, does that count, or does the patient have to be seen by the doctor?

Mr R.H. COOK: One doctor asking another doctor!

Dr G.G. JACOBS: Okay; it is an important point.

Dr K.D. HAMES: The four-hour rule has nothing to do with who sees the patient and when; that is a different, commonwealth category in terms of time to be seen by a nurse practitioner or a doctor. It was a bit incongruous, really; we were doing really well on getting the patients efficiently managed going through the ED, yet those two categories in particular, 3 and 4, were seen outside recommended times. It was a bit perverse, really, for that to happen, but we want to meet both those targets; we think they are both important, and we will make sure that that happens. In respect of other specific areas where the money is to be spent, I do not know whether either of the area health service representatives want to tell us where they are spending the money in those EDs or country health. While they are thinking about it, the director wants to get a word in edgeways!

Mr K. Snowball: In respect of four-hour rule responses, it is not just about emergency departments, as the member knows. Much of it is about what happens behind the emergency departments, in the hospital itself—things like acute assessment units—so it is giving the wards capacity to do more of the work-up work that would otherwise have been done in ED. It is also about being able to ensure that our ambulances, for example, go to the nearest hospital that is best able to treat the patients. We do not want too many patients going to one hospital; it puts it under unnecessary pressure, so in terms of the four-hour rule, that is part of it, but it has to be comprehensive: how are people getting to the right hospital at the right time; how are they assessed; how do we fast-track those who can be fast-tracked through nurse practitioners or others; and how do we reorganise it so that all of the work-up for individual patients is not done only in ED, so that they are sitting around waiting for results of tests or whatever it might be? We need to continually ensure that every step in a person's treatment is lined up and done effectively and quickly. That is what we are seeing; the change in our hospitals has been quite phenomenal around understanding that all parts of the hospital have responsibility for not just their part of the hospital but for how other parts of the hospital works. If there is pressure in ED, one does not just stand back and say, "Gee, they're busy in ED today". It is actually about making sure that staff work out ways to free up beds to allow patients to be treated on the ward instead of just waiting for something to happen. I am really pleased with that sort of approach.

Dr D.J. Russell-Weisz: From a North Metropolitan Area Health Service and Sir Charles Gairdner Hospital perspective, some of the areas that we will be enhancing in relation to the ability to treat those triage 3 and triage 4 patients can be actually quite simple and short term. It can be as simple as increasing the number of clerical staff at the desk in ED, because we found that that was one area where we were getting hold-ups, all the way through to potentially putting more medical staff on the floor, but some of the things that we found are in the very short term solutions. Also, it is not just about the ED; it is about actually enhancing our medical and our surgical assessment units behind the ED and in the hospital. We are certainly looking at enhancing our already successful acute assessment units at Sir Charles Gairdner Hospital in relation to providing additional senior cover out of hours and also in bolstering our surgical assessment unit and actually nominating a definitive place to have those beds that look purely at the acute assessment of surgical patients.

Ms N. Feely: Further to the comments of my colleague in the north metropolitan area, in south metro we have a multifaceted strategy in relation to these particular patients. We are refocusing on the streaming of patients into resuscitation, admission and discharge streams. We will be looking at whether or not we need to reassess our team-based care approach across the board, and there is an ongoing review as to senior clinician involvement in that. Under the leadership of the minister, we are looking at employing front-line staff who may be able to stream these patients more effectively through the front door, and the employment of both nursing and medical staff. This is very important, given the number of people who are coming through the EDs. For example, at Royal Perth Hospital on a normal Monday we might have an average load of patients coming through the emergency department of about 206; this Monday we had 254, which is the third busiest day in the hospital's history. The need to make sure the patients are streamlined is becoming absolutely imperative. So it is a combination of staffing, better streamlining processes, refocusing patient care and making sure that we can move people through as quickly as possible.

Dr K.D. HAMES: I just want to say, there are 94 extra FTEs in EDs.

Dr G.G. JACOBS: How many patients actually go to the GP clinic? For instance, there are 200-odd going to the Royal Perth Hospital accident and emergency, but how many went to the GP clinic?

Dr K.D. HAMES: It is a fairly fixed percentage. We will find out for the member after lunch.

Mr R.H. COOK: I notice that EDs will have a four per cent increase in staff, but the minister anticipates an 8.9 per cent increase in demand. Does that mean that the department will be asking staff to do more with less?

Mr K. Snowball: Part of the issue there is what staff increase we need to meet an increase like eight per cent; it is not an equal percentage increase. It is not the case that a three per cent increase in demand will necessitate a three per cent increase in staff.

Dr K.D. HAMES: It depends on the categories of patients coming in. Obviously, we need a few additional staff to deal with category 5s because we can get through them pretty quickly.

Mr R.H. COOK: That is a fair point. Between January and March this year, Fremantle Hospital experienced a 7.4 per cent increase on the same time last year. Is it still the minister's intention to close the Fremantle Hospital ED?

Dr K.D. HAMES: Yes, it still is, because we will expect those patients to go across to the new hospital, as the previous Minister for Health planned. We are still following his careful planning for the hospital in his former electorate. We have deviated to some extent in that we have more beds there than was previously planned, although he increased the plans for retention of staff just before the last election. There will need to be a clinic of some sort, a bit like what the former Labor government planned for Royal Perth Hospital—to have a GP-type clinic that is able to see lower acuity patients or even stabilise higher acuity patients before transferring them to Fiona Stanley Hospital ED. Yes, it is planned to shut that ED. The member will have seen in the clinical services framework the planned services to be provided at that hospital. That was not in the original Reid review, but we will be doing some waitlist surgery there because it just seems appropriate to make good use of the theatres that are already there to churn through some of those waitlist surgery patients that we need to keep up with to meet the demand.

Ms J.M. FREEMAN: I refer to the line item "Enterprise Bargaining Agreements" on page 127. What are the assumptions that underpin the amount that appears there, and how was the amount arrived at?

Dr K.D. HAMES: The state wages policy, full stop.

Ms J.M. FREEMAN: What would that be?

Dr K.D. HAMES: Whatever the state wages policy is; that is not the responsibility of my department, it is the responsibility of Hon Simon O'Brien, who manages wages negotiations for all government employees.

Ms J.M. FREEMAN: Is that what the government has offered other people who have done enterprise bargaining agreements? Have those been the assumptions of previous years?

Dr K.D. HAMES: Yes, I think so; the same assumptions.

Ms J.M. FREEMAN: Does that include dental nurses?

Dr K.D. HAMES: Yes.

Ms J.M. FREEMAN: Is the reclassification of dental nurses included in the amount?

Dr K.D. HAMES: This is a global amount that matches wages policy, and until negotiations are actually concluded, it will be there.

Meeting suspended from 1.00 to 2.00 pm

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

The CHAIRMAN: The member for Kwinana.

Mr R.H. COOK: I refer to page 131 of budget paper No 2. This comes under the issue of infrastructure to do with the new Midland health campus. The commentary in that dot point states that "a broader range of clinical services" will be provided at the new Midland hospital. We all understand that this is in the context of the fact that, at this stage, the preferred operator under the contract negotiation process, St John of God Health Care, has stated publicly that there are some clinical services that it will be unwilling to provide. Given that St John of God has announced that there will be a range of services that it will be unwilling to provide, why is its tender for services not considered noncompliant? The minister has given an assurance to the house that these services—around which we do have some concerns—will be provided, but he has not detailed exactly how that will happen, given also that some of these services are completely contrary to St John of God's code of ethical

standards. I therefore ask the minister to please explain to us where we are at in relation to that contract negotiation.

Dr K.D. HAMES: In terms of being noncompliant, no, that is not the case. St John of God made it clear at the very start that there are certain services that it will not provide. Those services relate to contraception and termination of pregnancy, largely. St John of God does not provide those services in any of its hospitals. Some of those services are currently provided in some of our hospitals—not all of them. Late-stage terminations certainly would not be done at Swan District Hospital or Midland hospital; they would be done at King Edward hospital. Pregnancy control advice is a service that normally would be provided by a general practitioner. As the member knows, there is a clinic in Midland that does most of the metropolitan area terminations. But there are some services that we would expect to be provided at our public hospitals, and it was made clear at the start that St John of God would not be doing that. So we had the choice of saying that St John of God would not be compliant, and of getting down to, in the end, just one group. We wanted to make sure that we kept a strong and competitive tender. It was felt also that those services were only a small number in the context of the total number of services that would be provided at that hospital and that they could easily be provided at alternative locations such as Kalamunda hospital or King Edward hospital, or at GP clinics, and it was therefore appropriate to proceed with the tender.

We have now made the decision as a government that those services will be provided on site. Virtually none of those services—vasectomies, terminations and those sorts of things—requires hospital admission; those services are generally day surgery cases. So we will be taking part of the land on that campus site out of the contract, and an option will be provided, under negotiation with government, for a private sector provider to have something like a day surgery centre that will provide not only for those types of cases, but also for a lot of the other stuff that people might have done, such as wedge resections of toenails and the like. Therefore, rather than contracting St John of God to provide those services on that site, those additional other services will be provided on that site. That is the compromise that we have reached. We want to make sure that if a person goes to Midland hospital for a service that would have been provided at that hospital had we had not contracted out that service, the person will still be able to access that service.

With regard to the signing of the contract, I will hand over to Dr Russell-Weisz, who has the detail of that, to say whatever he is allowed to publicly say.

Dr D.J. Russell-Weisz: I will just say that contract negotiations are reaching near completion, and we will be able to advise accordingly.

Ms J.M. FREEMAN: I understood the minister to say that Midland hospital currently does not do late terminations. I want to confirm that it currently does do first-trimester terminations, and it also provides a range of advice on contraception. If a woman has been sexually assaulted, she can go to Midland hospital and she will get advice about her sexual health and her sexual needs and be tested for pregnancy so that she can make determinations and choices. If a person wants to get a vasectomy, that service is currently available at Midland hospital. But I gather that under this new arrangement, that person will have to take a trip for the snip. Is that the case?

Dr K.D. HAMES: That service will be provided on the same site, so the person will not have to take a trip anywhere. Those additional services will be provided at the location of the day surgery centre. Some services, particularly referrals for sexual issues, are generally made to King Edward hospital for follow-up management. There will be a general practitioner centre opposite the hospital to provide additional GP-type services.

Ms J.M. FREEMAN: But will people be referred? If a female goes to the new Midland hospital, which will be run by St John of God, and St John believes that she is questioning her ongoing capacity to have a child, for whatever reason, and wants a termination, or if a male is questioning whether he wants to continue to have children and is looking at the option of a vasectomy, will St John of God—the privatised hospital in Midland—refer those persons to the clinics that the minister is aiming to set up, which obviously will be private health clinics?

Dr K.D. HAMES: It will be the same as happens in a lot of other hospitals. Peel Health Campus and a lot of other hospitals have facilities that are in effect part of the structure of the hospital and provide those services that the member has listed.

Ms J.M. FREEMAN: So will they refer? That is what I want to know.

Dr K.D. HAMES: Yes, they will, but to the clinic next door, at that same health campus site. That happens with lots of things. If the member is talking about people going to the emergency department, I would not expect any of our EDs to be giving advice on that sort of thing.

Mr R.H. COOK: But the other EDs do not operate according to a code.

Dr K.D. HAMES: If a woman went to Royal Perth Hospital ED and said she was thinking of having a termination, the ED staff would say, "Go and get counselling", or "Go and seek advice from your general practitioner", or "Go to a clinic". The ED staff do not have the experience or the knowledge to provide detailed advice on contraception, for example. So it depends. An ED is an emergency department; that is what it is for. People go to emergency departments in emergencies to get acute treatment for acute illnesses. People do not go there for counselling or advice on medical issues. If someone goes there because they are bleeding, for example, and are concerned about losing their pregnancy or they go there following a rape, it will manage those patients. However, it will not see someone coming through an ED. Others may go to an outpatient clinic for those things, but there are not normally outpatient clinics at Royal Perth Hospital that deal with contraceptive advice; patients get sent down the road to whatever clinic. If a patient in my surgery wants a termination, I send them to a clinic in Midland to have that.

[2.10 pm]

Mr R.H. COOK: The point the member for Nollamara makes is that there is a positive obligation on someone who works for the Catholic health service to not refer that person to another service when they believe there is a likelihood that that service will counsel that person to have a termination or any other form of interference. I do not have any problems with St John of God's ethical code of standards; if someone pays to go to a private institution, that is what they can expect when paying their money. However, this is a public institution. If someone went to the front desk of Royal Perth Hospital, they would get a very different service from what they would get if they went to this private operator. This private operator requires its staff to behave in a very different way.

Dr K.D. HAMES: That is true, but I do not buy the argument that the member has just put. If I was working in an emergency services department and someone came to me seeking urgent immediate treatment, I would provide it and I would also expect the hospital to provide it. If I was at Royal Perth Hospital ED and someone needed to go somewhere else, I might say, "If you're after a termination, there is a clinic down in Midland." St John of God might instead say, "That's not advice we provide. I suggest you go and talk to your GP or the medical clinic across the road who will give you that advice." One thing we went through when debating the legislation in this place was that people seeking terminations have to be provided with counselling advice. People with the expertise to provide that advice to the patient are general practitioners, not secondary hospitals in our health system. The services that St John of God will not provide or refer patients for are vasectomies, terminations and those sorts of procedures. There is a limited a number of them. We are talking about 250 a year compared with 29 000 total patients a year. We are putting a day care facility on the campus site that will be privately operated. Patients will go through a separate door from the one to get to the ED. That facility will have this sort of advice available and give referrals because it will operate independently of the main hospital to address that area of concern.

Mr R.H. COOK: Does this not seem like an extraordinary length to go to patch up what is clearly a broken-down contractual process? The government is setting up a whole new clinic because the government's privatisation agenda is not working to provide public health.

Dr K.D. HAMES: The model that we are putting in place, in effect, gives people all the benefits that they would get from going to Joondalup Health Campus, for example, which people in that area love; it is a hospital that is run by the private sector at a significant cost saving to government. Any cost associated with what we are doing here is far, far less than the cost saving to the ordinary taxpayer in providing services we can then spend on other health services or other government initiatives within this state. My glass is half-full, not half-empty. Although it creates some minor issues that have resulted in extra costs for us, I regard it as an opportunity to provide an even better service for the people of Midland by having a day surgery centre that will do not only that very small number of services that the major hospital will not provide, but also a significantly expanded number of services that will be of benefit to the local community.

Mr R.H. COOK: How long is the contract that has been negotiated with St John of God?

Dr K.D. HAMES: It is for 20 years.

Mr R.H. COOK: Can the minister advise the range of services that the hospital will provide in, say, 15 years? I do not mean when the contract starts; I mean what services will be provided in about 15 or 18 years. Can the minister provide a list?

Dr K.D. HAMES: I am not sure whether we have gone that far in the clinical services framework. We go up to only 2020.

Mr R.H. COOK: That is my point exactly. The government is tying us into a 20-year contract with a health provider that will not provide a full range of services and the minister does not know what range of services will

be provided. The government is essentially handcuffing the public health system to this private contractor that has already told the government before it signed the contract that there are things that it will not do. In 15 years the government does not know what services will be run out of that hospital, but it knows that whatever they are, the government will be bound by the fact that this private contractor will not do a range of things.

Dr K.D. HAMES: That is clearly not true. The proof of it not being true is in the services that are provided at other hospitals that have these sorts of contracts.

Mr R.H. COOK: How does the minister know what will be provided in 15 years?

Dr K.D. HAMES: We have a contract. It is a purchaser–provider model. We set those things that need to be provided when we renegotiate the contract. We set what has to be provided for those 20 years of service, and then following that, we set the next lot. At that time it can always revert to government if the government is not satisfied with the standard of service. I go to Dr Russell-Weisz to explain exactly the services that will be provided.

Dr D.J. Russell-Weisz: Initially, we will set a range of services that are significantly enhanced from the current Swan District Hospital. That is enhanced —

Mr R.H. COOK: Is that you or the private contractor?

The CHAIRMAN: The member cannot talk to the adviser.

Dr K.D. HAMES: I appreciate the member interjecting on me and I am happy to put up with that, but —

The CHAIRMAN: The member has to go through the minister.

Mr R.H. COOK: I am just trying to clarify whether it is the actual public health service or the private operator.

The CHAIRMAN: Do not look at me. Go through the minister.

Mr R.H. COOK: I am explaining to you what I am doing.

The CHAIRMAN: I am explaining to the member what he should do; that is, go through the minister.

Mr R.H. COOK: Is the minister talking about the private model or the public —

Dr K.D. HAMES: I am not prepared to take the interjection because Dr Russell-Weisz got one sentence out. I would like him to finish and then the member can ask another question.

The CHAIRMAN: Deputy Leader of the Opposition, let Dr Russell-Weisz answer.

Dr D.J. Russell-Weisz: The Midland health campus is expected to be operational in 2015. For that first financial year, the services are mandated as per the clinical service framework, which has determined what services the hospital will provide. The core services extend from expanded medical, surgical, intensive care, emergency and obstetric services to what we have now at Swan District Hospital. How those services change over the next few years post 2015 is determined in exactly the same way as the Joondalup contract. An annual notice is negotiated between the state and the operator at that time, and the state determines what services it requires as it changes from year to year. It is quite right to say that in 15 years there might be some services that we have not predicted today that we would like to purchase from the operator, as we would do at other sites around metropolitan Perth. We have the ability to do that through that annual notice that we negotiate with the operator each February prior to the next financial year.

Dr K.D. HAMES: In some ways this follows the National Healthcare Agreement. With north metropolitan, south metropolitan, country health services and children health services, we move more into that same style of negotiation. A contracted delivery of services needs to be provided.

Ms J.M. FREEMAN: They do everything.

[2.20 pm]

Dr K.D. HAMES: I know that the member for Nollamara says "they do everything", but she needs to look at the sorts of services that the hospital will not provide and whether they need to be provided at a secondary hospital or at an alternative location, because a lot of them should not be performed in a hospital; they should be done at alternate clinics. As I say, in terms of the standard of services provided by a secondary hospital, the number is minuscule. Having worked for two or three years in an emergency department, I could count on one hand the number of times each year that I came across any of the issues the opposition is saying will not be provided at that secondary hospital.

Mr R.H. COOK: In some respects it is a point of principle, but could the minister clarify whether the contract gives the private operator the right to say that it will provide public health services consistent with the teachings

of the Catholic Church? If there are new rulings by the Catholic Church on particular medical procedures, does the contract allow the hospital to opt out of providing those services even though they might have been contracted to perform those services prior to that?

Dr K.D. HAMES: In effect, the member is asking what happens if the Catholic Church changes its mind and has another list of things. The contract will be in place. No, the contract will not say that the list can be changed. The hospital has provided a list of services that it will not provide, and that is it.

Mr R.H. COOK: It is a very powerful contract that beats the Pope; it is good one! The Catholic healthcare document on ethical standards refers to the need to provide a conspicuous demonstration of symbols of Catholicism throughout the institution, such as the hanging of crucifixes or pictures of other Catholic-based institutions or symbols. Can the minister clarify whether that issue has been addressed in the contract or will this public hospital look very much like any other St John of God facility with all the adornments that go with that?

Dr K.D. HAMES: I ask Dr Russell-Weisz to respond.

Dr D.J. Russell-Weisz: This issue has been raised. I will have to get back to the member with where the actual contract specifies those individual issues. However, it is in the contract that it will be a public hospital and that it will operate very similarly to a public hospital.

Dr K.D. HAMES: Dr Russell-Weisz cannot provide those things because it is part of the contract. I think the question that will come back to him is whether crucifixes and the like will be hung throughout the hospital.

Mr R.H. COOK: I am relaxed and comfortable about that but obviously there are people in the world who would not consider it appropriate for a public health institution to have those there.

Dr D.J. Russell-Weisz: I will confirm that.

Dr K.D. HAMES: Is it Dr Russell-Weisz's understanding that that will not be the case?

Dr D.J. Russell-Weisz: My understanding is that it is not the case, but I will confirm that.

Dr K.D. HAMES: It is also my understanding that they will not be. Of course, as with any hospital, rooms will be made available for people to conduct their services.

Mr R.H. COOK: Is that supplementary information, Mr Chairman?

The CHAIRMAN: No, because it is part of the contract.

Dr K.D. HAMES: Dr Russell-Weisz will double-check that and I will let the member know.

Ms J.M. FREEMAN: I refer to page 127 and the $2.3 million allocation in the 2012–13 budget to pay Serco to manage the facilities at Fiona Stanley Hospital. Given that the hospital will not be operational until 2014, why is Serco being paid money for operations when it is not operating the hospital at this point in time, and what is the breakdown of those payments? Is not a contract for when the contract commences rather than before it commences?

Dr K.D. HAMES: I will hand over to Nicole.

Ms N. Feely: Under the contract there are three phases: The POT phase—pre-operational transition—the transition phase and the operational phase. I understand that this money is paid on a monthly basis and that it is part of the contract negotiations to Serco for the delivery of both of its pre-operational systems. In addition, an ICT contingency component is paid.

Ms J.M. FREEMAN: Is the ICT component the information and communications technology package?

Ms N. Feely: Yes.

Dr K.D. HAMES: Obviously part of the contract is that during the construction phase of the building Serco must get a lot of stuff in to do their work. Part of the total contract to provide the service it is providing is to have people there working with the builders and architects to make sure that the systems are put in place. If it were not Serco, we would be paying for those things to be put in anyway.

Ms J.M. FREEMAN: I thought that one of the benefits of privatising this sort of service was that the service had to be paid only once it had been delivered. The hospital is still being built and the government is paying the contractor.

Dr K.D. HAMES: No, there are a lot of benefits to contracting out to the private sector but that is not one of them.

Mr R.H. COOK: Every other state government says that it is.

Dr K.D. HAMES: I am sure they do not. Most other state governments that have done the same sort of thing are Labor governments, I might add, including the former Western Australian Labor government when it contracted out to Serco for the detention centres. There would have been components in that contract for putting in equipment. The contract has a start and finish time. The bulk of the payments for the contract are made once the private operator is actually providing the service but part of it covers the cost of installing equipment and the like. That is how they work.

Ms J.M. FREEMAN: Is the minister absolutely sure that when Serco was contracted to run the detention centre, that money was paid to Serco prior to the operation of the centre?

Dr K.D. HAMES: No, that is not what I said. I said that I presume or suppose that that was the case. I do not know that for sure and nor would I bother to find out. The reality is that we have a contract to provide the service and we would be paying for someone else to do that work if we were not paying Serco to do it.

Ms J.M. FREEMAN: So —

The CHAIRMAN: If the member has a further question, it must go through the Chair.

Ms J.M. FREEMAN: I cannot see you —

The CHAIRMAN: Lean forward.

Dr G.G. JACOBS: We would like to ask questions too.

The CHAIRMAN: You do not have your name on the list.

Mr P. ABETZ: I have.

The CHAIRMAN: I know you do, but you are further down the list.

Dr K.D. HAMES: I think they should all get their name on the list.

The CHAIRMAN: It does help.

Ms J.M. FREEMAN: This is the POT phase and is paid on a monthly basis. How long will that funding go for? I gather that there are 12 payments for a pre-operation system and an ICT system. Can the minister outline what is entailed in the pre-op system or provide that as supplementary information for me?

Dr K.D. HAMES: Ms Feely.

Ms N. Feely: The POT payment is a monthly payment on average of about $3.074 million and we also pay a $440 000 ICT contingency fee plus GST on that amount. That payment will be paid until December 2013, which is when the POT phase will be finalised.

Ms J.M. FREEMAN: Is the minister able to table what the $3.074 million entails, which services have been charged for it and which services have been delivered?

Dr K.D. HAMES: I am advised that the contract, including the details of what Serco is required to do, is on the website.

Mr M.P. WHITELY: I refer to stage 1 of the reconfiguration of Osborne Park Hospital under "Works in Progress" on page 144. There is a total budget of $44.1 million. No expenditure was allocated for that project this year or in 2013–14; only $60 000 is budgeted for it in 2014–15 and $414 000 in 2015–16 out of a total budget of $44.1 million. In last year's budget papers it was $2.5 million for 2011–12, $9.3 million for 2012–13 and $27.5 million for 2013–14.

[2.30 pm]

The CHAIRMAN: What page are you referring to, member?

Mr M.P. WHITELY: It is page 144. Obviously all the funding has been pulled out of this important project. Given that Osborne Park Hospital is the second busiest maternity hospital in the state and that we are in the middle of a very big baby boom, where will parents go and why has the pin been pulled on such an important project?

Dr K.D. HAMES: This money has nothing to do with providing for maternity services at that hospital. It was specifically allocated for some new additional buildings that were proposed for mental health services. Two things have happened with that. One is that we are providing lots of additional mental health services at other hospitals, including Fiona Stanley Hospital and Midland health campus as part of the new phase. Secondly, as part of the total issue of balancing the budget, particularly given the huge capital works component in health services and the reduction in GST payments to the state, we were asked to find projects that could be pushed to the out years, and this was one of those.

Mr M.P. WHITELY: It is basically saying that the needs can be met elsewhere, so why is it still in the budget at all? If the needs are going to be met elsewhere, the minister cannot have it both ways. Either it is needed and it should be funded or it should not be in the budget at all.

Dr K.D. HAMES: It has been moved for three years. The view at this stage is that it is still required but not in the short term.

Mr M.P. WHITELY: That contradicts what the minister has just said.

Dr K.D. HAMES: The member makes a good point, and it may well be decided with those additional services being provided in other locations that it is not necessarily required, but at this stage that decision has not been made and we are still of the view that it will be needed. Therefore, the designation of funds is still there under the estimated cost but it is not listed in the four-year forward estimates while we think about it basically.

Mr M.P. WHITELY: Just to be clear, the $44 million is entirely for mental health facilities; that is what was proposed.

Dr K.D. HAMES: Yes, that is correct.

Mr M.P. WHITELY: Just to be clear again, where else were these beds picked up?

Dr K.D. HAMES: Part of this was to replace the beds in Graylands and move them to these facilities. But, as I say, part of the mental health service is being provided both at Fiona Stanley and at Midland, so there is a bit of a question there. In fact my preference would be to redevelop Graylands, and I have said that to the minister.

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

Dr K.D. HAMES: No, I have said that to the Minister for Mental Health, the minister responsible for this and Graylands. My preference would be to construct buildings at Graylands rather than at this location. But that will be up to the mental health minister to work those things out.

Mr M.P. WHITELY: A further question through you, Mr Chair. How many mental health beds were proposed for Osborne Park and how many extra mental health beds are being provided elsewhere in the places the minister identified?

Dr K.D. HAMES: Fifty are provided at Osborne Park.

Mr M.P. WHITELY: The $44 million would have presumably provided a significant number of beds, not just an extra 50 beds.

Dr K.D. HAMES: Fifty beds will replace largely what was at Graylands. The reality is that we are doing the division on mental health services later today and I will have the minister's advisers there. Can I suggest we leave these questions until the advisers come in?

Ms J.M. FREEMAN: I have a further question on Osborne Park Hospital.

Dr K.D. HAMES: Before the member for Nollamara does that, can I have some clarification of our agenda for today from the shadow minister?

Mr R.H. COOK: I thought we would go for about another half hour.

The CHAIRMAN: The Chair has a question; do not forget him!

Dr K.D. HAMES: There are two other divisions to go: the Disability Services Commission and the Mental Health Commission. I think I have people coming at 3.00 pm for mental health services.

Mr R.H. COOK: I thought three o'clock or a bit after and then we could go on to the others.

Dr K.D. HAMES: I am sorry, member for Nollamara.

Ms J.M. FREEMAN: Given that it is the fiftieth birthday this year of Osborne Park Hospital and the minister celebrated in such grand style with my nieces —

Dr K.D. HAMES: Very nice they were too!

Ms J.M. FREEMAN: Yes, and with my mother and my sister! What is the proposal now that this is not going ahead, at least in the short term, to assist with an upgrade to Osborne Park Hospital? Is there any more money in the budget to ensure that Osborne Park continues to maintain its excellent service to the community?

Dr K.D. HAMES: It is an excellent service and I was very pleased to attend that function to recognise the fiftieth birthday. I have actually delivered children at that hospital. More importantly, I point out that the former Labor government intended to close the maternity services.

Ms J.M. FREEMAN: No, it would never have done it; I would not have let it.

Dr K.D. HAMES: We do need to plan for the future of Osborne Park, but as I mentioned earlier, we are still very keen to progress the relocation of King Edward Memorial Hospital to the site there, and that too is a very old run-down hospital under stress and under pressure. Demand at Armadale–Kelmscott Memorial Hospital is growing significantly. At some stage we will have to do a Midland equivalent for Armadale, and the same in Peel. Peel Health Campus will probably reach its capacity over the next two to three years. There are, therefore, other demands, but that is not to say nothing is being done. I am advised by the director that master-site planning is occurring now to look at the demands for growth at that hospital and the time slots we need to put in for growing the service being provided at that location.

Mr P. ABETZ: I refer to the line item halfway down page 131 under the heading "Infrastructure", which shows an allocation of $117.9 million for redevelopment of the existing site at Busselton Hospital. Could the minister enlighten us on the current status of that project and when the building works will commence?

Ms J.M. FREEMAN: It is not going anywhere!

Dr K.D. HAMES: The member for Nollamara is exactly right: it is not going anywhere—the hospital that is. The construction plans are going exceptionally well.

Ms J.M. FREEMAN: Plan, plan, plan!

Dr K.D. HAMES: We have money for that allocation. We are very well advanced in design. It will be an 84-bed hospital with a community health centre, a community mental health clinic, community-based aged care, a renal dialysis service and a dental clinic. Ian Smith from the WA Country Health Service will answer in more detail exactly where the contract is at. When is construction expected to start—just for the member for Busselton to hear?

Mr I. Smith: The tender for the builder closes on 19 June. We have done the preliminary design; that is out to tender. We will be in a position then to assess the short list of restricted tenderers and that will be happening in the second half of this year. When the actual construction will commence is dependent still on getting the final environmental approvals, both from the Department of Environment and Conservation and from the commonwealth, but we have built that lead time into the building program. We therefore expect that construction will start—I will have to check—I think at the end of this year or early next year.

Dr K.D. HAMES: Not far away at all, is it? I remind members that there was something like $70 million or $80 million in the original budget, and $40 million in royalties for regions money was added to that, taking it to $117.9 million altogether so that we can get a first-class hospital.

Mr R.H. COOK: Can I clarify that point? Will the hospital include an aged-care cohabitation facility? I think the operator was in some discussions with St Ives.

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

Mr R.H. COOK: Basically on the same spot sharing water, catering and all that.

The CHAIRMAN: Members, go through the Chair, please.

Dr K.D. HAMES: Yes, Mr Chair. The proposal involved an aged-care provider who was interested in providing an aged-care service adjacent to the hospital in the other location. That provider remained interested with the change in location, but as we went through the tender process and the provider worked out the costs of construction and details around the provision of service, it decided that it was not economically viable and withdrew.

[2.40 pm]

The CHAIRMAN: As Chairs, we are allowed to ask a question or two.

Dr K.D. HAMES: Do you want to ask about Albany Hospital?

The CHAIRMAN: I do. I would like to congratulate you on the great work you are doing at Albany Hospital, minister. You received $4.4 million from the commonwealth government for new cancer services at the new health campus. Can you advise what that will provide and if there are any other new MRI machines, stroke clinics or anything like that in the new Albany health campus please?

Dr K.D. HAMES: I will ask Ian Smith to answer that.

Mr I. Smith: The starting point is that the $4.4 million for the cancer service will enhance the primary health care and ambulatory cancer services, so there is an increase in the number of chemotherapy beds available, additional staff and a better environment for the joined-up cancer service, including Breast Care nursing staff and whatever working from the same part of the wing.

The CHAIRMAN: Does that have anything to do with the hospice?

Mr I. Smith: No; the hospice is a separate organisation that delivers palliative care under contract to the WA Country Health Service. That will continue separately from the chemotherapy services, which are under the main part of the ambulatory care wing of the hospital. One of the key items of reform for the new Albany Hospital is an active rehabilitation component. A 15-bed wing is being designed to enable active rehabilitation of many of the elderly people in Albany, so they will not just sit on the ward. It is being designed to get a much better outcome-focused solution for that cohort of patients in Albany. On the third point about the MRI machine, the tender has been awarded to local company Great Southern Radiology Pty Ltd. It is actively seeking to get a commonwealth licence to put an MRI machine into the building, and the building has a design to allow an MRI to be in that area.

The CHAIRMAN: I also mentioned a stroke clinic. Will anything like that be provided as a service in the new hospital?

Mr I. Smith: In the national partnership agreement funding with the commonwealth, we will be starting not quite an inpatient stroke unit but more a combination of a community-led service and enhanced inpatient service, so additional therapy staff will come to deliver. We will not badge it as a stroke clinic, but the combination of these extra resources plus what will happen in the 15-bed rehabilitation ward will enable this active rehabilitation to occur and cater for the vast majority of people who will fit into the stroke category.

The CHAIRMAN: Will any other services be provided in the new hospital that are not currently there?

Dr K.D. HAMES: A whole bunch of new services will be provided, including additional mental health capacity, which will be increased by six acute beds, and improved maternity, nursery and delivery suite services. Infrastructure will comply with current standards, whatever that means. There will be improved capacity to meet theatre, day surgery and central sterilisation services department requirements; high-dependency unit and isolation facilities; and improved emergency department capacity.

The CHAIRMAN: Can I have a copy of that, minister?

Dr K.D. HAMES: Sure.

Mr A.P. JACOB: I draw the minister's attention to infrastructure on page 131 of budget paper No 2. I refer to my favourite project, the $229.8 million contribution from the state government to the Joondalup Health Campus redevelopment. Can the minister please inform us on how the redevelopment is progressing—in particular, that early spike in presentations we saw following the opening of the new ED, and whether that has stabilised?

Dr K.D. HAMES: This question was about Joondalup, was it not?

Mr A.P. JACOB: Yes.

Dr K.D. HAMES: The member is very involved in a lot of things to do with the extension of Joondalup hospital. Lots of additional services are being provided there by Ramsay Health Care. It is an excellent example of how public–private partnerships can work in providing a high-quality service. The hospital will go from 280 to 489 beds. We have seen the increased size of the ED. There has been a significant increase—initially up about 18 per cent—in demand to the ED. I do not know what it has settled at now. There are an additional 120 acute medical surgical beds, 15 rehabilitation beds and 10 palliative care beds, and five theatres, an expanded renal dialysis service and an expanded chemotherapy service. The member will recall that one of the issues we discussed was related to cardiothoracic services. I have given an indication, particularly remembering now that under our current plan cardiothoracic services will go to Fiona Stanley Hospital, that some will still be done at Sir Charles Gairdner Hospital. Once the cardiothoracic unit is established, the opportunity is there for us to contract out services to do some patients north of the river, the member for Ocean Reef's area. Dr Russell-Weisz can comment on the number going through the ED.

Dr D.J. Russell-Weisz: The emergency department attendances were originally up 18 per cent. We expected that to settle after four to five months, but it has stayed at that level. More recently, the hospital has had its busiest day on record for ED attendances, yet its admission rate has gone up by only one to two per cent, so it has taken in many more patients. It is seeing more patients from the local area and it is utilising all the new beds that are available. The increased capacity the minister referred to will clearly come on board once we can access the 70 beds that are being used privately once the new private hospital, which is being co-located, is built on site. That will come into place next calendar year.

Dr K.D. HAMES: I think some of the numbers we have just heard about, particularly the continuing increase in demand with no increase in the number of admissions, are clearly reflective of the lack of GPs in the member's area. It is certainly an area that is underserviced by general practitioners. As I pointed out before, it is a commonwealth responsibility. That means that it is a direct transfer of commonwealth government costs to the state, not that the commonwealth goes out and determines the number of GPs in an area—clearly, it does not.

But it is an area in which the state government has to pay the costs that are being transferred to us by patients not being able to see GPs in their own areas.

Ms J.M. FREEMAN: Have those areas been classified by the Department of Health as areas of need?

Dr K.D. HAMES: I do not know. Lots of places are in the same boat. My electorate was very short of GPs for a while, but I think the number has risen just recently. The member for Nollamara's area is well covered for after-hours services. There is a huge dearth south of the river. There is no after-hours clinic anywhere from between Fremantle Hospital down to the member for Kwinana's area. None of the areas in between have after-hours GP services.

Ms J.M. FREEMAN: That is because the area of Mirrabooka has been designated as an area of need.

Dr K.D. HAMES: I have to say that I do not know. The Chief Medical Officer sends me documents on regular occasions to sign off as areas of need. They are from spots across the state where an area of need has been determined. I do not know specifically what is there. I would have thought the member for Nollamara's electorate was reasonably well covered compared with some others.

Ms J.M. FREEMAN: There is not a doctor in Balga at the moment.

[2.50 pm]

Dr K.D. HAMES: But Balga is one suburb amongst lots of others.

Mr R.H. COOK: The best I could do, sorry, is to stick my question under "Total Cost of Services" on page 127. What I am interested in is —

Dr K.D. HAMES: I used to do that all the time!

Mr R.H. COOK: I know! I want to ask the minister about state funding for medical research. I am not referring to the capital funding for the Western Australian Institute for Medical Research north and south; I understand the parameters and the framework for that. I am interested in state-funded medical research that takes place within Western Australia, particularly the level of funding in 2011–12, 2012–13 and across the out years.

Dr K.D. HAMES: The answer is "not enough". The member will be aware that at the Australian Medical Association function, the Premier said that the AMA had convinced me, the Minister for Health, of the need for additional funding for research, but that I had not yet convinced him. However, let me tell the member that I am still working very hard at it.

The government has put in some additional money. We have core levels of funding, which really are base funding, that go to Fiona Stanley, teaching, the Western Australian Institute for Medical Research and other different groups. That funding really pays the base costs to keep those operations running. In addition, in the past year we made some additional funds available. Richard Larkins did a review that detailed a better model for managing the distribution of research funds. We are adopting that model and appointing a committee that will have overall responsibility for that. We allocated some funds through that structure, particularly for Duchenne muscular dystrophy research and research on the use of testosterone in managing Alzheimer's disease and a range of other things. I do not have the details of that, but about 11 additional areas have been funded. The reality is that we need more and I intend to continue to seek that. I particularly want to see extra funding for research in children's services and cancer services and I will continue to fight to get that.

However, overall, the point made by the AMA was that there is this $40-odd million deficiency in research funding. The way it was presented suggested that the state should fund this, whereas quite clearly it is commonwealth funding that we were missing out on—that is, our share of National Health and Medical Research Council funding. I think we get three-point-something per cent. Some of the advice I have been given is that we need to increase our state funding to gear up to get that funding—to provide that capacity.

Mr R.H. COOK: That is why Victoria and Queensland get so much—because they are already doing so much.

Dr K.D. HAMES: No, Queensland's amount is well below its share and so is New South Wales —

Mr R.H. COOK: New South Wales is playing catch-up; that is right.

Dr K.D. HAMES: Of all the states, Victoria gets the bulk of the funding; virtually every other state misses out on its fair share based on population.

Mr R.H. COOK: But I think we are the only state whose actual number of applications is reducing.

Dr K.D. HAMES: I do not know whether that is the case because I have not seen Queensland's figures. I was surprised that Queensland and New South Wales get significantly less than their population share, so I would not be surprised if it was the case for them as well. The reality is that we need more funding for medical research. There are two ways to get that: one is through this sort of fund and the other is through more of an overall

science fund that covers not only medical science but also other sciences. I think there is an opportunity for both sides of government to look at developing that sort of bulk funding to allow for research in a range of areas. We are well behind the eight ball, in my view, and we need to improve.

Mr R.H. COOK: Just to clarify, I asked whether the minister could provide the funding levels in 2011–12, 2012–13 and through the forward estimates.

Dr K.D. HAMES: Yes. We have got funding —

Mr R.H. COOK: Not now; the minister can provide that answer as supplementary information.

Dr K.D. HAMES: We will provide supplementary information that provides the current and forward estimate levels of research funding. I think that I have seen a document that states that already, but I do not have it with me. This is not identified as a line item in the budget, which is why the member could not find it.

The CHAIRMAN: You have been very lenient; you are very kind, minister.

Dr K.D. HAMES: We will provide as supplementary information the total, including the base figure that covers WAIMR as well, so that the member can see what the total state government research funding is.

[*Supplementary Information No A24.*]

Dr G.G. JACOBS: I want to ask the minister about elective surgery waiting lists. I refer to page 129, which notes that there was an increase in elective surgery activity of 1 034 cases over the nine months to 31 March 2012 from the corresponding period in the previous year. Why has there been an increase? What impact has that increase had on the waiting list? Is the demand for elective surgery expected to grow further over the next year?

Dr K.D. HAMES: Yes, it is expected to grow further and the number of people needing elective surgery continues to grow. The growth in demand on our hospitals creates significant capacity constraints. We have to clearly improve our efficiency in that. However, the good news is that we have done a significantly increased amount of surgery. In fact, we remain above national targets, or at least we were at the last test for commonwealth funding. We were second-best, but I think that we are now equal-lowest for the median wait time. The number of people on the waitlist has gone up. To say that I am not concerned about it is inaccurate. The number has gone up, but our efficiency has improved significantly. The number of extra surgeries we have done has improved significantly, so we now have a higher rate of people being treated within the appropriate time than ever before. However, with the growth in demand, at some stage it will reach a critical point at which we will not be able to maintain that standard, unless we continue to improve the surgery that we provide. We have to look at how we can do that in public hospitals, where we are looking at nearly 100 per cent occupancy rates. How do we fit that in? Therefore, we have to look at the people who come through the hospitals. Are they being treated in the appropriate place? Should they in fact be treated closer to the patient's point of origin? A good example of that was someone from my electorate who needed a hip replacement. They had no comorbid conditions, so they needed standard treatment, but they were a category 2 patient—in a lot of pain—for a hip replacement. They were given the names of two doctors by their general practitioner—one was at Peel Health Campus and the other was at Fremantle Hospital. They called the local doctor, but he was on holiday, so they straightaway went to the doctor at Fremantle Hospital. My constituent saw that doctor and was put on the waitlist as a category 2 patient. However, that doctor is so much in demand that his category 2 wait was about eight months, so that patient was never going to be treated in the appropriate time and he never needed to be in a tertiary hospital setting. Therefore, we will look at how that system of referral works to ensure that patients who have no comorbid conditions and therefore could have surgery at a Rockingham, Peel, Armadale, Midland or wherever hospital do not end up being treated at Royal Perth Hospital, Sir Charles Gairdner Hospital or Fremantle Hospital, where the costs are higher because of the management of tertiary patients. Therefore, to take some of the pressure off, we have to improve that system of where patients go.

Some cases that end up on the elective surgery waitlist are cases that the member and I could do in our surgeries, but people might find their GP is not willing to do so. A good example of that was a patient who had a sebaceous cyst. The GP did not want to excise the sebaceous cyst on the patient's back, so the patient was referred to a surgical outpatient clinic that has something like a year's wait for a patient to be seen in the first place before they have the surgery. That is totally silly, so we have to look at those lists and how they work.

Mr R.H. COOK: I have a further question, but I do not think the minister is finished, sorry.

Dr K.D. HAMES: It is all right; I was close enough to finishing that I could probably add in whatever I was going to say in answer to this question.

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

Mr R.H. COOK: The minister says that we are reaching more people within the recommended time. When this government came to power, I think that rate was sitting at about 87 or 88 per cent. As of the last elective surgery waitlist report, I think it was still sitting somewhere between 88 and 89 per cent, so it is at the margins. However, I guess the most important thing is the fact that about 12 000 people were on the waiting list when this government came to power and now there are about 17 000, so approximately 5 000 extra people are on the waitlist and 2 000 of those are over-boundary. The minister is right to say that this is not an area that he is not concerned with. Obviously, he would be concerned about it, particularly since, in the January–March quarter report the department missed every national target so it will not get the bonus payments that come with that. The minister says that the department is going to meet those targets progressively. What does "to meet those targets progressively" mean; and, what new initiatives—new operating theatres or new activity programs—in this budget suggest that the department will be able to reduce those waitlists or keep a lid on those people going out of boundary?

[3.00 pm]

Dr K.D. HAMES: There were lots of components to that question. Part of it is not true; part of it is that we are failing to meet national targets. The national targets have a time line, and we have not yet reached that time line. If the time line was today, but we had to meet —

Mr R.H. COOK: The minister reported against them, and it showed that the department did not meet any of them.

Dr K.D. HAMES: Yes, I know, but that is not the point. What we reported is that at the end of the year, this is the target we have to meet.

Mr R.H. COOK: Yes, that is right.

Dr K.D. HAMES: At this stage we are short of meeting that target. We met the last target and —

Mr R.H. COOK: The department is not within a bull's roar.

Dr K.D. HAMES: — we got our payment. By the time we get to the next target, we need to meet that work. That report is a very transparent way of showing that we need to improve on some of those things. Part of the problem is the difference in reporting mechanisms between different states, and we have been having discussions with Tanya Plibersek about that. A good example of that is bariatric surgery. All our bariatric surgery is done by a certain number of specialists. It is category 2 surgery, so it needs to be done within 90 days, but we have very little bariatric surgery being done. Virtually all of them—a whole cluster of them—are out of boundary, so one of the things we will do is contract out to Joondalup to provide those services. Once that is done before the end of the year, that will allow us to meet that target. I have just been to Queensland where I said, "What are you doing with these patients?" They said, "We won't do them. We don't put them on our list." That is how they meet that target; they do not have these really difficult patients to deal with.

In terms of the numbers, yes, they have gone up, but the numbers do not matter. We have that whole tail of people waiting to get on the waitlist, but just suppose we suddenly found a mechanism, like the one in the United Kingdom, to see all those people within 12 weeks; suddenly we would have a massive number of people coming onto our waiting list. We have been, I think, more efficient in getting people onto the waiting list. The good news for them is that we are seeing nearly every one of them—89 per cent, which is the highest it has ever been, incidentally—within the correct time. The actual number of people who come along to get something done does not matter as long as they are seen in the relevant time. My concern about that number is that without suddenly having lots of extra beds and lots of extra theatres and lots of extra surgical capacity, how long can we keep going and meeting those standards? I will hand over now to the director general, who keeps waving notes at me, to let him say the things in his notes.

Mr K. Snowball: I will talk about the plans around increasing capacity, particularly in theatres. Additional theatre capacity at Joondalup Health Campus is coming online from 2013, so that is five theatres. At Osborne Park, there will be two extra theatres in the next two years, which is the surgicentre, and this is the commonwealth-funded part of the national partnership agreement that is provided to all states.

Mr R.H. COOK: I thought that was part of the cutbacks for Osborne Park, which was the reason I was getting so excited there!

Mr K. Snowball: No. Rockingham is another one. We now have four theatres there, so we can increase the capacity; in fact, occupancy there at the moment is only around 74 per cent, so there is room for us to go up right now in terms of services at Rockingham. In respect of the performance of the system compared with other states, as the minister described, the proportion of people who waited more than 12 months for elective surgery in Western Australia last year was 1.6 per cent, and that is lower than the Australian average, which is 2.9 per cent.

We are actually performing pretty well when compared with other states. Probably the key bit is as follows: the number of patients coming onto our waiting list is increasing; for example, between 2006–07 and 2010–11, we had the highest annual average increase in admission for an elective surgery waitlist compared with any other state. That basically means that we have been putting a huge additional number of people through our elective surgery—so much so that we are now the equal lowest median wait time for elective surgery in the country at 29 days, compared with the national average of 36 days. That is a big turnaround in being able to treat people more quickly, despite the fact that increasing numbers are coming onto those waitlists.

Mr P. ABETZ: The fourth dot point on page 133 of the *Budget Statements* refers to the Friend in Need—Emergency program, which was an election promise that started in 2009. I note that the planned spend in the coming financial year is $28 million, which is a fairly significant sum. Can the minister enlighten us as to whether the program has been a success and how it is currently functioning?

Dr K.D. HAMES: This program has undoubtedly been an enormous success, and just shows what can be done when services are contracted out! The plan for this program came from us when in opposition, and largely came from my experience as a general practitioner dealing with Silver Chain's palliative care service. It provided an amazing standard of service for palliative care that gave me the ability as a GP to share the care of a patient who was dying of cancer at home. Silver Chair would provide backup nurses for 24-hour care if that was required, as well as backup doctors who often had more experience than I. I could ring up, for example, about a morphine drip and find out details about things I should and should not do.

We felt this program could be significantly expanded because a GP sees lots of patients in his or her rooms who the GP feels he or she could care for, but the patients are sent to hospital because it is just too difficult for them to be managed at home. The program applies to patients who go into ED but are not admitted, to patients who are ready to go home but wait an extra couple of days to have dressings changed or to be reviewed, and particularly to patients in nursing homes who have something as simple as urinary tract infection and become incontinent and the staff just do not have the time to look after the needs of those patients because staffing ratios in a nursing home, obviously, are pretty low. This program gives us the opportunity to link up with Silver Chain for any of those circumstances, including having extra nurses to go to the nursing home and help to care for the patient in the nursing home so that the patient need not come into hospital. We have coordinators in each of our tertiary hospitals who organise discussions with patients, who coordinate with Silver Chain, and who make sure those patients have somewhere to go. At the latest estimate, it was worked out that they were caring for 800 patients a day at home whom we contract for and who would otherwise probably have been in our hospitals. The problem is that we do not have enough hospital beds, as the member knows, and the reality is that the beds were needed four years ago when Fiona Stanley Hospital was originally due to be on stream. Delays to that project have contributed, as have the growth in demand and population. But this program allows us to look after all those patients at home who would almost certainly otherwise be busting our hospitals at the seams. This has been a great program. Yes, $28 million is a lot of money. We put it on for the first four years of government, but now that has been rolled into recurrent expenditure as part of our Health budget because obviously it is not something we could ever stop. It is critical to looking after those people at home, and often that is where patients want to be—in the comfort of their home—providing they have all the care that Silver Chain provides. Of course, that is not just nursing; it is other services as well—feeding the dog, looking after the house and all those things that people stuck at home need to have done.

[3.10 pm]

Mr P. ABETZ: What a brilliant system.

Dr K.D. HAMES: Yes, and I am pretty proud of it.

Mr R.H. COOK: On page 137 on which this particular activity is detailed, all the other home-based hospital programs are lumped in. I do not want to hold things up now, because we are keen to move on, so perhaps by way of supplementary information, could we have a breakdown for each of the home-based hospital programs? Has the Friend in Need—Emergency program undergone an evaluation given that it is in its fourth year of operation? I assume it is subject to contract with Silver Chain. Will the contract renewal be subject to competitive tender; and, can the minister tell me the cost difference between Hospital in the Home and FINE? Again, all that can be given as supplementary information if we need to move on.

Dr K.D. HAMES: I am happy to give that as supplementary information, but the member will need to provide the details to the staff up here so it is all written down exactly.

The CHAIRMAN: The minister wants it for *Hansard*. I will read those questions into *Hansard*. They are about home-based hospital programs: can the minister please provide a breakdown for each of the home-based hospital programs; has the FINE program undergone an evaluation given it is now in its fourth year of operation; what is

the term of the current contract with Silver Chain; will the contract renewal be subject to a competitive tender; and what is the difference between Hospital in the Home and FINE?

[*Supplementary Information No A25.*]

Dr K.D. HAMES: I just say that we have done a review of all that and the distribution of the program, because some hospitals are better at using it than the others. Fremantle Hospital has been keener to use its in-hospital services than the others, but we are working on that. We fund both programs at present and there is evidence that both provide specific services of value, but we are looking to rationalise how those services are provided. We will provide that detail for the member.

Ms J.M. FREEMAN: Mr Chairman —

Dr K.D. HAMES: Can I just ask whether we said we would go until 3.00 pm and then switch over? Is that still what we are doing?

Ms J.M. FREEMAN: Yes, we are just finishing. I have one more question—my last question. I refer to "Land acquisition" under "Completed Works" on page 145, and I note the expenditure figures for 2011–12 in that line item. I understand that —

Dr K.D. HAMES: I am on page 145, but which acquisition is the member talking about?

Ms J.M. FREEMAN: "Land acquisition"—it is the next line item after "Kununurra integrated district health service". I understand that the Department of Health has finally done the deal with the Department of Housing over the land on Milldale Way, Mirrabooka, and that the titles have been exchanged. Can I get confirmation of whether that land has now gone to the Department of Health and the future plans for that land?

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

Mr W. Salvage: I can confirm that the deal with the Department of Health and the Department of Housing is being concluded.

Ms J.M. FREEMAN: "Being concluded" or "has concluded"?

Mr W. Salvage: I believe it is being concluded between the Department of Health and the Department of Housing. The Department of Health paid a deposit on the land some time ago of about $1 million and it is now dealt with as part of an exchange with land that the department owned in Cannington, so we were able to settle the deal with the Department of Housing. We will have to look at its future use as part of our capital works planning going forward.

Dr K.D. HAMES: Can I ask what being "settled" actually means? A letter of intent has been signed.

Mr W. Salvage: An in-principle agreement has been achieved.

Dr K.D. HAMES: An in-principle agreement?

Mr W. Salvage: Yes.

Ms J.M. FREEMAN: Did titles shift hands? How does it all work?

Dr K.D. HAMES: I presume.

Ms J.M. FREEMAN: Have the titles shifted hands?

Dr K.D. HAMES: No, because although we have signed an agreement on land swaps, costs and all of those things, and that has now been sorted—everyone is in agreement—we just have to go through the process of doing it. Does anyone have any idea how long that takes?

Mr K. Snowball: No, I do not.

Dr K.D. HAMES: No-one knows how long that will take.

Ms J.M. FREEMAN: Are there any expectations about how long that will take?

Dr K.D. HAMES: Does anyone have any indication?

Mr K. Snowball: The usual is a couple of months.

Dr K.D. HAMES: The usual is a couple of months, and I am not making any decisions yet about what to do with that site, if that is the next question.

Ms J.M. FREEMAN: That is what I was told last year. I was told that that was being done last year and that the titles would be happening in a couple of months. I can go and get the thing. Therefore, we have something that

was going to take a couple of months 12 months ago that will still take a couple of months 12 months later. If it could be managed, so I do not turn up at the next period of time —

Dr K.D. HAMES: I would like to see evidence of that through *Hansard*. I know we were getting close to agreeing, and it has taken an extraordinarily long time, but do not think I said the same words last year that I said this time with the surety I am expressing.

The CHAIRMAN: There was consensus that we would finish this division at about 3.00 pm. It is now 3:15 pm. I will now put the question.

The appropriation was recommended.