NATIONAL HEALTH FUNDING POOL BILL 2012

Second Reading

Resumed from 20 June.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [3.23 pm]: I rise to speak on the National Health Funding Pool Bill 2012, which is an important piece of legislation. It is legislation about which this country can be rightly proud because it represents a significant step for our health services. I make the comment at the beginning that I am the lead speaker on this bill. We on this side of Parliament are in agreement with the bill and support it. I would also like to begin by congratulating the Deputy Premier; Minister for Health on his new appointment in this chamber and wish him all the best in that role.

Mr C.J. Barnett: I congratulated him; he is excited.

Mr R.H. COOK: I am sure he is excited!

Mr C.J. Barnett: He was a bit emotional about it; but he is very excited.

Mr R.H. COOK: Rumour has it he was very emotional about it, Premier! Despite his enthusiasm for the role, we wish him all the best in that capacity nevertheless and look forward to him spending many hours in this chamber guiding the debate over the coming 10 weeks.

Dr K.D. Hames: Nine!

Mr R.H. COOK: But who's counting?

This legislation is supported by this side of the chamber. We believe that a very important part of the national health agenda is being implemented by the Council of Australian Governments to bring the health systems in all the state jurisdictions into a national framework to improve efficiency, to drive reform and to make genuine improvements to health services. This legislation is fundamentally to do with the management of the funds that will flow to the hospitals under the national health reform agenda and is part of the agreement that was reached by COAG. Compromises were made by all parties as the state and federal governments reached agreement over the national funding model.

Unfortunately, this legislation is about a month and a half late. This scheme began on 1 July 2012. It is not surprising, however; we are getting used to legislation in relation to these things arriving late in this place. I cast my mind back to the national health professionals' regulation legislation, which was also committed to this place with some time pressures. I hope that we will not be confronted with the same time pressure when the Minister for Health ultimately brings the public health bill into this place—a bill that is widely anticipated by health stakeholders everywhere. There should be no impediment to the minister bringing that legislation into this place.

From the Minister for Health's track record, we know that either bringing legislation into this place or sending it through the necessary processes of accountability and the scrutiny of parliamentary committees is not necessarily his great passion—we understand that. However, there are obligations on the Minister for Health. We would like the public health bill brought into this place as soon as possible. We are now discussing a bill that essentially retrospectively reflects changes that have already been made. The reason we can look at this legislation in retrospect is that the changes this legislation enshrines have, in some ad hoc form, been managed to date under the Public Sector Management Act.

Dr K.D. Hames: Can I say that I have an excuse in that we were waiting for federal legislation first, but it is not a great excuse because other states have done it faster than us.

Mr R.H. COOK: Sure.

We also understand that this is uniform legislation. In the main, this legislation is agreed across all the state jurisdictions and upon which they are all legislating together. From that point of view we will not be seeking to amend the legislation, but we wish to understand some details of its function. We will be asking some questions of the minister, which we will invite by way of interjection or by way of response in his reply to the second reading debate, to clarify issues so we do not have to go into consideration in detail.

Dr K.D. Hames: All right; good deal.

Mr B.S. Wyatt: Lengthy consideration in detail!

Mr R.H. COOK: Lengthy consideration in detail, yes.

As I said, this legislation in effect enshrines the National Health Reform Agreement reached between the state and federal governments under the COAG jurisdiction. It replaces the National Healthcare Agreement process which, up to that point, governed the management of the joint funding process. I think it has been acknowledged

by everyone that the federal government was in some part slipping in its share of the funding model. Under the national health reform process, the commonwealth government will take up the lion's share of the growth in our state public health spend. That is a very important process because we all understand that there will be exponential growth in healthcare funding and it will require the might of the commonwealth government to make sure we can keep on top of those costs. But there are also efficiencies to be gained in the system by virtue of a national framework. Importantly, we have the opportunity to compare and contrast the performance of different hospitals and to compare and contrast the performance of a group of hospitals within the state or within even a health area network. We are very proud of the changes that have occurred under the national health reform agenda because they, essentially, will put in good stead the entire nation in making sure it meets the challenges of health care into the future.

One of the very important aspects of the national health reform agenda—many people will cast their minds back to the last federal election—and one of Labor's important contributions to the debate, was to try to stop the blame game; that is, to try to stop states blaming the commonwealth, to stop this habit of simply saying, "It's not our fault; it's someone else's fault", with great frustration within the community and extreme frustration to patients. I think the entire health system was poorly served by that process. The important part of the national health reform agenda is to make sure we can stop this blame game. By setting up the joint funding pool we will be in a position to do just that. It is important to note, however, that even in these early days the blame game continues to be part of our health debate. It is perhaps disappointing that we cannot at this stage say that once and for all the blame game will end. Members will appreciate the frustration of people involved in the public health debate about the disconnect between primary and secondary health care in this country. That process will continue because there is this disconnect between people visiting their GP and people going to hospitals. Admittedly, part of the conflict between those two policy areas will be remedied by the federal government having weighed in heavily with funding for secondary health care. But there is still some way to go before we have actually cracked that nut—that is, integrated primary, secondary and tertiary health care in this country—to make sure there is no cost shifting between the states and the commonwealth.

But the blame game continues. Only, I think, last month the minister spoke at a function for one of our important health stakeholders, the Australian Medical Association, and he said in his speech that he cannot put his finger on any reason why we are looking at a nine per cent, at least, growth in presentations at emergency departments. In fact, he specifically said that the acuity of patients presenting to EDs is just as high as it has always been; he said the only difference we are witnessing today is that there are more of them. The problem confronting our EDs is chronic, but there is nothing in particular to distinguish the acuity of patients coming to EDs this year from what has been the case in any other year. Not one or two weeks later we heard another explanation. His department came forward and said, "It is actually about people going to EDs when they don't need to and unnecessarily blocking our emergency departments because their need is not as high. They are going to EDs simply because they might have a cold or something of that nature."

Dr K.D. Hames: Just to clarify; that was a different argument. Throughout most of the year, what I said the first time is accurate. For that particular few months during the flu season there was a big increase in those numbers.

Mr R.H. COOK: It is the very same argument the minister is using to explain that our hospitals are not coping under the level of demand; they are being overwhelmed. We are not talking about months; we are talking about weeks.

Dr K.D. Hames: There are both scenarios.

Mr R.H. COOK: This weekend the minister came up with the latest blame in the blame game; namely, it is not the minister's fault our hospitals are struggling; it is actually the federal government's fault, but it is not the fault of the federal Minister for Health; it is now the fault of the Minister for Mental Health and Ageing. Once again, a state Minister for Health is entering into the blame game. It is always someone else's fault; it is never our fault. It is not that we have not anticipated that the level of demand would be greater; it is not that we have not resourced our hospitals enough; it is not that we simply do not have the policies in place to support our doctors and nurses on the front line. It is someone else's fault. Quite frankly, I do not know how the federal Minister for Mental Health and Ageing is responsible for the bed blockage or the shortage of beds at Princess Margaret Hospital, where just last week on two separate occasions operations were cancelled or postponed due to a lack of beds. That is not the fault of the Minister for Mental Health and Ageing. I suspect there are not too many transition patients sitting in Princess Margaret Hospital —

Dr K.D. Hames: Forty per cent–plus of its presentations were influenza.

Mr R.H. COOK: As I said, it is disappointing that the blame game will continue.

Dr K.D. Hames: I didn't do that headline by the way, nor did I like it.

Mr D.A. Templeman interjected.

Mr R.H. COOK: It takes more than a photo opportunity with a stethoscope to resolve the issues in our hospitals. It takes more than simply trying to blame the federal government for the fact that our hospitals are not coping.

As I said, one of the key aims of the national health reform agenda was to stop this blame game once and for all. I hope this legislation goes part of the way to making sure that is the case.

The National Health Funding Pool Bill provides the mechanism for undertaking a number of key reforms, some of which are around the innovations that are being examined in terms of funding. Specifically, this legislation will enshrine the process of activity-based funding, a process I acknowledge this state government has been looking at for some time, and which some of the other state governments already have in place. Activity-based funding is obviously an important reform and it is pleasing to see that this legislation will continue to extend that principle to the commonwealth level. Obviously, activity-based funding provides a very specific capacity to make a comparison of the costs associated with funding between hospitals—for example, whether a particular procedure is more expensive to undertake in a hospital in the southern suburbs than in a hospital in the northern suburbs, or more expensive in hospitals in smaller states such as Western Australia and South Australia than in hospitals in larger states such as New South Wales and Victoria. This mechanism will actually provide us with an opportunity to drive that reform process further.

We obviously have some concerns about how activity-based funding will impact upon the Western Australian landscape or context. In particular, the local market rate for undertaking a procedure may be greater in this state than it is in other states because of labour market pressures. In his reply to this debate, I would first of all like the minister to explain to the house the local market pricing mechanisms that the national efficient price will be able to take into account. This is a very important component of it, because what we do not want to do is sign up to a national funding model that in effect enshrines disadvantage to Western Australian hospitals because of either our geographical circumstances or our labour market circumstances. We want to be assured that the activity-based funding model, particularly under the national efficient price, will make allowances for those variations between different jurisdictions while at the same time keeping downward pressure on costs.

Dr K.D. Hames: Especially in regional areas like Port Hedland where you have got rents of $2 500 a week.

Mr R.H. COOK: Precisely.

Dr K.D. Hames: It is a huge pressure. So I will go through all that.

Mr R.H. COOK: I deliberately did not mention regionals, because we understand from the briefing that the minister kindly arranged for us that a range of hospitals will continue to be funded on a block basis, and others will shift to the activity-based funding basis. While the minister is taking notes, I would also like him to clarify in his address in reply those hospitals in Western Australia that will continue to be funded on a block basis and those that will shift automatically to the activity-based funding. I understand also that a tranche of hospitals will be transitioned. I would like to know what those hospitals are and what it is about the characteristics of those hospitals that means they are treated differently. We ask these questions not to criticise the activity-based funding model but to understand how it will be implemented in Western Australia and obviously how regional and state variations will be taken into account.

The innovation that is associated with this is a very important aspect of this legislation, because innovation and driving innovation will be an important part of meeting the challenges of our hospital system into the future. I want to provide members with a snapshot of some of those challenges. In the metropolitan area alone, based upon current projections, we will be looking at a growth rate of at least nine per cent in our emergency departments. Many of our emergency departments, particularly in the northern suburbs and at Joondalup Health Campus, are already under pressure and already have emergency department presentations in excess of our two main tertiary hospitals of Sir Charles Gairdner Hospital and Royal Perth Hospital; they are bursting at the seams. Our hospital system is also struggling with a blow-out in elective surgery waiting lists. When the government came to power, the elective surgery waiting list had a smidge over 12 000 at 12 275. At the end of the previous quarter, 16 728 were on the list.

Dr K.D. Hames: And our waiting times are lower.

Mr R.H. COOK: The waiting times are comparable to what they used to be.

Dr K.D. Hames: They are the lowest they have ever been.

Mr R.H. COOK: There was a dip when the minister first came to power when he put in that extra funding and some of the commonwealth funding came in. The minister took it down to about, I think, 87 or 88 —

Dr K.D. Hames: Percentages.

Mr R.H. COOK: That was in terms of the percentage of patients who received their operations within boundary.

Dr K.D. Hames: That is true, but our average waiting time is the equal best in Australia compared with previously being one of the worst in Australia.

Mr R.H. COOK: But in terms of overall numbers, it is still sitting at about 89 per cent of patients receiving their operations within boundary. Eighty-nine per cent is pretty much the same as it was under the previous government. All that has changed is that there are almost 4 500 more people on that elective surgery waitlist.

Other statistics are also alarming. In particular, our dental health system is fundamentally crippled under this government. Over the last 12 months alone, we have seen an increase of over 24 per cent in the number of people waiting for dental health care. There are now 24 000 Western Australians who are in pain, waiting to receive dental care or dental treatment from our public dental health system. That list, as I said, has grown by 24 per cent in the last 12 months alone.

Of course, the other thing to mention in relation to elective surgery waiting lists is that this government came to power promising the people of Western Australia that it would publish within six months a list of all those patients waiting to wait to see their specialist. This is a point about which the minister made a great deal of noise. The minister said that he wanted to have a published list of not only people on the waitlist, but also those people waiting to wait; that is, those people who have been referred from their GP to see a specialist but have not yet seen a specialist. The minister himself estimates that that figure is anywhere between 19 000 and 24 000 patients statewide. This is another broken election promise.

Dr K.D. Hames: I have just got my people scurrying, because I was told it would be on the website by now. They are just going to go and check.

Mr R.H. COOK: I am sure that if the minister had the opportunity to actually meet one of his election promises, he would be leaping to his feet in this place to make a glowing ministerial statement and say, "At last we have fulfilled one of our main election promises!" The fact of the matter is that the minister has not come in here and made that announcement. I, like many others, am a regular visitor to the website. If it has crept onto the website, it has done so in the darkness of night and with very little fanfare. I think that is because the minister knows that it is essentially a broken promise, because the minister said that he would be flinging that published report out to the public. I think it was to be that within six months of getting elected, the minister would have such a list published, and no such list exists.

Dr K.D. Hames: We have, because we have given you answers as to what that number is. Before, when I got the answer off Jim McGinty, it was not with any great accuracy, either.

Mr R.H. COOK: I think what the minister said in answer to my question some time back was that it was about 19 000 and he —

Dr K.D. Hames: I think it was 24 000.

Mr R.H. COOK: Certainly 24 000 is the figure that the Australian Medical Association uses, so many of us use that figure. I think in fairness to the minister, though, he said that he thought it had come down from 24 000 to 19 000.

Dr K.D. Hames: It was 36 000 when Jim was talking about it at one stage.

Mr R.H. COOK: Suffice to say, we wait with bated breath. Obviously, the minister waits in great anticipation of his advisers scurrying back into this place with news that the report has at last made it onto the health department website. I must say that it is with unusual humility, because the minister has not taken the opportunity to advise Parliament that he has actually met that. Perhaps that is because the minister is too busy putting out media releases about wine festivals and other tourism things. These sorts of changes that take place in the health portfolio elude the minister nowadays and slip his attention.

Dr K.D. Hames: You know that is not true. It is something that I did give my commitment to. The director general agreed that he would put it on as quickly as possible. We gave the opposition those figures. I said, "Fine; put them on the website. That is what we promised to do." He said that it was difficult getting those figures absolutely accurate. I said, "That is fine; put them on there with the rider that it is impossible to get absolutely accurate figures." The reason is that there are always referrals coming in and it is not known from all of those different outpatient clinics exactly how many people are waiting to be seen. But I take the member's point, and, hopefully, I will have an answer.

Mr R.H. COOK: If it does happen, minister—I could perhaps draw the speech out longer and wait until they get here—that will be one of the few innovations that the minister has actually taken charge of.

Dr K.D. Hames: Apart from the four-hour rule.

Mr R.H. COOK: No; in fact, the four-hour rule was —

Dr K.D. Hames: And apart from the Silver Chain service.

Mr R.H. COOK: The Silver Chain service is simply an outsourcing of the Hospital in the Home program. The four-hour rule was a pleasant surprise when the minister arrived in the portfolio, because his director general was already hard at it.

Dr K.D. Hames: Let me tell you: he wasn't. There was a committee of staff that was going over there to have a look at it. I added myself to it, it is true —

Mr R.H. COOK: In fact, there was a space there that said "Minister for Health: soon to be advised". The fact of the matter is that the Director General of Health was already hot on the heels of that issue. If the minister had not hounded him out of his position, perhaps the four-hour rule would be in better shape today. Although it made some great gains to begin with, it is fair to say that it has coughed and spluttered ever since. The chap who discovered that the program had merit and that we should implement it in Western Australia was, unfortunately, hounded out of this office by the member for Vasse.

Dr K.D. Hames: It sounds good, but it is not true.

Mr R.H. COOK: It was either that or the former Director General of Health is a liar. When in his final press conference he talked about his achievements in that position, he mentioned the four-hour rule, about which he said, "By the way, that was my idea." He was absolutely right. I know that the Minister for Health has claimed this idea ever since, but it was a pleasant discovery that the minister found once he gained office.

Dr K.D. Hames: I question his recollection of events.

Mr R.H. COOK: I am sure the minister would, because this man left under very sad circumstances. He was a great man who made a great contribution to our health system and who, quite frankly, deserved much better treatment than he received from the Treasurer of the time. Quite frankly, he deserved greater protection from his minister in that process. We lost a great servant of our public health system when he was quite sadly hounded from his position, essentially, by the government's frontbench henchmen—people whom the minister was clearly not able to stand up to—which created a very sad set of circumstances. The fact is that it was the director general's idea and he was the person overseeing that reform. The fact is that the main gains made in that reform were essentially made in the time he was taking personal carriage of the program. We have continued to see some improvements, I grant.

What other innovations has this government brought to the health system? Of course, there is the great innovation of privatisation.

Dr K.D. Hames: Is this relevant to the bill?

Mr R.H. COOK: Clearly it is, because the minister is engaging with me very enthusiastically.

Dr K.D. Hames: I always do.

Mr R.H. COOK: Clearly it is a topic in which the minister is keen to engage in the context of this debate, so it must be relevant. Apart from the two innovations the minister discovered upon getting into office—the four-hour rule, which was not his idea, and privatisation—which were not mentioned prior to the last election, we have the outsourced Hospital in the Home program and —

Dr K.D. Hames: There is the huge increase in the patient assisted travel scheme funding based on the Senate committee report, which was our election commitment.

Mr R.H. COOK: There have been increases in PATS funding, particularly the contribution the minister's National Party colleagues made to the Royal Flying Doctor Service, but that is called topping up; that is not innovation. From that point of view, this bill is one of those innovations for our health system that the minister will be able to say took place during his time. But the minister was dragged kicking and screaming to the process, engaging in what would have to be described as a pretty unsavoury piece of political brinkmanship with the federal government.

Dr K.D. Hames: Do you mean the fact that they were going to take 30 per cent of our GST?

Mr R.H. COOK: I mean the fact that, like a number of genuine processes of reform, the minister has taken the path of playing federal–state politics rather than looking at where gains can be made. However, I commend both the states and the commonwealth government for now coming up with this compromise package, which

fundamentally looks pretty good. It looks like a pretty reasonable response to what was essentially an impasse between the state governments and the federal government.

For members' information, as the minister pointed out in his second reading speech, essentially this bill concerns the appointment of an administrator who manages a joint funding pool, and that administrator is responsible for dispensing funds to the area health networks that oversee the funding of hospital services within their particular area. This administrator is appointed by different state jurisdictions and is the same person across each of the jurisdictions. The pooled funding mechanism will become that pool of funds through which the large component of the growth in health expenses will be paid. That gives rise to a number of questions that I would like the minister to clarify in response to the second reading debate—again, not because we seek to criticise but because we seek to understand. Some of those points relate to what happens, for instance, when members of the council, who comprise the ministers for health across each of the states so assembled, cannot agree upon the appointment of the administrator. What happens when we have a set of circumstances in which one state decides to become recalcitrant or to frustrate the process and in that sense tries to undermine the entire process associated with the appointment of the administrator? The legislation makes clear that the members of the council must agree upon the appointment and then they must all appoint the same person as the administrator. We seek to understand what the minister anticipates will be the contributions over 2012–13 and 2013–14 from both the state and the commonwealth governments to create the pooled fund in Western Australia; that is, what will be the value of the fund and its two components? Just to summarise, we wish to understand: which WA hospitals will be funded on an activity-based funding basis; which hospitals will be required to transition to activity-based funding; and which hospitals will continue to be funded on a block basis?

As I said, the Labor opposition supports this legislation, because we believe it is very important that as a nation we continue to meet the challenges of delivering a health service that continues to reform, to create efficiencies and to meet the funding challenges into the future. The national health reform task force observed that by 2050, if the funding requirements of our health system continued to grow as they had to date, they would outstrip the entire revenue base of all the states and local governments of Australia put together. Clearly, we have to find a mechanism to move forward in a way that will enable the system to draw upon a larger pool of funding—the commonwealth government is obviously in a better position to meet those challenges—but also to move forward in a way that allows us to continue to build efficiencies into the system. These efficiencies should allow for a comparison around the cost of procedures and other aspects of health service delivery not only between jurisdictions and hospitals, but also across entire jurisdictions, so that we can see whether the Western Australian government is performing better against other state governments and in what areas—because we do perform better! The minister obviously takes great delight in coming into this place to point out when that is the case. Obviously, there are areas in which we fall back into the pack somewhat and therefore there are areas in which we need to improve.

Dr K.D. Hames: I'm just recalling the things that I've done. I'm up to 11 so far. That'll fill out my speech; that'll be good.

Mr R.H. COOK: That will be good, minister.

Dr K.D. Hames: There's a saying that relates to that and it comes from a movie: "What have the Romans ever done for us? They built the aqueduct. Yes, but apart from the aqueduct, what have the Romans ever done for us?"

Mr R.H. COOK: One of the key things that the Minister for Health has done—I compliment him on this—is that he has substantially carried forward the reforms of the previous Labor government in implementing the recommendations of the Reid review. Although I think the minister has continued Labor's vision in health, he is not continuing Labor's plan for health care. Although he understands that the Reid reform changes are very important, he does not understand the importance associated with that in driving change at a secondary hospital level to make sure that those hospitals take the bulk of patients and that we need to continue to invest in smaller hospitals to drive down the cost of health in this state.

It is pleasing to see that this legislation has come to this place. It is obviously disappointing that it has taken some time for it to do so; indeed, it is after the start date of the funding process, although I take on board the interjections from the minister in relation to that. As I said, the Labor opposition will be happy to support this legislation.

MR J.C. KOBELKE (Balcatta) [4.01 pm]: I also rise to say a few words in support of the National Health Funding Pool Bill 2012. Clearly, the whole area of health is a very complex one, and the minister, as a medical practitioner, has a far greater depth of understanding than I. We are dealing with not only the provision of medical services and all the complexity that goes with that, but also the management systems, the location of

those services to meet the needs across our large state and the funding for those services. This bill makes a major change in the way that the funding is to be provided. The funding will be activity based, but it will be only two years before that will impact on the level of funds flowing through, if I have it correct, minister. The system will be in place for the current year and next year, but the real impact on the level of funding will be seen in the year following that.

Dr K.D. Hames: Yes, except that the commonwealth has guaranteed that we won't get less funding and has guaranteed growth of something like $6 billion beyond 2014 to 2020. But, at the end of the day, we are dependent on the commonwealth government—not just the current government, but future governments—providing that money.

Mr J.C. KOBELKE: I accept that, and I will touch on something in that direction. The point I am making is that the funding mechanisms for both state and commonwealth funding will be changed in this legislation. In large part, it will be activity based. There will be a system for setting the amount of money that is provided for a particular procedure, and that will be standardised. If the state does those procedures at a lower cost, it will keep the money; if the delivery of those particular procedures costs more, the state and the area health bodies that are set up will have to find that money from other sources. The first point I want to make is that this move has been made in the United Kingdom, and I think the system applies in Victoria.

Dr K.D. Hames: And in South Australia, too.

Mr J.C. KOBELKE: How long has South Australia had it for?

Dr K.D. Hames: I am not sure exactly, but the minister said about five years, roughly.

Mr J.C. KOBELKE: Has it been that long?

Dr K.D. Hames: Yes. He convinced me to go to that. He's a very good minister and he told me how well it's working.

Mr J.C. KOBELKE: The issue I was coming to is that, on the evidence from other jurisdictions, it appears that greater efficiencies can be driven through this funding mechanism. Clearly, we would want to support that. But, as the member for Kwinana said earlier, we need to make sure in the detail that it delivers real outcomes, because we can have a very good system in principle, but the devil is in the detail. If it is not put together correctly, the funding system may not deliver the better outcomes and efficiencies that we are hoping for. We see this as a step in the right direction. Hopefully, the state government, the federal government and the agencies that will be established under this legislation will ensure that it is administered well, that the challenges that will arise as we go through it will be resolved, and that we will end up with improvements in the health system. That is the hope. There is some reason to believe that it can deliver.

I want to turn to an interjection that the minister made in debate some time ago. I was addressing my concerns that we could not maintain the increased level of funding for health that we have seen over the last four years. Clearly, I see that as driving the approach in this state, across Australia and in the UK and other places. The demand for health services continues to grow for a range of reasons that I could go into, but I will not do that now. We therefore need mechanisms that ensure that the use of funding for health is efficient and that we get the best possible outcomes. The point I am coming to is that in that debate, I indicated that in the five years under the minister's government, recurrent expenditure has gone up by over 50 per cent. In those five years from July 2008—there was a Labor government then, but the Liberal government took over a couple of months later, so it had control of the budget in that year because it brought in a whole lot of new expenditure—to the 2012–13 budget that the government has just brought down, recurrent expenditure has gone up by just over 50 per cent. When I put that to the minister about the problems with health, he said that there were no problems because health funding has remained at roughly the same percentage of the state budget. I accept that because I have not checked the health figures.

Dr K.D. Hames: It's about 24 or 25 per cent of total state expenditure. As we earn more, we spend more.

Mr J.C. KOBELKE: So what the minister is saying is that in 2008, health expenditure was about 24 per cent of the total recurrent budget.

Dr K.D. Hames: In 2005 or 2006, it was 25 per cent.

Mr J.C. KOBELKE: And the minister is saying that it is the same now.

Dr K.D. Hames: Yes.

Mr J.C. KOBELKE: But the point I am making is that although recurrent expenditure has gone up by over 50 per cent since 2008, the health budget also has gone up by over 50 per cent, or close to it in actual dollars.

Dr K.D. Hames: You've got to remember that it's compounding, so you can't just do a single comparison. It's going up by about nine per cent a year.

Mr J.C. KOBELKE: Let us be absolutely clear on the statistics. I am not seeking to mislead. If the expenditure at 30 June 2008, which was the end of that financial year, is compared with the budget that was brought down for 30 June 2013, the increase—not the annual increase—over those five years is over 50 per cent, which does not average out at exactly 10 per cent a year, but it is about that.

Dr K.D. Hames: I think that's fair enough.

Mr J.C. KOBELKE: From what the minister is acknowledging in his interjections, health expenditure has grown by something close to that. I put the point to the minister in that debate that that was simply not sustainable. We cannot have growth in health funding approaching 10 per cent every year.

Dr K.D. Hames: We can if state income and state expenditure is the same. In Western Australia, we've had significantly increased income as a state government over the year, and that's given us the capacity. We've had a lot more money to spend. Twenty-five per cent is the same percentage, so it's affordable. If our income started dropping below the increases we've had, we wouldn't be able to sustain it.

Mr J.C. KOBELKE: I appreciate the interjection of the minister because he is helping to open up my concern by the very statement he has made. Although recurrent expenditure in the budget has grown by over 50 per cent in those five years, revenue has grown by only 32 per cent. That is why it is not sustainable. Over those five years the government has had a growth in revenue of only 32 per cent. Health cannot grow by eight or nine per cent a year.

Dr K.D. Hames: It is easy enough to say that those percentages are different, but the reality is that if the percentage of expenditure is exactly the same now as it was 10 years ago, your figures cannot be accurate, can they?

Mr J.C. KOBELKE: My figures are absolutely accurate. The minister does not seem to have grasped what I am saying.

Dr K.D. Hames: I do. I do understand. I am just saying that you're wrong.

Mr J.C. KOBELKE: Minister, just listen for a moment. There might be a communication issue here because, as I said, the minister has a thorough understanding of health—or I would like to think he does—but he does not seem to have an understanding of the finances that health requires. That is what this bill is about. The government cannot continue to grow health expenditure by something approaching 10 per cent a year. It is simply not sustainable. The state is doing well. A growth in revenue of 32 per cent in those five years is quite good. We did slightly better in some of the years under Labor. I am not claiming the credit; the economy was going even faster for a while there, so we had even better revenue. The government has had a big reduction in GST. We got a bit of that, but that is really hurting this government. The government has had a drop-off in its land taxes and an increase in some of its mineral royalties. The government has had a huge increase in payroll expenditure because employment growth has been strong. However, to have a growth in revenue of 32 per cent over five years does not allow the government to increase health expenditure by eight, nine or 10 per cent each year. That is the very point of this legislation. This legislation is trying to put in place a funding mechanism that recognises the real pressures on health and creates a new way of ensuring sufficient spending to maximise the outcomes for the people of Western Australia. Whether they are inpatients or outpatients, the people of Western Australia rely on our health services and our hospitals for various procedures and we have to make sure that we get the best possible outcomes. Hopefully, because of the complexity of the whole system, we will see some of those changes. Putting money into a preventive program may reduce expenditure on delivering services to people who are chronically ill. Although that is a more complicated picture, one can hope that improving the way the service is delivered so it is more efficient, and improving health outcomes through preventive means, will start to put downward pressure on the increasing demand for health services and the increasing cost of them. I do not know whether the minister perhaps has not got his head around some of the numbers in the expenditure —

Dr K.D. Hames: I have. I will give you the graphs. I will convince you on paper if I cannot convince you with words.

Mr J.C. KOBELKE: First, what is the minister trying to convince me of?

Dr K.D. Hames: If we have two cups of sugar and at the start of our term 25 per cent of that cup is being used for health and the other 75 per cent is used for the rest of the services the government provides, after four years, we have suddenly got two cups of sugar instead of one because we have greater income—you say that it is only 30 per cent higher, but whatever amount that is of growth of income of the state. If I am still using only

25 per cent of the total amount of that growth, I am not using a greater share of the total expenditure of the state than I was before, which still leaves 75 per cent to spend.

Mr J.C. KOBELKE: I do not argue with that. The minister has missed the point. The point is that the health system is on the public purse for a growth rate of eight, nine or 10 per cent a year. It gets used to that growth rate. We cannot sustain that growth rate, because we will not continue to have a growth rate in revenue at that level. That simply has not existed and it will not exist. The level of expenditure increase in health—which we have had and which has hopefully led to a lot of extra services being delivered, which is great—is not sustainable. That is what this very bill is about; it is about putting in place a more efficient system. The minister can say, "That's okay. We are always going to take only 25 per cent. In the budget after next year's budget we will have no increase in revenue." The minister cannot turn around and say that we will have no increase in health expenditure. All the pressure is there. The system wants the extra money.

Dr K.D. Hames: I do now get and accept your point, but in suggesting that I did not understand you, you missed a line I used, which was, "That depends on the revenue growth." If the revenue does not grow at the percentage it has been growing at, sure, you have difficulties. I said that with the growth we have currently, we have the capacity. So, I agree with the point.

Mr J.C. KOBELKE: I take what the minister has said and I appreciate his interjections. To bring it back to the bill, what the minister is saying does not, in my view, reflect the reality. The reality is that when the minister sits down to organise the health budget with his department and then goes to Treasury and government, he does not say, "What's the revenue growth going to be? I want a quarter of it." The minister does not work that way. He knows that. He says, "I have this many beds. I have this big a waiting list. I have ambulance ramping. I need the money to fix the problem." That is how it works. Do not give me this nonsense about looking at the revenue and taking 25 per cent. It does not work that way. That is the point I am getting at. It is a difficult management issue. This legislation offers us part of the solution; it is not the total solution. This legislation offers a new funding mechanism, which, hopefully, will drive the whole system to be more efficient so that we get better outcomes. It will not stop the increased demand. It will not really take away the need to put more money into health. The cost driver is not the revenue; the cost driver is people who are not well. With the ageing population —

Dr K.D. Hames: I do not agree with that statement at all.

Mr J.C. KOBELKE: The minister does not disagree. Perhaps when the minister interjected on me before, he misunderstood what I was saying. I was very surprised that the minister did not pick up the point I was trying to make; I accept perhaps that was through me not putting it clearly enough. We have had a situation of very high growth in expenditure in health that is not sustainable. Therefore, we really have to look at that seriously. That is only part of the answer. Another part of the answer was the Reid review to try to structure the services so that they were closer to people and to increase efficiency by removing the duplication across our tertiary hospitals. The Liberal–National government has come in and scrapped that. Now we will have —

Dr K.D. Hames: No, we haven't.

Mr J.C. KOBELKE: Services were going to be transferred from Royal Perth Hospital to Fiona Stanley Hospital. Now some are going to Fiona Stanley Hospital and some are staying at Royal Perth Hospital, and the government will simply not get those efficiencies. The government will get some efficiencies because it has a great new hospital, and by its newness and its construction and the thought that has gone into it, it will produce some efficiencies.

Dr K.D. Hames: You were moving Royal Perth, in effect, to Sir Charles Gairdner Hospital. It was going from 500 to 1 000 beds, so you were just moving it from one spot to another. You weren't getting rid of it.

Mr J.C. KOBELKE: Yes, but it is all the specialties. That is part of the problem the government has; how will it run the same specialties at Royal Perth Hospital as it will at Fiona Stanley Hospital?

Dr K.D. Hames: Easy.

Mr J.C. KOBELKE: The minister says "easy"! The point is made by the minister's interjection. He is a doctor. He is a health professional. He simply wants to deliver those services and he is not giving a second thought to how to organise and pay for it. The point I make, which may not be popular with the minister or with sick people out there when we take it at first look, is that we have to have a system that will provide the services. When people cannot get services in our hospitals, when they are stuck in the ambulance ramping and when they are on long waitlists, it is not easy to explain to them that it is because this government does not worry about making the system efficient. It is not worried about that. The minister is a GP who just wants to respond to the needs of people.

[Member's time extended.]

Mr J.C. KOBELKE: He just wants to respond in a caring way. That is great. But in a system as large and complex as health, that will not work. I ask the minister to perhaps start thinking a bit more about how he can drive the efficiencies in health, which is not easy. He is well aware; he has a very strong and vested interest in health. A simple little example is his response to people taking gifts from pharmaceutical companies. His view is that it means those doctors can travel and pick up information when they are going to conferences and that is good. The fact that it is opening up corruption does not worry the minister. I am very concerned about it. That is how corruption is driven. But because there is a bit of positive spin of allowing our doctors to get those trips and there is value in that, the minister is willing to put up with the risk of growing corruption in the system.

Dr K.D. Hames: There is far more scrutiny under our government than there ever was under yours. Do you think it didn't occur while you were in government?

Mr J.C. KOBELKE: I take the interjection from the minister. He said there is far more scrutiny under his government. It has put in place a system under which the doctors and the people involved in buying the drugs from the pharmaceutical companies have to report their gifts. The Auditor General did a spot study that found that 15 per cent of the people who got gifts registered and recorded them, and the minister says, "We've got much greater scrutiny", and puts in place a system that does not work. The Auditor General showed very clearly that it did not work, minister. Again, that is another example in which this minister, who is a medical practitioner, has not really put on the hat of a health administrator who wants to get real value out of our hospitals—real value for the public, for the people who need the services, from the money we are putting in. I certainly do not begrudge the money going in—it is needed—but I want to make sure that it is well spent and we get the outcomes, and the funding model in this bill is a part of that.

The last little thing I want to say is that what the minister has done with the price of parking, particularly at Osborne Park Hospital, relates directly to this measure. I go back to the last Minister for Health in the Court government, John Day, who is the current member for Kalamunda. In negotiating the enterprise bargaining agreement with the nurses, he cut some costs by reducing the hours they worked per week, which reduced their income. That was not the only cause of it, but we then had all these nurses leaving the system and we did not have enough nurses. Therefore, the system started to grind to a halt. When Labor came in, it had to fix that, fix the nurses' pay regime and make sure that we had enough nurses so that the system could run properly. What I am saying to the minister about his pricing of parking at hospitals is that he could undermine the good work that we have in this bill because that will be one of the drivers for people to leave the health service—the very important workers who provide those services. If they have to do shift work and park at Osborne Park Hospital or other public hospitals, and the cost of that parking is a deterrent to their continuing that work, we will start to see the attrition rate go up, so we will have fewer nurses and fewer people working in our hospitals, and the problem of actually delivering the services also will start to become even greater.

I think the minister is taking this penny-wise and pound-foolish approach to the cost of parking at Osborne Park Hospital and other hospitals. It is simply trying to grab some cash from the people who make our hospitals work. I believe that runs counter to this bill and what it is trying to do in putting in place a funding system for health that will give us greater efficiency and better outcomes with the amount of money being spent. I hope the minister will have a big rethink of that because I know that if the minister has not said it, the health department has said that it has a program to get its hospital workers to use more public transport. It is a nonsense to have a young woman who works as a nurse and who has to work a shift until early in the morning or start a shift at nine o'clock at night using public transport. Having car parking for staff at our public hospitals is not the same as having car parking for someone who works in the city from nine till five. We have to provide a good, safe parking environment at very low or no cost to those people. If the minister starts to put in place another disincentive for people working in our hospitals, as he clearly is with his huge increases in the cost of parking, it could lead to a diminution in services at our hospitals because he will find it harder to get the good staff we need.

It is great that this bill provides a new model for funding. We hope that the management of it will really deliver. That in itself will be a challenge. However, when the minister has moved away from the Reid review reforms and when he has attacked the people who work in our hospitals by requiring them to pay ever-increasing amounts for parking, I believe that undermines the efficiencies of a really well run health system. I hope the minister will think again about trying to get money out of people's pockets because he cannot meet all the growing demands and put in place a cohesive overall management system that works with the provisions in this bill to help improve the health system for the people of Western Australia.

DR A.D. BUTI (Armadale) [4.25 pm]: I rise to make some comments on the National Health Funding Pool Bill 2012 that is before the house. As was mentioned by the previous speakers, this bill is to give effect to the national Council of Australian Governments' agreement on health reform of 2011. I believe Western Australia is one of the last states, if not the last state, to give legislative effect to the agreement. Members will recall from the debates at the time that the Premier had major concerns about ensuring that the commonwealth government did

not take control over certain funding responsibilities of the state. Basically, this legislation gives effect to the agreement that was reached by the various health ministers and the Premiers. Therefore, there is uniform legislation in the various state Parliaments and also in the commonwealth Parliament. The agreement sets out the financial arrangements for Australian public hospital services and provides the governance arrangements for primary health care and aged care. It is interesting that the minister, by way of interjection on the member for Balcatta, mentioned that the portion of the state budget that is taken up by health is about 25 per cent a year. It is an incredibly important area of government. Any government, particularly any state government, that has the first responsibility for health in the constitutional system that we live under has to ensure that it is able to cope with the funding pressures that the health system imposes on governments of any persuasion.

Nothing in the agreement that the legislation gives effect to will necessarily bring solutions to the funding problems or the difficulties of state governments in meeting their responsibilities for health. This comes back to the old problem of fiscal imbalance, I think it is called, whereby the commonwealth, of course, gathers most of the revenue in the total Australian economy, but the state Parliaments or state governments often have the major spending responsibilities. If I am correct—we will have to look at it in detail, minister—one of the objections that the state of Western Australia had to the agreement and to the act which was before the commonwealth Parliament and which has now been passed related to proposed section 248. Western Australia did not feel that it was necessary to confer powers on the administrator of the commonwealth in regard to the funding arrangements. I have not been able to look in detail at the legislation, so I will be interested to see whether that opposition by the state of Western Australia still remains.

As I mentioned, health is an important area for many reasons. It is important because about 25 per cent of the state budget is spent on health. I think it would be a courageous minister who would stand before this Parliament and say that that percentage will decrease. If anything, it will probably increase. Of course, how much it will increase is uncertain at this stage but, as the member for Balcatta mentioned, it is unsustainable. I take the minister's point that if the total revenue of the state increases, it can spend more money on health, but as a percentage —

Dr K.D. Hames: No, it has stayed at the same percentage for the last 10 years, so our income has been increasing enough for us to maintain that 25 per cent. But the member for Balcatta is right in the sense that if we start coming off the surge we are having and we have a big drop in revenue, it will become unsustainable, which has happened in every other state.

Dr A.D. BUTI: That is right.

Dr K.D. Hames: So that's why this is important, because it helps that balance.

Dr A.D. BUTI: That is exactly right. I think proper due in this process has to be given also to the federal government because, really, the funding of health has been a bit of a mess for a number of years. Part of that is because of the demands on the health system of every state jurisdiction and that the commonwealth government has the primary funding responsibility. Even though the states, of course, have responsibility for the health system in each state, the funding comes from the federal government. That is why there is always this tension that develops in this fiscal imbalance in which revenue comes in from the federal government but spending takes place at the state government level.

As was agreed by the minister, of course he would consider health to be of primary importance and a primary responsibility of any government. His previous profession as a doctor attests to his commitment to health. In any democratic system it is obvious that health is a very important responsibility and duty of government. Any government that makes a real mess of the health system probably has its days on the Treasury benches numbered, although it is a bit strange at times that during some election campaigns the health debate is minimised; it does not have major priority. Health is often talked about during the term of government, but when it comes to election time, it often takes a bit of a back seat, similar to education. Education is often talked about during the term of government, but when it comes to elections, it is not often talked about. I think that if we asked most people what they consider state governments to be responsible for and what they have to get right, health would have to be in the top three or four. I would be surprised if that was not the case. But at election time, that is a different issue. But I think if we asked anyone in Western Australia about how they consider health and the responsibility of government to get it right, they would consider it very, very important.

The National Health Reform Agreement goes only to part of the solution. All it really tries to do is ensure that we have a funding model that allows for the proper funding of hospitals and the public health system from the central government to the various state governments. Whether that will be successful, time will be the decider based on the effort and the system that has been put in place. At one stage, this agreement looked like it was going to fall down, partly due to the opposition of the Premier. However, it is good that eventually agreement

could be reached so that legislation arising from the health reform agreement could come before the commonwealth Parliament and now the Parliament of Western Australia.

I mentioned that most citizens in a democratic society would consider that health is a very important issue, and that is backed up by human rights law that is recognised at the international and national level and no doubt the Western Australian state level. The right to proper health is considered a human right recognised under the United Nations international human rights instrument. Under article 12.1 of the International Covenant on Economic, Social and Cultural Rights, it is recognised that everyone has the right "to the enjoyment of the highest attainable standard of physical and mental health". Of course, the high standard that is possible varies between nations because of the different resource bases that nations have. But in a rich society, a rich state such as Western Australia, there is no excuse for every citizen not to be able to be the recipient of proper health care.

I will be perfectly honest and say that every government, whether Liberal or Labor, has had problems trying to deal with the demands on the health system. At the moment a state Liberal government, the Barnett government, has the responsibility to ensure that we have a proper health system. It is good to go back and look at what happened four, five, six or seven years ago only if it has an impact on what is happening today. In the end, what is important is what citizens receive today, not what they received five, six or seven years ago. Can they go to hospital and be confident? Can they be guaranteed that there will be appropriate health care? Will the National Health Funding Pool Bill, which gives legislative effect to the Council of Australian Governments' agreement of 2011, assist? It will assist in regards to the funding model that state governments will have to deal with. However, the state government has to ensure through its minister and the cabinet process that our health system is properly funded. Efficiencies will have to be imposed on the health system, but those efficiencies cannot be to the detriment of quality health treatment of our citizens.

If I can maybe bring it a bit closer to home, the hospital services in my electorate, the Armadale hospital, has been under strain because the population of Armadale and the surrounding areas has increased enormously, as of course it has increased in other areas. Most areas of the Perth metropolitan region have increased in population. I challenge the minister to be able to claim that the funding and the services provided at the Armadale hospital have matched the increase in demand. I do not think that they have because in effect it is a regional hospital. It services not only the Armadale metropolitan area and part of the south east corridor, but also part of the rural regions south of the Armadale area. I would make a strong claim that it should be a beneficiary of royalties for regions! That might solve all the problems. If we could make Armadale a rural region, I am sure that we would clearly benefit from royalties for regions.

Mr P. Abetz: I'm with you!

Dr A.D. BUTI: I thought the member might be!

Mr D.A. Templeman: All of you are trying to jump on the bandwagon!

Dr K.D. Hames: And all of Mandurah as well!

Dr A.D. BUTI: That is right.

Before I return to the issue of the Armadale hospital, I will just backtrack to a point that I was going to bring up about the national funding agreement. One of the major problems in our federal system in not only health but also other areas is the blame game. The state government blames the federal government and the federal government blames the state government. One aim of the national agreement is that the blame game may stop. I doubt that it will stop. There are many people on the other side of this house who if there was a change of federal government would not be able to say a word. Some of them never mention anything but federal issues! We could think that we are the commonwealth Parliament because these people have an inability to talk about state issues. However, let us hope that this agreement will end the blame game to a degree. I am sure that the Western Australian government in agreeing to conform to most of the COAG agreement on health and bringing in this legislation does agree with the sentiments of the federal government that the blame game must stop, because the blame game will not help improve the health system.

The funding of the health system is incredibly complex. It is one of the most difficult areas, if not the most difficult area, that any government has to deal with. Therefore, if this funding agreement, which is reflected in the legislative provisions of the bill before us, even in small measure helps provide a more efficient form of funding from the commonwealth to the state level and overcomes some of the fiscal imbalance—a result of our constitutional federal system in that state governments do not have the ability to raise revenue to the same degree that the commonwealth government does—it will go some way to help a state government of any persuasion to fund the health system.

I return to the local issue of the Armadale–Kelmscott Memorial Hospital. The Minister for Health did not challenge my statement that funding of Armadale hospital has not kept pace with the demand that has been

placed on it. I am sure that many of the member for Southern River's constituents utilise Armadale hospital because the only public hospitals in the south east corridor are Bentley Hospital and Armadale hospital. The demands on Armadale hospital are enormous and growing every day; the hospital services the south east corridor and also takes in the rural regions to the south of Armadale. Clearly it cannot cope, and there is a long history here. Although the National Health Funding Pool Bill 2012 does not necessarily deal particularly with mental health, health funding will of course impact upon issues such as mental health. While preparing my contribution to this debate I came across an article from November 2010, when the member for Eyre was Minister for Mental Health. In the article he talked about the issue of a man who had been discharged from Armadale hospital less than 24 hours after presenting with what was later diagnosed as a severe mental illness. Of course that was unacceptable, and to give the then minister his due, he launched an investigation into that tragic situation.

The issue of mental health interacts with the public health system, which of course the Minister for Health has jurisdiction over, along with the Minister for Mental Health. The mental health situation is actually quite alarming; I have recently received information about the demands being imposed on our public health system in respect of juveniles and adolescents with mental health problems. As the minister would know, there was a report in last week's *The West Australian* about the tragic situation of three teenage suicides.

[Member's time extended.]

Dr A.D. BUTI: I am led to believe that both ward 4H of Princess Margaret Hospital for Children and the Bentley adolescent unit, both of which deal with adolescents with mental health problems, are at bursting point, to the extent that there are some adolescents with mental health problems who have to be catered for in the adult wards. Teenagers presenting at hospitals with acute mental problems is an incredibly serious matter, and it places enormous stress on their families. If hospitals cannot find a bed in the specialised wards that have been set up to treat, supervise, care for and monitor adolescents with mental problems, we have a major problem. I would be interested to know how the minister intends to try to overcome the problems that our public hospital system is experiencing in trying to cater for young people with mental health problems. As I said, there are waiting lists at Princess Margaret Hospital and Bentley Hospital for young people who present with mental health problems and often with high-risk suicidal tendencies. I believe that the acute community intervention team that has been set up is stretched beyond capacity.

There have unfortunately been a number of suicides in my area; only a few weeks ago I received a phone call about people seeking to end their lives by laying on railway lines, and I have written to the Minister for Transport about this. If members drive down the stretch of Albany Highway that runs parallel to the railway line between Gosnells and Armadale, they will see at least two or three spots where flowers have been placed; those flowers are there in memory of people who have taken their own lives on the railway line. I do not intend to try to play politics on this issue, and I know that the Minister for Health would not either, but that is an incredible worry for us as a society and for the minister as Minister for Health, and the public health system has to attend to it. I implore the minister to work with the Minister for Mental Health to come up with an arrangement by which we can increase the capacity of hospitals to ensure that adolescents who present at specialist units such as the Bentley adolescent unit are able to be treated in an appropriate manner rather than being shunted off to adult wards, or not even given a place. Something desperately needs to be done.

Yes, the government has agreed to this National Health Reform Agreement, although it has taken a while for it to come to the party. It has at last brought this legislation before the house and hopefully it will, in some way, improve funding of our hospitals which will, in turn, hopefully ease some of the pressures on the state government in trying to deal with a large health budget. But I am yet to be convinced that the Minister for Health and the government have a rational, long-term and sustainable strategy for ensuring that the increasing pressures on our health system are met and that hospitals, apart from Fiona Stanley Hospital, are properly funded and served. Demands are being placed on our hospitals, including Armadale Hospital, and they are at bursting point.

The member for Balcatta raised an important issue. It may not seem to be important and it may not even seem to be directly related to health care and health services, but the issue of parking for nurses is related to health services. Nurses in many respects are key to the running of both public and private hospitals, and if they cannot be retained, we will have a major problem. I am sure that the minister would agree that finding enough nurses to run our hospitals, even if the funding is there, is quite problematic for the state government. Our nurses work incredible hours under incredible stress for pay that is, at best, reasonable, so for them to then be hit with parking expenses is quite deplorable. As the member for Balcatta mentioned, nurses are being encouraged to use public transport. I am all for the use of public transport; the more we use public transport, the less congestion there will be on our roads. But public transport does not run 24 hours a day and as we know, nurses work shifts. For example, the last train to Armadale from Perth is around midnight during the week and around 1.00 am on the weekends. We are expecting a female nurse to walk from Armadale Hospital to the nearest train station at Sherwood, which is about 800 metres, late at night and on her own, and to then wait at the train station on her

own, get on the train, and disembark at another station further along the line. Armadale station always cops criticism for being a bad station, but most of the crime that occurs on the Armadale line does not occur at Armadale, but further up the line.

Mr M.J. Cowper: They're scared of the local member!

Dr A.D. BUTI: That is right; they are scared of me! It is a shame that the member for Victoria Park is not here, because a lot of it occurs at Burswood. The member for Cannington is not here either; a lot of it is in Cannington as well! But seriously, to expect a nurse —

Dr K.D. Hames: You make a good point about parking but there is no charge for parking at Armadale.

Dr A.D. BUTI: No, not at Armadale.

Dr K.D. Hames: Nor is there an intention to do so.

Dr A.D. BUTI: That is fantastic! Some concerns expressed to me last year —

Dr K.D. Hames: There was a proposal before and I refused to support it.

Dr A.D. BUTI: That is a great decision the minister has made, and may he think about that at other hospitals.

Dr K.D. Hames: Perhaps I will have to add this to my list of innovations!

Dr A.D. BUTI: Yes, "innovations" is right. I hope the minister might consider that it is not appropriate to impose fees for parking at other public hospitals.

We support the bill before the house. It goes some way to providing an appropriate government structure for the funding of health services in the federal system that we live with, but of course we must end the blame game. It has to go beyond a state rights issue and we have to find ways to ensure that health services are properly funded in Western Australia.

MS R. SAFFIOTI (West Swan) [4.51 pm]: I apologise for my voice; I have got a cold or the flu. However, the Minister for Health will be happy to know that I have not been clogging up one of his emergency departments!

Dr K.D. Hames: Well done!

Ms R. SAFFIOTI: As has been outlined by previous speakers, the opposition supports the National Health Funding Pool Bill 2012 as a reform to health funding across Australia. This bill seeks to pool funding from both the commonwealth and the state and then to apply it to an activity in our hospital system. The bill therefore has a focus not only on what we put into the system, but also on what we get out of it; it has a focus on the level of activity in the health system. It is important to note that from 2014–15 commonwealth funding for public hospital services in WA will vary depending on the level of activity delivered. However, from 2014–15 the commonwealth will fund 45 per cent of the efficient cost of growth in the public hospital system over that year, and from 2017–18 the proportion will increase to 50 per cent. That is a significant contribution and a significant increase compared with commonwealth funding in the past.

Dr K.D. Hames: It's 50 per cent of the growth.

Ms R. SAFFIOTI: Yes, I understand that. However, funding 50 per cent of the growth is still a significant amount.

I recall a figure—total rather than growth figure but it is still important to make the point—produced around May 2007 indicated that the then Howard government was contributing about 30 per cent to hospital funding in Western Australia. There was a significant debate at the time that I recall resulted in the share of commonwealth funding for our hospital system falling from around 37 per cent to 30 per cent under the Howard government. One of the reasons for much of the significant pressure on the health system at that time was the underfunding from the Howard government. This bill indicates a clear commitment from the federal government to inject more commonwealth funding into our state hospital system. That is a very positive contribution. The idea of pooling that funding and then relating it to activity will make sure that we have an efficiently and effectively run hospital system that will focus on getting the appropriate level of activity required to properly service the Western Australian community.

I want to touch on the issue of aged care, as I note the minister in the weekend newspaper referred to issues about aged care in Western Australia. Despite the introduction of this bill, which is really about pooling funding for hospital services, I still believe some issues of financial responsibility and delivery remain for the health system across Australia. Whether those issues relate to general practitioner services, aged care, dental health services or the hospital system, I believe a lot of reform and improvement can be made to ensure we deliver a better health service. I must say that before I had children I did not really use the health system that much and did not consult a doctor very often. Now, especially with a young family, I have become more focused on the

different types of services delivered and the need for better coordination and better delivery between GPs and our hospital system. I believe that is particularly so when we try to get the best care for our children, and I do not think we have quite got to that level yet.

Aged care is a huge issue facing all states of Australia. I believe an emergency meeting about funding from the commonwealth is being held today by some parts of the aged-care industry. I want to make a particular point that I believe is relevant to easing pressure on our health system: the state government should be doing all it can to encourage aged-care provision throughout the state. There are a lot of little, practical measures that can be taken by the state. Just as the commonwealth has volunteered to come in and better provide for our hospital system, the state could be a bit more proactive. I will give members an example. I want the Minister for Health to hear this example, which demonstrates what the state government can do to take some pressure off housing affordability generally and our hospital system particularly. It relates to an ongoing issue that I have had with the Minister for Water for about two years. I raised the issue with the previous Minister for Water and, frankly, if the previous Minister for Water were still around, he might have resolved it because he was a bit more action oriented.

There is a proposal for an aged-care facility in part of Ballajura called Paradise Quays, with which the minister might be familiar. The proposal has been before state government and the local council for about two and a half to three years now. The private sector is willing to build an aged-care facility for about 150 people—I think that is the number; I cannot remember exactly. Again, this is all about older people getting out of their bigger homes and wanting to live in a more suitable environment in their later years. It is also about taking some pressure off the hospital system. I have been told—the minister may confirm this—that if there is a safer place to send older people from hospital, such as an aged-care facility where medical help is in proximity to the facility, they can often leave the hospital system sooner; otherwise they have to stay in hospital if they are going to an empty home with no support services.

This proposal for an aged-care facility has therefore been before the council and before government and has been held up for about three years because of an issue that we have already put in front of government. The issue relates to a 200-metre buffer around the Mirrabooka waste water treatment plant. The buffer is preventing this aged-care facility from going ahead because there is a cost involved in changing that treatment facility and removing the buffer. The type of chlorine used in that treatment facility is not used in new facilities. However, to change and refit the facility to a different type of water treatment will cost, we are told, between $750 000 and $1 million. I have asked the Minister for Water on several occasions to work with the Water Corporation to get this buffer removed—whether it be partly or fully funded—to allow this aged-care facility to go ahead. When we consider the role this aged-care facility would play in the community, potentially 200 people could move from their home into the facility. What does that mean? It means they would leave their home and allow the home to go to other people who are in need of a home in this housing affordability crisis. What does it mean to our hospital system? It may mean less pressure on our hospital system. As I said, it would cost $1 million to facilitate 200 new homes. To me that is a very cost-effective way for government to look at the issue. However, this is where I believe government is not working proactively to sort out these problems. Frankly, some ministers on the other side of the house do not want to sort out problems and do not believe it is their role to sort out problems. This issue is a classic situation and has been going on for two or three years.

I acknowledge that there is a problem with aged care, but I also acknowledge that as the controller and owner of land in WA, the state government can be far more proactive. Instead of building detention centres next to people's homes, it could look at being a bit more proactive with some of that unused land and at providing some housing for older people in Western Australia. I wanted to raise that with the minister because, frankly, I was pretty angry when I saw the article in the paper on the weekend. There are issues in the aged care sector but I think there will be more examples than the one I have given. With a minimal investment from the state government, we are not only helping that facility get off the ground, but also there are flow-on impacts on housing more generally, and also the hospital system is very important.

As I said, this funding pool is a good first step. It is a good thing that the commonwealth government is taking a genuine interest in ensuring that there is sufficient growth for health services in WA. I believe that it is an issue that was ignored under the Howard government, in particular, by the then federal health minister. Pooling this funding and allocating on an activity basis will lead to greater accountability and better services. As I said, I still believe there is a lot of room for reform in the health system. In particular, improvements can be made in the interaction between HealthDirect, GPs, the locum service, the hospital service and the emergency departments. As I said, I am a far more frequent user of the health system than I was previously, and there are significant issues. People go to emergency departments because they believe they can get quality health care. That is one of the key issues. When people present there, it is because they need a proper answer to what is wrong with them. There will be many instances of people going to GPs and trying to get answers but not getting them. That is why they present at EDs. I think these advertisements that have been shown over the winter are a bit unfortunate. I do

not think people rock up to EDs because they need a tissue. People do not present to EDs unless there is an issue. It is not a nice experience to go to an ED. People who go there have genuine concerns and issues about their sickness, their parents' sickness or the sickness of their kids. I think the ads trivialise what happens during the flu season and the season more generally during the winter.

The last thing I want to reiterate is the comments made by the members for Balcatta and Armadale about parking and nurses. To suggest that nurses can catch public transport to do their shifts again trivialises a real issue. In many instances there is no public transport or adequate public transport in many suburbs around the metropolitan area. If there was adequate public transport, I would not use it during the very late hours by myself. A lot of people would be in my situation. The whole issue of parking for nurses has been mismanaged. It is a case of trying to get some quick revenue rather than trying to properly address the issue of parking at our hospitals.

MS J.M. FREEMAN (Nollamara) [5.03 pm]: I, too, want to speak on the National Health Funding Pool Bill 2012. I understand that this bill is a result of the National Health Reform Agreement. I thank the member for West Swan for giving quite a concise history of the national health reforms and the funding that has come from this. This funding was not so forthcoming from the previous Howard–Liberal government. I congratulate the federal Labor government on being able to deliver such a service that is vital to an efficient and effective health system that we will all want to be proud of. Clearly, we are proud of the current health system. While there are many issues that always confront us, we still have a health system to be proud of. This legislation is a way forward to ensure that we continue to grow that system and are strategic about how we grow that and in our thinking about those sorts of things. It is my view that it is not strategic to privatise those health services. The minister knows my position on that, but I wanted the opportunity to put it on the record that I do not think it is strategic to spend good taxpayers' money when delivering services in a privatised area. That just means that the people in our community who can least afford it—that is, the low-income workers in hospitals—end up paying for the quality service that we require from them and health and hygiene issues are compromised. That was certainly the experience that I had when I dealt with Royal Perth Hospital. The cleaning service was privatised. I had to represent workers whose health was compromised by the serious chemicals they had to use, such as Prefin, to deal with an outbreak of Vancomycin-resistant enterococci. I have lived the experience of what happens when those health services are privatised. That experience shows us that it is not something we want to see. We also do not want to see the ineffectiveness of having a service that cannot give all the public services and the reproductive health guidance and be limited in what it can deliver. That is a failing in this privatisation model that the government is delivering for the Midland campus. The minister knows my views on this. I just wanted to put them on record. I did not rise to make that point.

I wanted to endorse the comments of the member for West Swan when she spoke about the need for better coordination and delivery of health services totally in the state and in commonwealth administration. In particular, I wanted to talk about the interplay between the commonwealth District of Workforce Shortage program and the state's area of need for medical and GP practices. The minister would be aware—I have raised it in this house before—that the suburb of Balga no longer has a GP practice. As members could imagine, not having a GP practice in that area has a major impact on a suburb with a population of around 10 000 people. The Balga community make-up is such that incomes restrict costly travel to medical practices in neighbouring suburbs. Average weekly earnings are about $200 less than the average earnings of Western Australians. It is also an area of high medical need, with 5.1 per cent of the population in that area needing assistance in the tasks of day-to-day living compared with 3.6 per cent for the Perth statistical division. This suburb has a great need for a medical practice. To put this in a personal context, I was recently talking to an elderly Macedonian gentleman, aged about 74 years, who keeps up his health, frail as he is, by walking down to the local supermarket and to his doctor on a regular basis. He has high care needs and is quite frail. He used to walk to the local medical practice to receive his care. Now he has to rely on the public health system to pay for him to get taxis to health care services. Not only is he not getting that exercise, but also he has to try to find ways of accessing the health services he needs. He tells me that instead of waiting at another doctor's surgery, he might as well go to hospital because at least he will get a taxi there. I have tried to dissuade him from that but he has no service in his area to go to. It is really an interesting aspect to how we try to encourage doctors into the area.

The minister would know that under the District of Workforce Shortage program we can increase the allocation of Medicare numbers so that those Medicare numbers can go to doctors from overseas and different pools of doctors. We have to show that there is a demonstrated need for doctors and we cannot get doctors through the normal advertising process. I have worked with the pharmacist in the Balga area on this. He has advertised but had no success. That Balga pharmacist has convinced a young doctor to come in for two days a week to provide some service. He has set the doctor up in a sort of medical centre near the pharmacy and people are able to make appointments through the pharmacy. But this person is not sure he wants to set up a practice because, as the minister knows, setting up a practice involves the same difficulties as setting up a business. Balga is in absolute

dire need. There was a time when Balga had three medical practices, which was pretty reasonable—the minister would be aware of the area I am talking about. In April this year the last practice, which I think had about eight doctors, closed down. There is now no service.

I also wanted to raise the bureaucracy around being able to solve this problem. There is a state process around the establishment of an "area of need". A District of Workforce Shortage application has to be made to the Commonwealth, and as part of that a classification has to be made that it is an area of need. The state government has to designate an area of need before a District of Workforce Shortage application will even be looked at. It seems to me that the area of need has no impact at all; an area can be classified as an area of need but it will not have any impact on Medicare numbers because the classification of a district of workforce shortage is also needed. It seems that the health department is using this process purely as a control mechanism.

Dr K.D. Hames: We don't; I sign off on them all the time. But they can't get the commonwealth area of need declared, which would allow them to get international medical graduates. We would like them.

Ms J.M. FREEMAN: The minister says he signs off on them all the time, but we are not getting a commonwealth District of Workforce Shortage declaration so people are getting a false impression of what they are doing. All I am saying is that there does not seem to be any need to have an area of need declared. We need to be working with the commonwealth to better coordinate how we deal with District of Workforce Shortage issues; this is the sort of stuff we have to be working on, not a bureaucratic process.

Dr K.D. Hames: I am having a conversation this Friday with the minister.

Ms J.M. FREEMAN: Good. Will the minister talk about Balga, because that is a perfect example?

Dr K.D. Hames: If you give me a letter to take, I would greatly appreciate it.

Ms J.M. FREEMAN: I will absolutely give the minister a letter to take. I have already written to the federal minister, and I have lodged a petition in the federal Parliament about this issue. I can give the minister the petition, and we have more petitions to go to the federal Parliament. We are pursuing this. I do accept and acknowledge what this minister says, but thrown into the mix is this bureaucratic process of area of need that people think delivers something, but it delivers nothing. People get frustrated by red tape, and it does not help in fixing the problem. I am working with someone to try to deal with it. I know it has to be a private practice; I am not expecting any miracles in terms of the government suddenly coming in and fixing something up, but I need to work with a process that is clear, concise and capable of being followed. I thank the Department of Health because someone came out to explain it to us so that we could navigate our way through what is a difficult course. So I will give the minister a letter; I am glad I have raised this.

Dr K.D. Hames: Are you going to stay for my reply?

Ms J.M. FREEMAN: Yes; I am happy to stay for the minister's answer; well, unless it is really boring, and then I am really not going to stay, and that is likely to happen!

Dr K.D. Hames: I will hear yours first.

Ms J.M. FREEMAN: Yes; well, you know—tsetse fly!

Dr K.D. Hames: I will hear your bit first in case you nick off.

Ms J.M. FREEMAN: I thank the minister very much. I never nick off, minister—I am here for a good time as well as a long time!

Dr K.D. Hames: I am going to tell you what I want to do.

Ms J.M. FREEMAN: I thank the minister very much.

I do not want to repeat myself, but people must have effective and efficient access to this process. People will not attend public hospitals if they have their medical assistance needs met in their own community.

I also want to ask a question to which I think I know the answer. The National Health Funding Pool Bill 2012 is not clear on what is meant by "services". Does "services" include capital, or is that completely separate?

Dr K.D. Hames: It is completely separate; totally separate.

Ms J.M. FREEMAN: Okay. But my question is: how will that affect Department of Health land? The member for West Swan raised government-owned land that could be used for aged care; I want to raise the land in Milldale Way, Mirrabooka that we could work on right now, minister. I am happy to work with the candidate who is running against me in Mirrabooka—who is a good friend of ours—to utilise that Department of Health land that has been sitting there for some period of time.

Dr K.D. Hames: If you could get commonwealth money, I would let them use state government land.

Ms J.M. FREEMAN: That is a promise, is it, minister, if I can get commonwealth money to build a facility? What type of effective facility could we get there? Perhaps what we should do, minister, is get state government money because the state government has sat on that land for such a long period of time. There is a need to deliver health care in that area.

Dr K.D. Hames: Perhaps you are forgetting that we were going to build a surgicentre there with the government last time —

Ms J.M. FREEMAN: Absolutely; happy to work with the state government again to do that.

Dr K.D. Hames: — and your government canned it.

Ms J.M. FREEMAN: Not my government; I have not yet been in government. I am hoping that will happen after March 2013.

Mr R.H. Cook: On 10 March.

Ms J.M. FREEMAN: Yes, I am very much hoping that I will be on 10 March, minister.

I hope that instead of sitting on that land and leaving it to degrade and cause great problems in that area, we will actually —

Ms R. Saffioti interjected.

Ms J.M. FREEMAN: Yes, we do not want a detention centre on it; we want a health service on it. I thank the member for West Swan very much.

We want an effective health service for the large and diverse community in that area. It would be good to know, as the member for West Swan said, that the Department of Health as the controller and owner of that land is being proactive on how it can be used to ensure that it delivers to the community, just as this bill will deliver a more effective and efficient health service in Western Australia and Australia as a whole.

MR M.P. WHITELY (Bassendean) [5.16 pm]: I will not take an extraordinarily long amount of time. I will try to be as quick as possible, and I just make one point on the National Health Funding Pool Bill 2012.

The minister's second reading speech stated —

> The key reform agreed to under the National Health Reform Agreement is that commonwealth funding for public hospital services will, from 2012–13, be funded on an activity basis, wherever possible.

I want to emphasise just how important the words "wherever possible" are when it comes to mental health funding and the delivery of mental health services within the public health system. I support the move to activity-based funding. We obviously need to be concerned about efficiency within the public health system and incorporate appropriate safeguards to measure the success of treatments and operations et cetera, such as the amount that need to be re-done or the amount of adverse events that occur afterwards. With all those sorts of checks and balances in place, it is possible to build a system that measures the direct provision of physical health services. It is possible to establish a system based around activity funding that delivers good health outcomes at as low a cost as achievable. The basic aim of activity-based funding is to get maximum bang for the buck, which makes a lot of sense in relation to physical health.

But mental health is a different game altogether. The success of the treatment of a physical ailment is far easier, in the immediate sense, to measure. When people present with mental health problems, those problems are incredibly complex and have occurred for a whole diversity of reasons and are not as easy to measure. It is not like measuring how many successful appendectomies a hospital does in terms of re-do rates and adverse events et cetera or by saying this hospital is spending $13 000 for each appendectomy and another one is spending $18 000 for an appendectomy and they are getting similar results. Those sorts of comparisons cannot be made in mental health services. The nature of the condition or distress is quite different from physical health services. I think there will be a real problem if we try to apply an activity or case-based approach to mental health services.

In my experience, having been a long-term advocate and campaigner in the area of mental health, the worst mental health services—the worst of psychiatry—is often the quickest in terms of case throughput. In other words, if we simply measure the number of patients treated, how quickly they are treated, how much is spent on treatment and how quickly they are passed through the system, those who would get the best results in terms of patient throughput per dollar spent often have the worst mental health outcomes. The answers to providing good mental health outcomes for people are based around long-term measures such as social engagement, employment opportunities and psychosocial outcomes. It is far more difficult to measure efficiencies of mental health outcomes on an activity-based approach. That creates a unique problem for the Minister for Health and the Minister for Mental Health. It is not as easy to say, "We dealt with X thousand patients and we spent this much

money doing it. We have achieved a five per cent efficiency dividend because we did it five per cent cheaper than last year." That cannot be done with mental health. If mental health is to be measured in that manner, in the long term that will cause worse outcomes because people will be pushed through the system. People with complex needs will be given a quick diagnosis and prescribed —

Dr K.D. Hames: Can I interject to tell you what is happening?

Mr M.P. WHITELY: Yes, I would love to hear.

Dr K.D. Hames: It may save you the need for a long conversation.

Mr M.P. WHITELY: It will not be long.

Dr K.D. Hames: Mental health is not in for the first two years, recognising exactly the problems you describe: how do we work out what is an efficient price? In two years' time it is proposed, when all the rest are bedded down, to bring in some component for that, but how that will be done—recognising all the things that you have said being absolutely true—is still to be decided. We will have lots more discussion over the next two years until we get to that point.

Mr M.P. WHITELY: I am reassured by that, minister. I am glad to hear that. That is a very sensible outcome. It is good to hear that sort of recognition in mental health services.

Australia needs to move towards a more recovery-based mental health approach rather than a diagnosis and prescribed-based approach. A recovery-based approach is necessarily a more messy system because it actually recognises the complexity of people's individual circumstances. Rather than putting people into pigeonholes and saying, "You've got a problem with psychosis, depression, or whatever", treating them in those boxes and pushing them through the system in those boxes, a recovery-based approach concentrates far more on an individual's circumstances. It is a messier system. It is a real challenge for those people trying to design a system that deals with individual circumstances. I am glad to hear that, minister. In that two-year process, do not be overly driven by the concerns of the bean counters. I say this as a former accountant. They will try to drive towards a system that measures dollar throughput and patient throughput in the funding cycle over the next 12 months. That simply does not deal with the complexity of mental health services.

While I am on my feet, I might take this opportunity to ask the minister about another issue allied to health—organ donation. I have not heard from the minister on that and I am very keen to hear his response to the legislation we have brought into this Parliament and whether he will support it or introduce alternative legislation.

Dr K.D. Hames: We were advised that we do not need legislation to achieve it. The Department of Transport agreed to implement exactly the model that we discussed and was put up, which requires drivers' licences. The department is in the process of working out how to do that in terms of the technology needed as part of that system. It is not this legislation, obviously —

Mr M.P. WHITELY: I know that, but I —

Dr K.D. Hames: It is easier if I arrange a briefing or an update for you.

Mr M.P. WHITELY: Does it need to be done by regulation?

Dr K.D. Hames: Yes; by regulation.

Mr M.P. WHITELY: Is there a possible time frame? Are we looking at this year?

Dr K.D. Hames: I definitely hope it will be this year.

Mr M.P. WHITELY: Is it basically around that driver's licence system that I identified in my legislation?

Dr K.D. Hames: Yes.

Mr M.P. WHITELY: That will be a great innovation, minister. I look forward to that happening.

DR K.D. HAMES (Dawesville — Minister for Health) [5.24 pm] — in reply: I thank members of the opposition for their support for the National Health Funding Pool Bill 2012 and their comments. The member for Nollamara, who was going to hear me talk earlier, is not here, so I will not start —

Mr R.H. Cook: The problem is you were not interesting enough!

Dr K.D. HAMES: That is true. It is hard to be interesting when I have not actually gotten up yet!

Mr R.H. Cook: You got to your feet, we knew it was going to be boring, and she was out!

Dr K.D. HAMES: I will start with the history of the National Health Funding Pool Bill 2012 and the National Health Reform Agreement. There was a significant difference of opinion between the state and commonwealth governments about setting up this national reform process. Before we started, the national government wanted a 30 per cent component of GST funding from each state as an automatic deduction from GST. The commonwealth was going to take over responsibility for the distribution of the funds, which we totally disagreed with. We put forward alternative proposals, in conjunction with New South Wales and Victoria. We finally reached agreement on this particular model in which commonwealth and state government funds are notionally pooled. We will create a state fund, based with the Reserve Bank, and have an administrator, who cannot be directed by the commonwealth and can be given information only by our director general for the distribution of funds from this state. We agreed to put in activity-based funding, but I have to say we were already doing that—in fact, the process had already started. It started based on advice I had from my good friend, the Minister for Health and Ageing in South Australia, who talked to me at length about this system, which is in place in South Australia. I think it was operating in other states as well, but on his advice I decided to introduce that system in Western Australia. It was certainly well supported by health department staff. It had been tried before without success, but I am confident the model this time around will be a success because of the way it is done. Activity-based funding is already in place.

The other agreement with the commonwealth was that we would have boards. We have put in governing councils, which is a different model. Again, that was something that we had planned to do. There was no downside in us doing that. There was some argument about the commonwealth funding those bodies directly because we wanted it done through the state and to distribute it. In the end, it was accepted that we would fund those directly—again, based on an agreed activity-based model, given that the state government in effect had control of the fund.

Mr R.H. Cook: Around the governing council versus the board, what do you see as the fundamental difference in terms of the governance? Is it the funding?

Dr K.D. HAMES: No, it is nothing to do with the funding; it is the control of the health system. Jim McGinty got rid of all the boards—for good reason, in my view. They were independent, working in silos, focused, as they should be, on the health services delivered by their hospital, but without taking in the broader context of the needs of the state in place.

A member interjected.

Dr K.D. HAMES: Yes, it is a bit controversial. The South Australian minister did the same. Interestingly, Victoria retained all its boards, even for the little hospitals.

Mr T.G. Stephens: It was Liberal Party policy at the time.

Dr K.D. HAMES: I think it is probably still Liberal Party policy to have boards. We have created governing councils, which is a balance between the two designs. As a state government, we want to have the ability across the whole system to manage health, which is what the former health minister under the previous Labor government wanted to do, and to be able to say, "We are bringing in the four-hour rule", and not have individual boards saying, "No, we're not doing that." We want them to have involvement in the management of the system.

Mr P. Papalia: What will Tony Abbott do?

Dr K.D. HAMES: I do not know what Tony will do. Probably what Mr Rudd was going to do. I seem to recall Mr Rudd wanted to take over the whole Australian health system. It was interesting that during the course of this debate on national reform I asked the former federal Minister for Health and Ageing, Nicola Roxon, what was going on and she did not know. The reason she did not know was Mr Rudd would not tell her! He was such a control freak that it was out in his office that —

Several members interjected.

Dr K.D. HAMES: Yes, he might have noticed that. The whole health reform system was coming out of his office without any involvement by the poor old Minister for Health and Ageing, Nicola Roxon; who was, incidentally, a very good Minister for Health and Ageing.

Mr P. Papalia: That is why Colin and Kevin were such good mates!

The DEPUTY SPEAKER: Members!

Dr K.D. HAMES: Can I get on with my response; that would be handy?

The DEPUTY SPEAKER: Let us carry on, Minister for Health.

Dr K.D. HAMES: We are putting in the governing councils; we are putting in activity-based funding. The funding is not all activity based; there is a block component of funding. That is absolutely essential to deal with issues such as mental health and a range of other services we require hospitals to provide that cannot be based on activity funding. It is a combination and it provides an opportunity for comparisons with services in other states and, in fact, competition within our state. Under the system of activity-based funding Fremantle Hospital is probably one of our worst performing hospitals. There are a number of reasons for that and quite a few of them are not its fault. Rockingham General Hospital is a similar case; nevertheless, that system provides that ability for comparison. National data of all the hospital activities allows us to make comparisons. One of the critical discussions we are having with the commonwealth government is about making sure we compare apples with apples. We know extremely well that in many, many cases we are not. One of the issues we struggled with was the comparison among states of the time in which patients are seen in an emergency department in terms of the response to waitlist funding and our rate of success in dealing with category 1 patients. States use different methodologies. In Queensland, where we were recently, patients stay in the ambulance sometimes for half an hour or even an hour until they get through to the ED. Those patients are not counted in the four-hour rule until they hit the hospital. In Western Australia the hours are counted as soon as patients arrive at the hospital, so they figure in both ramping figures and four-hour rule figures. In Queensland they do not do that. We have problems with long waitlist times for category 2 patients for gastric-sleeve surgery. When we asked why they do not have that in Queensland, they said they do not do gastric-sleeve surgery. They say, "No, we're not doing it; it's not one of the services we need to provide." Having the ability for proper comparisons of services between states is critically important. I have spoken to Minister Tanya Plibersek about this on a number of occasions. The commonwealth is supportive of the concept of getting through this process with clearly identified costs and clearly identified comparisons. We could never understand why New South Wales hospitals could provide a procedure at a lower rate than we could when they had more staff on at a particular time and their staff were more expensive. They were not including costs for things such as research that we were including in our costs. If a hospital did research, it would just leave it out. We include it; therefore, the costs are different. We must make sure we make proper comparisons.

In terms of what the National Health Funding Pool Bill will achieve, there is some greater commitment of funding. We have heard that the commonwealth will pay 50 per cent of the growth in funding. That is a positive; it is something that will achieve growth in the future. We recall that in the past the ratio of funding used to be 50–50 and consecutive governments have steadily reduced that. The percentage of commonwealth funding has continued to go down. Just over 30 per cent of funding that goes into that pool of state funds comes from the commonwealth. The rest is from the states. The commonwealth has never grown its funding at a rate that is adequate to cope with the demand within our hospital system. Now other states are paying the price because of the huge growth in the costs of health. Trying to meet the demand in their state hospitals is a massive burden on their state budgets. I do not know whether we will ever get back to 50–50 entirely, because it is only 50–50 of new funding, not existing funding. I guess my worry for the future is something the shadow Minister for Health will need to bear in mind. It does not matter which government—his side or our side—is over there in the commonwealth, I worry about how much it will stick to this agreement. When we are setting this national efficient price —

Mr P. Papalia interjected.

Dr K.D. HAMES: I am talking to him. When we are setting this national efficient price the safety for us is that the commonwealth has guaranteed that additional money. It has said that after 2014, we will still provide $1.6 billion; we will ensure states are not worse off and we will give them $1.6 billion after. Governments sometimes renege on their promises. If we find that this national efficient price does not fully cover the real costs of providing the service, then the risk is that a future commonwealth government will say, "We're not funding you that amount; we'll promise we'll fund you what you should be spending, which is this national efficient price." To that end, the group setting the national efficient price has given a five per cent loading for Aboriginality and a 20 per cent loading for regionality. In a community that is largely Indigenous, in the Fitzroy for example, we will get a 25 per cent loading—nowhere near enough. We took one of the federal members up there just last week and showed him. In my view it should be 100 per cent. I will go through how I get those figures. Staff up there are paid about 30 per cent extra to work there. That is the first loading. Secondly, there is a housing component and rents in Port Hedland, as we know, are $2 500-plus a week. The costs of providing housing for a staff member equates to about another 30 per cent of the cost of providing a service. There are inefficiencies of location such as sending in specialists. In a case in which an Aboriginal person needs dialysis we have to send a bus to get them from an outpatient clinic. We have to pay for a bus and a staff member to go to that community and pick up the person from the outpatient clinic and bring them in. There are a range of such additional costs that, again, are 30 to 40 per cent extra. I am putting to that federal member that is what the commonwealth should be paying. I have to say that he was very good and listened very carefully. I do not know

whether he will agree to that amount, but I think the commonwealth will make further allowances to cope with the disadvantage in those remote communities. The critical need for us now is to get through that component of the agreement.

The member asked some questions about what the activity-based funding covers. It is anything above 3 500 weighted inpatient separations. That means all the metropolitan hospitals: Joondalup, Kalamunda, King Edward, Osborne Park, Sir Charles Gairdner, Swan District, Armadale, Bentley, Fremantle, Kaleeya, Murray District Hospital in Pinjarra, Peel, Rockingham General and both campuses of Royal Perth Hospital. Of course, Pinjarra is in the country, so Pinjarra should be in the country section—just to let members know. That is right, is it not, member for Mandurah?

Mr D.A. Templeman interjected.

Dr K.D. HAMES: Pinjarra is listed with metropolitan hospitals. Do you believe that?

Mr D.A. Templeman: I am outraged.

Dr K.D. HAMES: So am I.

Mr R.H. Cook: Peel also should be in the country.

Dr K.D. HAMES: Yes, Peel also is in the country, along with Kalgoorlie, Albany, Broome, Geraldton, Hedland, Bunbury and Busselton. That is the list of hospitals and where they belong. Which services are in and which are out has been fairly well finalised between ministers. There was a bit of argy-bargy from different states, more particularly Victoria, about some services that should be counted in and some that should be out. The Silver Chain service is a good example. Is it a hospital service or a home-based service? Clearly, it takes the services to homes, but it provides a service that would otherwise be provided in a hospital. We are told that the Hospital in the Home program that Silver Chain provides can be included in our costs for funding, but there is argument between states about a range of things that should be in and should be out. That list has not been finalised yet, but when it is I will be able to provide it.

I have not finished responding to things that probably are not related to the bill but are things that I wanted to respond to that the member for Kwinana talked about. I will see whether I have time. This is the Romans argument: "What have the Romans done for us?" I will leave the Romans argument to the end.

Mr R.H. Cook interjected.

Dr K.D. HAMES: Yes, I am only up to 11 so far.

If I can, I will just let the member for Nollamara know—it is again nothing to do with the bill but something really important—about the provision of services in areas of need in this state. What the federal immigration minister did, when we have workforce shortages in this state, was declare Western Australia a region for the purposes of the act, because we are so far away from everywhere. It meant that if there was a workforce shortage for a chef in the city, it would be treated as a region to get that person to come in. I am going to talk to the minister about that same concept for Western Australia. We have far fewer doctors per head of population than other states and far more difficulty getting them because of our isolation. Perhaps not the inner-city component, but what I would like to talk about is areas from Nollamara and Balga and surrounds, where we clearly have a deficiency of GPs, we clearly have people from low socioeconomic backgrounds and we need to get adequate numbers of doctors there. I was talking to a representative from one of these big clinic groups. There is one down Rockingham way, one at Midland and one at Joondalup. The Rockingham one is declared "outer metro", so it is able to get international graduate doctors, and it has doctors bulging at the seams. The Joondalup one and the Morley one cannot do it; they have huge demand, but they cannot get those doctors because it is regarded as an inner metropolitan area. If we can get agreement with the commonwealth to change that definition for Western Australia because of our isolation deficiency, then I can declare an area of need in all of those areas outside the inner metropolitan area, in which I do not think there is a specific area of need. I do not mean right out as far as Armadale, although that would clearly be included, but areas about as far out as the member's electorate, in a circle around the state. If I could declare that an area of need and get provision for a district workforce shortage for that area and outwards by the commonwealth government, that would go a long way to solving our problems in being able to attract extra GPs to the state. I am going to put that to the federal minister at the ministers' conference on Friday. I am chasing the exact figures on what our numbers of GPs are per head of population to prove that we have a workforce shortage particularly in those areas. I do not think anyone is going to say that we have enough GPs in areas outside that circumference to cater for the need.

Getting back to the point made by the shadow minister about who I am blaming, I have to say I was quite embarrassed by that headline, because I do not normally get up and say it is not my fault. In fact, that was clearly a focus of the interviewer during the interview before I had a chance to say too much, so I said lots of other

things. It recognises the fact that for most of the year, the percentage of patients who could be seen by a GP but are not is pretty small through those emergency departments, and the point that David Mountain made is correct. If members look at the percentages of people who presented with coughs and flus during that time, and if I take July as an example, there were 8 500 presentations out of 50 000 that had influenza-type symptoms. That works out to be that about a sixth of patients who presented had those symptoms. Some of those were serious. Some 1 500 cases were admitted, which shows how serious they were. That leaves 7 000. Of that 7 000 that were left for the two months, the ED physicians recognise that about 2 500 or those are coughs and colds. When members say that that is not what turns up, that is what turns up! Even the ED physicians recognise that. In the middle of those is a whole group who had flu-type symptoms—that is, 5 000 others in one month—coming to our EDs in the metropolitan area. Some might have been moderately serious and definitely need to be there. For example, they were worried that they had pneumonia; families not able to cope; an elderly person with other medical problems.

GPs could have looked after a lot of those patients coming in, but they cannot get to see them. As members know, there are not enough there. They want to get to a GP. Particularly, as we have heard, for someone who is old and for whom it is hard to get a doctor, they would rather get down there and make sure they are seen. I forget who criticised the ads; I think it was the member for Armadale. We got them from the Labor government in South Australia. The Labor government in South Australia produced the advertisement. We bought it off them. They thought it was a good idea. It was a bit difficult, because we did have some deaths from flu at that time, so it was a difficult message. We do not want to discourage too much people who are really sick, yet at the same time the emergency departments were just being overrun. For example, if someone's dad had a heart attack and they went to the hospital and the beds were full of patients who really should be seeing a GP, I am sure they would be extremely unhappy. We needed to just ease that pressure a bit, and it worked. Following the start of those ads we had reductions. I have not seen the final figures yet, but anecdotally, certainly at Peel Health Campus the doctor in charge of the ED told me that following that advertisement, there was a significant reduction in people turning up for the lesser coughs and colds.

Mr R.H. Cook interjected.

Dr K.D. HAMES: Maybe. Who knows? It was worth the effort, in my view.

The system was under such strain because of the large numbers. When members think 8 000 people—that is, 16 per cent of all patients—presenting to a hospital have flu-type symptoms, that is a lot of people. It made it really hard to deal with.

A couple of specific questions were asked. One question asked by the Deputy Leader of the Opposition was: what happens when Standing Council on Health members cannot agree on a person to be the administrator of the national health funding pool? In fact, we had a bit of problem with this. Victoria did not agree with the person that we put up. Here I was arguing with the minister from Victoria. I might add that we were not very happy, because we thought he was very good. For some reason, the minister from Victoria did not like him. There was an alternative nomination, so we agreed on that other person. The answer is that the members of SCOH—that is, state ministers and the federal minister—will need to continue to consider nominees for the office of administrator until they can agree. We cannot have an administrator and then none of us agree on who it is. It is up to us to make a final decision on who that administrator needs to be. There is no alternative system; there is no fallback mechanism. We know that as ministers we have to reach an agreement—that is just the way it goes. It is like choosing the Pope: you stay in there under locked doors until the white smoke comes up.

The member for Armadale was concerned that clause 238 of the commonwealth national health reform legislation would result in the conferral of functions and powers on the commonwealth-appointed administrator in relation to the control of funds in the state pool account. I do not remember him saying all that. Anyway, the answer is that the commonwealth has now amended the commonwealth legislation to more clearly delineate the functions to be formed by the commonwealth-appointed administrator in a manner that is consistent with the National Health Reform Agreement, and therefore WA's concerns have been addressed.

I just want to address some of the issues raised by the member for Nollamara. Despite arguing for a while, we finally worked out that we were actually in agreement. I have the figures here; I think I can table that. I will at least give it to the member for Nollamara, because it has percentages of state expenditure on health going back to 2002–03. Members will see from me just holding up this document that the line is flat. The percentage of total expenditure —

Ms J.M. Freeman: Are you talking about the member for Balcatta?

Dr K.D. HAMES: Sorry, the member for Balcatta. I said Nollamara—that is his old seat.

The percentage is flat through Liberal and Labor governments over the years at roughly 25 per cent of total expenditure, but it is because, as we said, the state has a lot more money coming in, so it can afford it. Other states have not been able to afford it. That is where we are in agreement. If we get used to a growth of 10 per cent every year and suddenly our income drops as a state, then we are going to struggle to be able to pay the cost of running that health system. It is important, and the point the member made is that it is important for us to be efficient, which is definitely true. That is what we have to do. The other point he made related to the growth in spending. He said that our spending growth in health had been 50 per cent less than the Labor government's. My suggestion was that it had been the same. I have obtained interesting figures on the growth in health spending over comparable four-year periods. From 2004 to 2008, under the Labor government, growth in spending was $1.2 billion, which equates to 35 per cent. From 2008 to 2012, under the Liberal government, the growth was $1.37 billion, which equates to 28 per cent. So funding under the Labor government over those four years increased by 35 per cent and under this government it increased by 28 per cent. I think I have just proved that my statement was correct.

We are getting to closing time, so I will run through my Romans list. For those members who were not here, my Romans list relates to a question I was asked: "What have you ever done for health?"

Mr R.H. Cook: And do not try to include the aqueducts because that was the Greeks' idea!

Dr K.D. HAMES: What was the movie? In a scene in *Monty Python's Life of Brian* someone asked, "What have the Romans ever done for us?" The response was, "Well, they built the aqueducts." Then the question was, "But apart from the aqueducts, what have the Romans ever done for us?" Then the response was, "Well, they developed an education system," and then "Well, apart from the aqueducts and an education system, what have the Romans ever done for us?" The member for Kwinana suggested that I had not been involved in anything in this state that was innovative, so I have a lazy 11 list. That includes the four-hour rule.

Mr R.H. Cook: Someone else's idea!

Dr K.D. HAMES: It may well be that the former director general had the idea; I do not know. I was given the impression that it came from some of the senior staff in the health department. They wanted to go and look at the concept in the United Kingdom, where that was already in place under the Labour government. As soon as I became minister, I arranged for Gary Geelhoed and me to go over there and have a look. When we came back I said that it was fantastic, really good, and I said to Peter Flett, "I want you to introduce it", so he did the work to set up its introduction. It was done on my instruction. That was the extent of my involvement. Interestingly enough, I sent a committee across—I did not go with it—to look at how the UK managed to reduce the numbers on its waitlist surgery, but not a great deal came out of that particular visit. I believe it was critically important for me, as the minister, to be there to see how the four-hour rule worked and then insist that it be put in place. That did play a role in whether it was implemented. I am prepared to claim credit for that.

The Silver Chain home independence program was not just an extension of the existing program. That program came from my experience with Silver Chain as a GP working with cancer patients in terminal care. I thought it was such a great system that the government put in $20 million a year to bring that in for patients across the system. That was totally separate and in addition to the normal Silver Chain care. Now we have staff within the hospitals who will redirect patients or take them home early with up to 24-hour nursing care and doctor backup, if they want it. We have the patient assisted travel scheme, and Western Australia is the only state that has a comprehensive system in place. That resulted from a recommendation in a federal inquiry, and when we were in opposition we grabbed all of the things the inquiry said we should do and we did them. Now we are the envy of every other state. It is probably a long bow to claim credit for the Midland health campus, but we put out a plan, prior to the Labor Party, not to redevelop the old Swan District Hospital site, which was the former government's proposal. We put out our plan to build a new hospital in Midland, and then about a month later the Labor Party came out with that same policy. A part of the proposed new children's hospital was going to be built on that site. As the member knows, that was an initiative of the former government, but that site would have been too small and it was the wrong location—it would not actually fit there. The new location was not my idea, and it probably was an idea of one of the members in here. Jim McGinty had talked about the multistorey car park, but there were zero dollars and zero planning to build that, so this government got on and did that. The nursing support fund was definitely our idea.

Mr R.H. Cook: I will pay that one.

Dr K.D. HAMES: We cooked that up in opposition. In fact, the seniors' rebate was our idea as well, although that has nothing to do with my portfolio; it was an idea we had along the way, as you do in opposition. We had an inquiry and then there has been significant additional funding for St John Ambulance. We retained Royal Perth Hospital, which was clearly my initiative.

Mr R.H. Cook: It is hardly innovative.

Dr K.D. HAMES: No, but I can tell the member for Kwinana that if he had been minister now, not only would he have retained it, but he would have had to retain it because of the growth in population. The problem we have now is a lack of beds. We do not have enough bed space in the system.

Mr W.J. Johnston interjected.

Dr K.D. HAMES: Why would we want to take a built hospital and shut it down when we are so desperately short of beds? Members have to remember that the Reid review said that there should be one service or the other; in fact, the other option was one administration across both. That is hardly different. This government is following faithfully the rest of the Reid review; in fact, we have advanced the timing of some of those things. Newborn hearing screening was promised by both parties before the election. The Labor government provided no funding for that, but we funded it across the system. The overseas aid policy allows any of our hospital staff—nurses, doctors, physios et cetera—to take two weeks paid leave from the health system to go and work in international aid.

Mr R.H. Cook: I will pay that one.

Dr K.D. HAMES: I think that covers most things. The contribution of the member for West Swan had two components—one positive and one not so positive. The positive is that I agree with the member that we desperately need aged-care facilities, and I will encourage the Minister for Water to do everything possible to assist firms like the one she mentioned. We have done it before. When I was the Minister for Housing, we provided land to be developed by aged-care organisations in Bayswater. In fact, a lot of local governments have put up land to be developed for aged persons' accommodation. If the member's example has been bogged down, then the minister needs to get involved to try to find out. The aged-care issues that the member for West Swan talked about are not the same as the issue that the government is campaigning about today. We are campaigning about aged-care facilities for people who need permanent care in hospitals and not just for people who want to live independently. The problem the aged-care industry has is that the cost of construction in this state is so high that the amount of money they get, particularly for high-quality care, is not enough to make it profitable. Whereas the number of aged-care facilities available in the other states might be going up, in this state the number of aged-care places is decreasing. I did not bring up that issue with the media the other day; they raised it with me and I could do nothing but agree that it is a problem. We only have 70-odd patients in the system, which is why I was not making such a big deal of it. We could do with those 70 extra beds.

Mr R.H. Cook: It is 70 across the metro area.

Dr K.D. HAMES: That is the average number; it goes from 60 to 70. That was not the be all and end all and it was not my focus, but what can you do?

Mr R.H. Cook: Where did they take the photo?

Dr K.D. HAMES: At the Peel Health Campus in my electorate.

Mr R.H. Cook: When was that?

Dr K.D. HAMES: It was on Friday. Did I look older—or younger?

Mr R.H. Cook: I wondered where you found the stethoscope.

Dr K.D. HAMES: I have one at home. I am still registered.

That covers all of the issues raised by members, and I commend the bill to the house.

Question put and passed.

Bill read a second time.

Leave granted to proceed forthwith to third reading.

Third Reading

Bill read a third time, on motion by **Dr K.D. Hames (Minister for Health)**, and transmitted to the Council.

Sitting suspended from 6.00 to 7.00 pm