Division 34: Health, $3 600 465 000 -

Mrs D.J. Guise, Chairman.

Mr J.A. McGinty, Minister for Health.

Dr N. Fong, Director General.

Mr D. Cloghan, Chief of Staff, Office of the Minister for Health.

Dr P. Flett, Chief Executive, South Metropolitan Area Health Service.

Mr P.V. Jarman, Acting Director, Dental Health Services.

Mr R. Keesing, Infrastructure Consultant.

Dr R.A. Lawrence, Executive Director, Child and Adolescent Health Service.

Mr J.W. Leaf, Chief Finance Officer.

Mr T. Murphy, Executive Director, Drug and Alcohol Office.

Mrs C. O'Farrell, Chief Executive Officer, WA Country Health Service.

Dr S.J.R. Patchett, Executive Director Mental Health, Mental Health Division.

Mr M. Pervan, Director, Health Reform Implementation Taskforce.

Dr A.G. Robertson, Chief Health Officer, Health Protection Group.

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

Mr S. Toutountzis, Director Business Analysis.

Dr S.C.B. Towler, Executive Director, Health Policy and Clinical Reform.

Mr C.P. Xanthis, Acting Executive Director, Health System Support.

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

The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. This is the prime focus of the committee. While there is scope for members to examine many matters, questions need to be clearly related to a page number, item, program, or amount within the volumes. For example, members are free to pursue performance indicators that are included in the budget statements while there remains a clear link between the questions and the estimates. It is the intention of the Chairperson to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point.

The minister may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. For the purpose of following up the provision of this information, I ask the minister to clearly indicate to the committee which supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the committee clerk by 8 June 2007, so that members may read it before the report and third reading stages. If the supplementary information cannot be provided within that time, written advice is required of the day by which the information will be made available. Details in relation to supplementary information have been provided to both members and advisers and, accordingly, I ask the minister to cooperate with those requirements.

I caution members that if the minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office. Only supplementary information that the minister agrees to provide will be sought by 8 June 2007.

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

Members, I will allow further questions along the lines of a substantive question to a certain degree. I prefer that members note that, rather than try to ask four questions in one. The member for Dawesville.

Dr K.D. HAMES: I refer to the capital works program on page 581. I want to ask a series of questions, through the Chairman, as far as I am able, relating to infrastructure items in that capital works budget. I have been forming the view that our party needs to change its policy on the Fiona Stanley Hospital. Given what the minister is planning to put into the Fiona Stanley Hospital, as well as the 630 beds that are planned for that hospital, we would need to support what is in the "WA Health Clinical Services Framework 2005-2015", with the expansion to 1 000 beds, as was listed, by 2015, I think. In thinking that we would change our view and go

along with what the Labor Party proposes, I am finding it very difficult to work out exactly what the Labor Party does propose. The original proposal for Fiona Stanley Hospital was 600 beds roughly by 2010, with that expanding to over 1 000 beds by 2015. Now we know that those 630 beds will not be available, as things stand now, until 2013.

Mr J.A. McGINTY: By 2012.

Dr K.D. HAMES: It is 2012-13.

Mr J.A. McGINTY: That is the financial year in which it will occur, yes.

Dr K.D. HAMES: That is right - which means that it will be finished in 2013. In fact, everyone we talk to who is involved with that says that the minister is dreaming if he thinks it will be before 2013. However, the point is that that is only two years short of when the government had planned to have the extra beds. The minister will notice that in the out years, the figure for stage 1 of the Fiona Stanley Hospital is roughly $1 092 million. The last figure is $2 million for 2014-15. That is a relatively negligible amount. Therefore, I will go back a year. The figure in 2013-14 is $29 million, which I presume will be for lots of fitting out. When will stage 2 be done? Where is the money in the budget? I do not want the Liberal Party to say that it will commit to stage 2 and the Treasurer to then include that in his spendometer for the opposition, because the government does not have it in its budget.

Mr J.A. McGINTY: The Reid report, and the clinical services framework that followed it, refers to Fiona Stanley Hospital having 1 000 beds by the mid teens; that is, 2015 - I think the member is right. Part of the $4.1 billion that we often refer to is for stage 1. Stage 2 remains necessary, and it is something to which we are committed. It is beyond the forward estimates period, and so no provision has been made for it. The complete focus has been on getting stage 1 up and running. That is a four-year construction time frame. I still expect that it will be completed in 2012. The member may well be proven right in what he says. However, at this stage we are planning to start construction in September next year, 2008, with that concluding four years later. Of course, with the vagaries of construction, one can never be certain. We remain committed to the ultimate development of Fiona Stanley Hospital to a 1 000-bed hospital.

Dr K.D. HAMES: In what year? If we are to be equal on policy, and if the Liberal Party is to say that it will support the government's commitment to 1 000 beds, we must get some indication of when that might be. What is the government's policy on when stage 2 is to be completed?

[2.10 pm]

Mr J.A. McGINTY: It is something that will follow the completion of stage 1. I am not trying to be cute here. Stage 1 will now be completed two years later than was originally planned. It was to be completed in 2010 and will now be completed in 2012. We will be putting in a bid for stage 2 as we get towards the end of the development of stage 1 so that we can then begin the work to extend the hospital to stage 2.

Dr K.D. HAMES: Will the minister be putting in bids in 2012 to get the money for stage 2?

Mr J.A. McGINTY: It could well be before that but the construction will occur after stage 1. I cannot give the member a more precise time than that.

Dr K.D. HAMES: If I can continue with a further question, what will stage 2 contain? Obviously, the minister is now committed, as I understand it, to 140 beds from Shenton Park going to that hospital, but that will not be until 2017, according to what I have been told.

Mr J.A. McGINTY: My understanding is that the thinking is that it would be part of stage 2. Perhaps Dr Fong can answer the member's question directly on what is intended to be included in stage 2.

Dr N. Fong: The clinical services framework that we are currently working from states that Fiona Stanley Hospital will go to stage 2. The planning for that, as the minister said, has started already. We are continually updating and reviewing the clinical services framework. It is not a moveable feast but it is certainly a dynamic document. It is not meant to be set in stone for the next 20 years because, as the member knows, technology changes. There are a lot of other initiatives that we are confident and hopeful will kick in, such as ambulatory care reforms that may well inform any update to the review of the clinical services framework in terms of bed numbers. Nevertheless, the clinical services framework, as it stands, has an increase to Fiona Stanley Hospital, as the member stated, that includes stage 2 and the Shenton Park move there. My only comment would be - it is not a caveat - that it is being reviewed as we speak. We remodelled the clinical services framework, which brought about some minor changes to the clinical services framework, and that will continue.

Dr K.D. HAMES: The minister must have some idea of the proposed completion date, even a vague completion date. Reid went as far as to say in his document that it should be 2015, and he said that without any

planning, clinical studies or any of those things. The opposition did not support that in the early stages but we are now prepared to change, given what still has to go there. However, the department must have some idea of the date.

Dr N. Fong: Yes, we do.

Dr K.D. HAMES: What is it?

Dr N. Fong: We are committed to the timeframe for the commencement of Fiona Stanley Hospital stage 2 as soon as stage 1 is completed. That will kick on and be slightly later than it was under the original clinical services framework.

Dr K.D. HAMES: If we go back to what was planned -

The CHAIRMAN: Does the member have a further question?

Dr K.D. HAMES: Thank you, Madam Chair. The completion date was 2009-10 for Fiona Stanley stage 1, which meant there was a five-year time gap from the completion of stage 1 to the completion of stage 2. That would seem to me to be a reasonably logical time gap to expect. Based on stage 1 being completed in 2012, the chances are that stage 2 will be finished in 2017.

Mr J.A. McGINTY: It is something of that order. So far as the Department of Health is concerned, its own planning notes show Fiona Stanley Hospital with approximately 640 beds at 2012 and 1 000 beds at 2016. I think that is a bit optimistic and that it will be more like the gap that was originally proposed. However, the availability of funds for the next round of construction will determine that. We remain committed to the principle of 1 000 beds following on the construction of stage 1, but I am sorry I cannot be more specific.

Dr K.D. HAMES: I put on the record that we are prepared to make that same commitment so that there is continuity between us. However, the minister has not answered my last question about what else has to come on-site. I know that Shenton Park must go. Are there any maternity facilities? For instance, is the replacement of Woodside Maternity Hospital in the future plans; and, if so, will that also occur in 2017? What else is in that second package?

Dr N. Fong: Stage 2 of Fiona Stanley Hospital includes, among other things, obstetric services and the Shenton Park statewide rehabilitation service going back to the Murdoch site.

Dr K.D. HAMES: Such as?

Dr N. Fong: Just expansion -

The CHAIRMAN: I remind members of the protocols of this place. Members ask questions through me to the minister and the minister indicates each time whether the adviser can answer on his behalf, until I hear that the minister has given over the whole session to Dr Fong. The member may ask his question again.

Dr K.D. HAMES: Madam Chair, can I ask the minister, "Such as?"

The CHAIRMAN: No, I do not think so.

Dr K.D. HAMES: I mean a question to the minister.

The CHAIRMAN: The member can seek the information appropriately.

Dr K.D. HAMES: Minister: such as?

Mr J.A. McGINTY: The member has already indicated two areas. The move of obstetrics from Kaleeya Hospital to Fiona Stanley Hospital will not occur at stage 1. Kaleeya will continue to operate during that time and it is proposed that obstetrics will move at stage 2. The move of rehabilitation - in other words, Shenton Park - will also occur at stage 2. Dr Fong may have some other details he can add.

Dr N. Fong: It will be generally an expansion of already existing medical and surgical services. Stage 1 will include the full tertiary complement of services; therefore, it will be just a general expansion of more medical beds, more surgical beds and hopefully more day surgery beds. We intend to have an ambulatory care centre with a strong concentrated focus on day surgery. We expect to see that expand to deal with the closure of Kaleeya, and a curtailment of services at Fremantle Hospital, bearing in mind that Fremantle and Kaleeya Hospitals provide us with a buffer for the transition of those two hospitals at stage 2 of Fiona Stanley Hospital.

Mr J.A. McGINTY: I will add another matter in response to that. We announced the appointment this morning of the architects of Fiona Stanley Hospital. We announced at the same time that we had given instructions to try to put every bed in a single room, which I understand will be a first for a public hospital in Australia. That is something that we picked up in a recent visit to the United States, from both the point of view of infection

control as well as contemporary requirements for patient privacy. That will have a significant impact on the capital cost and we are working within the $1.1 billion capital envelope for that construction. That building escalation might mean that some things we intended to do in phase 1, such as one bed to a room, will be done when we get to the design stage. There may be items that need to be deferred; hopefully not significantly deferred. One benefit, now that the $1.1 billion will be paid into the Fiona Stanley construction account - subject to the budget passing through Parliament - is that it will earn interest that can then be added to the capital sum, which will hopefully be enough to add some improvements, such as single-bed rooms as well as absorb some degree of escalation.

Mr T.K. WALDRON: I refer to page 583 and the reference at the bottom of the page to new works commencing after 30 June 2008. Will the minister detail exactly what the $9 million for the upper great southern district entails, including the Narrogin Regional Hospital development and restructuring? When will it commence and when will it finish?

Mr J.A. McGINTY: I will ask Christine O'Farrell to respond.

Mrs C. O'Farrell: That amount of money has been put aside for the finalisation program of the upgrade stages of at least Narrogin hospital at this stage. It was acknowledged that the progressive upgrade was cut off at a time when it was not quite complete and our desire is to put aside an amount of money to enable that to be completed. Off the top of my head, I do not know exactly when that will come on stream. We have not done a business case for it yet, but the intention is to put together a detailed program to finalise and bring to completion the last bits of the hospital that did not undergo redevelopment in that last stage.

[2.20 pm]

Mr T.K. WALDRON: Is Mrs O'Farrell able to indicate a commencement time? I am sure that Mrs O'Farrell is aware that although Narrogin Regional Hospital is a very good hospital with good facilities, the fact that the last stage has not been completed is causing operational problems, particularly with the nurses station. I would like to be able to indicate to my constituents when it may happen.

Mr J.A. McGINTY: The current thinking is that the business case will be prepared by July 2009, that the tenders process will be over by June 2010 and that construction will commence in September 2010 and finish in September 2012. That is our current intent rather than a totally firm commitment. That is the time frame that we have factored in. It could move forwards or backwards.

Mr J.E. McGRATH: I refer to page 581 of the *Budget Statements*. Line item 8 refers to King Edward Memorial Hospital for Women and line 14 refers to Princess Margaret Hospital for Children. The government's intention is to eventually co-locate these hospitals to the Sir Charles Gairdner Hospital site. The forward estimates for King Edward is $3.5 million in 2007-08, followed by six years of $2.5 million. The forward estimates for Princess Margaret Hospital is $5.6 million in 2007-08, followed by $4 million and $3.5 million. What is the purpose of the forward spendings in the estimates? Given the government's intention, is it a case of putting good money after bad?

Mr J.A. McGINTY: The *Budget Statements* do not make provision for either Princess Margaret Hospital or King Edward to be rebuilt on the Sir Charles Gairdner Hospital site. The figures that the member referred to are capital funds to maintain the quality of the buildings while the hospitals continue to operate on their current sites. We have indicated our intent that King Edward be rebuilt on the Sir Charles Gairdner Hospital site. However, that falls outside the time frame within which we are currently working. Quite a bit of money has been spent on King Edward Memorial Hospital in recent times. Its building fabric is much better than the building fabric of Princess Margaret Hospital. So far as Princess Margaret Hospital for Children is concerned, we set aside $220 million to relocate Princess Margaret Hospital to the Royal Perth Hospital north block. That is not a view that is in favour in any sense; however, the government has not decided whether to provide funds to support moving it to the Sir Charles Gairdner Hospital site. It is something that we intend to work on during the course of the year. Significantly greater capital issues would be involved. If it costs $220 million to relocate Princess Margaret Hospital to the north block of Royal Perth Hospital and to upgrade that hospital, it will cost more than double that to build a children's hospital from scratch on the Sir Charles Gairdner Hospital site. The government has not made a financial commitment, although it is acutely aware of the arguments in favour of co-locating the children's hospital with the women's hospital on an adult tertiary site. The decision has not been made, mainly because of the extensive extra capital that would be involved.

Mr J.E. McGRATH: If the co-location goes ahead, will it be some time down the track?

Mr J.A. McGINTY: The Fiona Stanley Hospital will have a four-year construction time frame. One would expect that a women's and children's hospital might take less time than that. However, it is not planned currently in the forward estimates periods to commence construction on the new hospitals at the Sir Charles

Gairdner Hospital site. It is some years down the track; hence the need for the holding works to maintain the quality of the building fabric in the meantime.

Mr J.E. McGRATH: Can the minister advise when he would like to see this project completed?

Mr J.A. McGINTY: I would like the women's and children's hospitals rebuilt as new hospitals co-located with the Sir Charles Gairdner Hospital and, therefore, sharing much of the infrastructure that underpins that and having the benefit of being co-located with an adult tertiary hospital. That is particularly important when it comes to gynaecology, for instance. The synergies that would flow from co-locating the newborn intensive care and neonatal facilities at the women's hospital with the children's hospital are important. In terms of the time frame, we are still talking about the possibility of starting construction in 2010. However, it may be later than that because no decision has been made. That is an indicative view internally within the Department of Health. It is a matter of the overhead construction market and deciding when, post construction of the Fiona Stanley Hospital, we can financially and in terms of the building industry afford another major hospital development. I expect that the children's hospital will be constructed before the women's hospital.

Dr K.D. HAMES: Where does the minister get the double price from? The government is building a tertiary hospital on a greenfields site. It originally budgeted $600 000 a bed for the Fiona Stanley Hospital. We told the government it would be $1 million a bed. The government is now budgeting $1.4 million a bed. Reid suggested 180 beds at Princess Margaret, but it starts at about 230 or 240. How has the government doubled the $220 million? How has the government arrived at $440 million for a new Princess Margaret hospital?

Mr J.A. McGINTY: It is more than double. The figure is marginally in excess of $570 million, which seems to be extraordinary.

Dr K.D. HAMES: That is way above international construction standards. The Minister for Health has just visited some international hospitals.

Mr J.A. McGINTY: I agree with the member's point of view. It seems extraordinary but, nonetheless, that is the indicative figure.

Dr K.D. HAMES: Even though it is not included in the budget, that potentially puts PMH reconstruction out a long way. Is the government absolutely committed to it being on that site? What about the structure of PMH? How long will the existing hospital last given its severe infrastructure problems?

Mr J.A. McGINTY: The member is quite right: the building fabric at PMH is not good. That is why we need to rebuild that hospital. We cannot continually fix it up. It is reaching the end of its useful life. The government has not made a decision whether to allocate the additional $300 million-plus to support the construction. Officially, the answer is that we have not reversed the decision to move to the north block, even though nobody supports that move. That issue must be weighed up alongside other capital works priorities. The government has recently allocated nearly $1 billion to a desalination plant and $1.1 billion to the Fiona Stanley Hospital. People today are talking about nearly allocating $1 billion to a football stadium. It is a question of competing for the available dollars. I would much rather build a new children's hospital than some of those other things. Others might disagree.

Mr P.B. WATSON: I refer to the works in progress that will be commenced before June 2008 outlined on page 581 of the *Budget Statements*. The first item under the heading "Country" is the Albany Regional Resource Centre, which should be number one. Two years ago the government promised to allocate $26 million. A consultancy firm was brought in two years ago, yet nothing has happened. I hope that the Minister for Health is as bitterly disappointed about this issue as I am. Why has it taken two years for the consultancy firm to make a decision? What are the results of its findings, and what will happen in the near future at Albany Regional Hospital?

[2.30 pm]

Mr J.A. McGINTY: Dr Fong will begin and, if need be, Christine O'Farrell will also respond.

Dr N. Fong: The redevelopment of the main campus at Albany is a quite complex project. I agree that two years is too long. I hope there would be some recognition that the capital works program that our department is embarking on in planning, tendering and monitoring the works in progress and completing them is a significant one. Nevertheless, the money that was allocated to the Albany project is not a lot of money. We have to work out what are the different options that are available for that amount of money. Whether government accepts this or not, our department has commenced the work up of a number of options for that site, which might mean us putting in a bid for more money to do more than the $26 million currently allocated can do. As people would expect, with the construction market in Western Australia, $26 million is not going to do a lot when we consider that a brand new hospital in Vasse or Busselton is slotted to cost $65 million. We have been working on a

number of options. They have now been presented to the Chief Executive Officer of the WA Country Health Service. Those options include a total rebuild, a rebuild in stages or a patch up using the money that is available. We thought it prudent to not just go ahead with the $26 million that is there, although that is an option if there is no more money available, but to look at the overall picture. That will be presented to us and it will be up to the government with its list of priorities to deal with that issue. It is complex because we were testing the private sector to see whether there was any interest. As the member may be aware, a private healthcare organisation was interested in getting involved in providing day surgery and other ambulatory services at the hospital. It is still interested so we have been testing the market a bit, which has added a level of complexity. We hope to have a decision that we can present to the minister and the government some time in the next month or so. I am not sure whether Christine wants to add anything.

Mrs C. O'Farrell: By way of explanation, in that two-year time frame there were about 15 or 16 major complete rebuilds or redevelopments or significant capital projects. We scheduled Albany as a business case for last year. It was the product of that business case, as it was presented to me, that we really needed to make a decision whether we wanted to proceed with a program that would progressively, over many years, redevelop the existing hospital starting with quite a small amount of money that would, in fact, do very little for patient amenity given that some of the engineering services in the hospital need to be addressed as a matter of priority before anything else starts. Alternatively, we could go for a more cost-effective and better outcome arrangement with a rebuild. That necessitated going through a rather more complex and long-winded planning program to look at several options.

Mr P.B. WATSON: Considering that it has taken so long to get to this stage, I am sure that the minister and his department will observe the utmost urgency to make sure that we can get a decision on this because the people of Albany were promised something two years ago. They are not very happy. The opposition spokesman on health, the member for Dawesville, has visited and he is unhappy as well. It is a two-pronged attack by me and the opposition spokesman on health. It is a big issue for the electorate.

Mr J.A. McGINTY: Yes.

The CHAIRMAN: I do not know whether I heard a question. It was rather more of a fishing expedition, which hopefully the minister will listen to.

Mr J.A. McGINTY: At least it was not from the member for Collie-Wellington!

Mr P.B. WATSON: I was asking about the urgency of getting it done.

Mr J.A. McGINTY: I give the member the undertaking that, notwithstanding the recent history of this, following his recent visit to Albany, Dr Fong has assured me that it will be treated with the utmost urgency and ensure that the appropriate decisions are made in the very near future.

Mr P.B. WATSON: Thank you, minister.

Dr K.D. HAMES: I have had to do a bit of fishing to find a spot for my next question. Perhaps the minister can advise me of a better spot to ask it. I refer to page 579 and a fairly generic reference under the first dot point about emergency departments. I want to explore the winter bed strategy further and obtain from the chief executives - I guess not many of them are here - how the winter bed strategy works. I do not need to know so much what is going to be done this year, because I know there will be an announcement about the number of beds. My view is that there should be more beds available all year round. Nevertheless, there will be a winter bed strategy soon. My understanding is that hospitals expect it as part of their annual budgets. They know that they are going to get an amount every year but they cannot really count it as part of their annual budgets. They ease off on their nursing numbers outside winter and then increase them in response to increasing demand. The winter bed strategy is just part of their income for the year. The difficulty we have, as the minister knows, is that there are insufficient beds to cater for the current demand that has increased significantly in the hospitals. The director general said on radio 6PR in 2000 that 85 to 90 per cent is the ideal occupancy rate for hospitals. The international standard is 85 to 90 per cent. That is hard to achieve; everybody knows that and it costs money. The reality is that we do not have enough beds. I want the minister to talk about beds, particularly the winter bed strategy. Is it what I have been told? Perhaps some of the hospital representatives can tell me how the strategy operates.

Mr J.A. McGINTY: The greatest challenge today facing our public hospital system is that of the emergency departments. I am happy with the work in progress that has been made in every other area of health. There are always issues to be confronted. We have just been talking about the capital program in a tight construction market and things of that nature. However, this is the area of greatest focus. I met yesterday with the heads of the emergency departments, both the doctors and the charge nurses. We went through a range of issues involving emergency departments and the pressures they are under. If I can put it simply, the problem is that an

additional 15 000 people are fronting each year to emergency departments. That is just in the metropolitan area. That is having an enormous impact. We then find that, although emergency departments are capable of doing great things, if they cannot get rid of patients - I use that term loosely - after they have been stabilised and treated, there is a problem. It is amply shown in the access figures of people waiting too long once it has been determined that they are sick enough to be admitted to hospital to be given a bed. This is a very acute problem; staff are now saying that they do not want to work in emergency departments because they regard them as unsafe. They regard the conditions under which they work as oppressive, and I think they are right. From the discussion with the staff from emergency departments we want to ensure that the doctors and nurses in the emergency departments do not have unsafe working conditions or a sense that they cannot properly care for their patients. We have agreed with them that there ought to be a cap on the number of people who are in emergency departments receiving treatment or waiting for a bed. The best way to handle that, in my view, is by hospital administrators taking responsibility for ensuring a very efficient discharge of patients in order to free up more beds so that patients can be taken from the emergency departments. That is our biggest challenge at the back end; that is, to ensure that the beds are freed up in the emergency departments. My impression is that the emergency departments could handle even more than they are currently doing if they did not have to continue to care for people who should be in a bed in the hospital. That is always the issue they raise with us.

This is a most serious issue that needs to be addressed, and we are doing that in two ways. Firstly, from 1 July, as I know the member is aware, the extra 70 beds at the Bayswater Nursing Home will be made available. That will move care awaiting placement patients out of acute beds in hospitals and into that village. That will have an immediate and enormous effect. That is five weeks away. Some of those beds will become available during the month of June, but they will all be available by 1 July, which is not far away.

[2.40 pm]

Dr K.D. HAMES: Subacute patients?

Mr J.A. McGINTY: On top of that there are another 50 beds to which we plan to move essentially rehabilitation patients out of the acute beds they are currently occupying to free those beds up for emergency cases. We are looking at allocating the additional beds that will be freed up on a 70-30 basis - 70 per cent for emergency admissions and 30 per cent for surgical admissions. In addition to that, we are going out to the market in the south metropolitan area to find an additional 30 beds in the nursing home or aged care sector so that we can move another 30 care awaiting placement patients out of the acute hospitals. I will make the point very quickly that caring for the aged is a federal responsibility. I have spoken to Tony Abbott, and while he is my friend and we are normally able to do business together, he was unable to assist me on this, so the government is providing the additional funds.

Dr K.D. HAMES: He is the wrong minister; it is the minister responsible for aged care.

Mr J.A. McGINTY: Nonetheless, we did ask for federal support and the answer was no, so we are providing the funding to place those people in aged care facilities to free up the acute beds. Altogether, 150 extra beds will be available. The subacute beds will not be available until the end of the year, but most of the care awaiting placement beds will be available in five weeks.

Dr K.D. HAMES: Why are those beds not available until the end of the year? There are places outside. Kalamunda District Community Hospital is running at about 50 or 60 per cent occupancy, and Kaleeya Hospital is the same, based on the latest figures we have, which are fairly recent. There are hospitals that are running at far less than full capacity. As the minister knows, the patients at Royal Perth Hospital are a different mix from those at Sir Charles Gairdner Hospital. Royal Perth patients tend to be younger people who need longer-term care, so they could go to either of those two hospitals. Why can those not be used?

Mr J.A. McGINTY: I have mentioned the total of 100 care awaiting placement beds that the government will fund in the private sector to free up 100 beds in the system. Fifty care awaiting placement beds will be for subacute rehabilitation places. The reason that cannot be done immediately is that there is a requirement for medical and rehabilitation staff to be engaged to continue to provide treatment that is more complex than care and supervision in an aged care facility, so I am told. That is the reason for the delay there. The notes I have here state that 50 beds or places from the non-government organisation or private sector will be sourced as a cost-effective and outcome-oriented approach to the care of patients requiring short-term complex medical and/or rehabilitation interventions provided by medical directed multidisciplinary professional teams. It is hoped that 50 will come online by 1 January 2008. These subacute beds will increase mainly the number of rehabilitation beds within the system. Those patients are currently occupying tertiary beds. This strategy will also involve improving the use of the system's current rehabilitation bed stock.

The other issue that I should refer to is the opening of other beds within the system, in addition to that 150.

Dr K.D. HAMES: Is this the winter beds strategy?

Mr J.A. McGINTY: No, this is just looking around at what other beds are available to be opened. Sir Charles Gairdner Hospital now has all its beds opened, and it has 15 more than at this time last year. There are no other beds at the Sir Charles Gairdner Hospital that could be opened.

Dr K.D. HAMES: What is the total now for Sir Charles Gairdner Hospital? Can the minister provide details about bed numbers in each of our tertiary hospitals?

Mr J.A. McGINTY: There are currently 611 beds at Sir Charles Gairdner Hospital. I have mentioned that 15 beds have been opened at that hospital, and no further beds are available. South metropolitan, which includes Royal Perth Hospital and Fremantle Hospital, will open a further 64 beds over the next two months. Thirty-two are to be opened progressively from early June at Fremantle Hospital; 21 are to be opened on 1 July at Royal Perth Hospital; and Bentley will open seven general beds and Armadale four. The ability to work on these beds will depend upon the suitable recruitment of staff, which has been problematic in the past, but we are giving top priority to recruitment, particularly of nursing staff, to be able to open those beds.

Dr K.D. HAMES: The minister has not answered the question about the winter bed strategy.

Mr J.A. McGINTY: We have found in recent years that -

Dr K.D. HAMES: It does not work.

Mr J.A. McGINTY: It is not so much that it does not work, but winter is not winter anymore, if I can put it that way. That is not just climate change either. From the reports I have received from the emergency department people, February and March this year were very bad months for presentations. September and October last year were very bad months. We are seeing now not so much an accentuated winter peak as something that is a year-round phenomenon. That is something we need to respond to, and that is what the emergency department people are saying to us. I will just quickly respond on Kalamunda. The note I have here states that we have started using beds at Kalamunda by shifting subacute patients there. Kalamunda initially took 10 patients, and now takes 15. Depending on the success of the Mertone Village, where the 70 beds will be made available for the care awaiting placement patients, these 15 beds will either be converted to subacute beds or continue as care awaiting placement beds or will provide other support to the North Metropolitan Health Service. An additional 15 Kalamunda hospital beds may also be used, subject to staffing, and we are looking at utilising those beds that are not being fully utilised at Kalamunda.

Dr K.D. HAMES: Is Kaleeya Hospital the same?

Mr J.A. McGINTY: The position at Kaleeya is not as clear as I would like it to be. It was my intention that Kaleeya would have a certain number of beds dedicated to maternity, and the rest of the hospital would be a surgicentre. We have had difficulty recruiting appropriate staff, particularly anaesthetists, to work at Kaleeya, and therefore there has been some discussion in recent days about resuming the use of Kaleeya as a rehabilitation centre. I am not happy with that; I would rather that, not having an emergency department, the hospital be used for tackling the elective surgery waitlist. We are hopeful, as a result of discussions with surgeons and anaesthetists, of being able to fully utilise Kaleeya and its four or five operating theatres to make a solid attack on elective surgery in the same way that Osborne Park is doing in the northern suburbs. That is in a state of flux at the moment. We do not want to see beds lying idle, and we will use them for subacute rehabilitation if we cannot get the surgical proposal up and running.

Dr K.D. HAMES: Is the minister aware that the Victorian Labor government recently put out a document on managing the overcrowding of the emergency departments? It drew attention to Austin Hospital as the model to follow for managing patients through emergency departments. The minister may know that I recently visited that hospital. It has a system of monitoring patients all the way through from admission to discharge, with a single person controlling that whole process. It is an ideal model to follow, and if the minister does not know about it, I would suggest that he look at it, because it looks very good.

[2.50 pm]

Mr J.A. McGINTY: I thank the member for that. When we met yesterday with the emergency department doctors and nurses, we discussed having someone come in and review our procedures, because I am sure that we can do it better to address the current chronic overcrowding.

Dr K.D. HAMES: Austin Hospital is held up as the best in Victoria.

Mr J.A. McGINTY: I was not aware that the government had put out that document. I certainly engaged with the heads of the emergency department and asked them whether they had any ideas about what we can do and

how we can do it better. It is everyone's problem. As I have said, it is the most significant challenge that we face in the health system today. I thank the member for that. I will certainly chase that up.

Mr T.K. WALDRON: I refer to the fourth dot point under "Specialist services" on page 595, which states -

> Increased access by country residents to regionally based and visiting specialist services will be increased . . .

It then goes on to list those services. Access to specialists is an issue in country Western Australia and it is encouraging to read that it will be increased. What are the minister's plans to accomplish that improved access? Does he have in mind a certain number of specialists who will be regionally based, and where is he considering locating them?

The CHAIRMAN: I think I heard more than one question, member for Wagin.

Mr T.K. WALDRON: I do not want to confuse the minister, but I have noticed that he is very good at handling that sort of stuff.

The CHAIRMAN: I know, but I do not want to give the member inappropriate ideas.

Mr J.A. McGINTY: We do have a plan, and I will ask Christine O'Farrell to outline it to the member.

Mrs C. O'Farrell: We developed a detailed plan to increase the specialist services available in each of the regions in 2004. We have annually addressed key aspects of that plan and have made some significant progress. We have increased visiting services in all regions. We have begun employing specialists in our regional resource centres. As we have found that the market for private specialists in rural communities has become thinner and thinner, we have made that transformation into a regional specialist base. We have doubled and tripled the number of specialist psychiatrists in many regions. We have progressively converted most of our solo regional specialist posts into at least two positions. We had one surgeon in the Kimberley, one surgeon in the Pilbara, one paediatrician and the like, but we are now well on the way past two as younger people have come on board and expressed a complete unwillingness to cover positions on a solo basis.

Last year we undertook a program of consulting with rural doctors everywhere in the country, and for the first time we met with about 45 specialists from the metropolitan area who service the country. It was the first time that those people had ever been brought together as a group to speak to us about their points of view on the provision of services in the country. The main outcome of that meeting was a willingness and a desire by them to be involved in the future planning of specialist services. We have done a review of our initial WA Country Health Service review that we published in 2003 called "Foundations For Country Health Services". We anticipate that we will commence stage 2 of our attempt to expand medical specialist services in the regions with the direct involvement of many of the metropolitan specialists, with their linkages and networks into metropolitan services as well. The first action that we have commenced following the foundations process is the development of detailed clinical services plans for each region, which will include the medical workforce.

Mr T.K. WALDRON: I am encouraged by that answer. Mrs O'Farrell spoke mainly about visiting specialists, but she did mention that there were more specialists working in the resource centres. Did I hear her say that it was not inland areas and that they could be attracted only to Bunbury, Albany, Geraldton and Kalgoorlie rather than to Narrogin and that type of area?

Mr J.A. McGINTY: I draw the member's attention to the sixth dot point on page 592, which reads -

> The WA Country Health Service Specialist Services Plan is being implemented, including the recruitment of salaried medical officers and resident specialists in general medicine, general surgery, obstetrics, paediatrics and psychiatry. New and expanded services have been established through the Medical Specialist Outreach Program, including general surgery, gastroenterology and gynaecology at Merredin District Hospital, a sleep apnoea service in the Great Southern and additional orthopaedics and cardiology services in the Mid-West.

Mr T.K. WALDRON: I had read that.

Mr J.A. McGINTY: Yes. Is there more information that the member wants, because that refers specifically to inland areas? I thought the member's question was about coastal areas.

Mr T.K. WALDRON: Sometimes when we talk about country health, we talk about the big centres. Although I understand that, we always seem to get huge gaps in the middle that cause problems in my area and in other areas. I am encouraged by what the minister is trying to do and I support that. However, what is he achieving in reality outside those major resource centres, because a lot of people fall into those gaps? What he is doing in Merredin is good. I just wondered about the hospitals in Narrogin, Moora and those types of towns.

Mr J.A. McGINTY: I know that Dr Simon Towler would like to give some information about what is happening generally with specialist services. Perhaps Dr Towler can make that comment, and, if need be, we can go back to Mrs O'Farrell for further information.

Dr S.C.B. Towler: I want to add some comments about the whole issue of the specialist medical workforce in Western Australia and some of the important changes that are going on nationally. Members may not be aware that the Australian Medical Council, after the review by the Productivity Commission, is looking at the opportunities for what might be called accelerated registration in Australia and the general registration for people appropriately trained overseas. That represents a substantial opportunity for Western Australia. Those processes are being finalised by the commonwealth at the moment. My view is that this represents a substantial opportunity for Western Australia to attract additional specialists. We have some 93 per cent of the national average in medical specialty availability in this state. At some stage later, I hope I can comment on general practice because the deficiencies in that area are greater. However, in the medical specialist area, potentially significant opportunities are emerging. In my role as the chief medical officer addressing requests to declare areas of unmet need for specialty services, it has become very clear that there are ongoing difficulties in the country. I believe that the foundations document framework creates an environment in which we hope to attract specialists with greater ease. In a parallel endeavour, the WA Cancer and Palliative Care Network is currently engaged in conversations with Cancer Australia about helping us to develop a much closer relationship between the metropolitan area and country sites. We will be targeting Albany and the south west in a submission that we will put to the commonwealth government on providing greater support to clinicians working in the rural sector, so that the kind of support that is available in the metropolitan area is more consistent and that visiting services are part of a clinical services plan, which then dovetails with the work being done by country health services. The issue of specialty services away from regional hubs will remain a problem. Clinical services planning should address options to do that, and I am sure that Chris O'Farrell will be happy to comment further on the approaches that are being taken.

Mr T.K. WALDRON: I am happy with the answer, but it leads to some other issues with transport that I will talk about later.

Mr P.B. WATSON: One of the biggest problems with attracting surgeons to regional areas is that they miss out on the training that takes place in Perth. Has any thought been given to having a sister city relationship between hospitals? For example, a surgeon or obstetrician from Albany could go to Fremantle Hospital once a year for a month, and Fremantle Hospital could send someone to Albany so that that person could be updated on the latest methods.

[3.00 pm]

Mr J.A. McGINTY: Certainly the rebuilt country hospitals, and particularly the regional resource centres such as those in Albany, Kalgoorlie, Bunbury, and in the north of the state, will have a relationship with a tertiary hospital in the metropolitan area. That is the sort of thing that I envisage will flow from those stronger links between the regional resource centre and the metropolitan tertiary hospital. Dr Towler might be able to further comment on the issue the member has raised.

Dr S.C.B. Towler: I think the issue raised by the member is particularly important, and I would just like to point to a few changes that are going on in Western Australia, which I hope will provide some substantial resource. I think it should be a compliment to the universities and the regions that the development of the rural clinical schools, which has been largely focused on undergraduate training, is now such that at the moment we are considering options through the rural clinical schools for enhanced postgraduate development. That means that many regions now have an educational resource, so we hope to make use of that in a postgraduate environment to assist people working in the regions to get better access to education and training. At the moment, at the request of the director general, I am looking at the very broad sweep of issues to do with medical education, training and development for Western Australia. Profound changes are going on at every level of the medical education system. One of the targets we hope to take advantage of is exactly the issue the member has raised. Christine O'Farrell has already mentioned the improving relationship between the metropolitan areas and the rural sector in terms of support for specialists. We wish to enhance that. There are some programs funded by the commonwealth, particularly one that again goes back to cancer clinicians, in which money is made available to bring specialists from the country to get experience in the metropolitan area. That is one of the key elements of the cancer network and node program that we are putting together. I think the member's question is particularly pertinent and very relevant to Western Australia. We are very aware of it in trying to enhance what options we can in our relationship with the commonwealth.

[Mr G. Woodhams took the chair.]

Mr J.A. McGINTY: I will add one last thing. There is obviously a role for Western Australian Centre for Remote and Rural Medicine in this service. My understanding is that Ian Taylor has recently been approached and asked to become chair of WACRRM. As a former health minister and a former country member, he is someone who we all know will have an ongoing interest in it.

Mr J.J.M. BOWLER: I refer to the Kalgoorlie Regional Resource Centre redevelopment stage 1, which is listed on page 583 under the heading "New Works Commencing after 30 June 2008". The minister will be aware of the disappointment in the goldfields that what was promised in last year's budget has not been met. That has passed, but I am worried about the future. Can we be reassured that this year's budget allocations, which we can see on the page, will be met next year?

Mr J.A. McGINTY: I was aware that there would have been disappointment in the goldfields at the decision to defer by 12 months the $40 million expenditure on the upgrade of Kalgoorlie Regional Hospital to a regional resource centre status. The decision was made, essentially by Treasury, at a whole-of-government level to defer a range of projects in light of the overheated construction market. Three health projects were affected: Kalgoorlie hospital, the Sir Charles Gairdner Hospital project and the building of the new hospital in Midland were deferred by 12 months. A range of other government capital works projects across all portfolios were also deferred. Some were cancelled, such as the Northbridge link project; others were deferred. In health, those three were deferred out of the many dozen capital works projects that are being undertaken. I assure the member that this deferral was not because of a shortage of money; it was simply a shortage of construction workers to do the construction. That was the advice we received from the Department of Housing and Works and Treasury. In light of the fact that the people of Kalgoorlie have been asked to bear a 12-month delay, we will ensure that this time frame is now met.

Mr J.J.M. BOWLER: One last thing; because the whole project has been put back a year, it means that we will get less than $40 million. There will probably be building costs of eight per cent, which would be about $3.4 million or $4 million worth. Will we see an increase in the funding to counteract the delay by a year, and therefore the diminishing value we will get for that $40 million?

Mr J.A. McGINTY: Yes, is the simple answer to that. The two projects in health are fully escalated; that is, they have escalation built in to them. The first is the Fiona Stanley Hospital project, for which escalation is built into the project over the construction time frame concluding in 2012. The other project is Rockingham-Kwinana District Hospital, where I think construction work has now started. It is fully provided for. For other projects such as Albany and Kalgoorlie and for various other proposals, we will need to go back and say what is the revised capital cost including escalation. Therefore, Kalgoorlie will not lose as a result of this deferral. We will ensure that the same amount of work is done, and if that requires an escalation factor for 12 months to be built into it, it will be added to the total amount.

Mr J.J.M. BOWLER: Excellent news, thanks very much.

Mr M.P. MURRAY: My question is along the same lines. The third line item from the bottom of page 581 is $6.2 million for the Harvey District Hospital redevelopment. As the roof of the hospital is leaking very badly, the community has concerns about having to wait another year or so for the works to start. Can the minister give me some idea how this money, and works process, will roll out?

Mr J.A. McGINTY: I will ask Christine O'Farrell to comment on that. However, before she does, having visited the Harvey hospital on a couple of occasions with the member, I appreciate the need for this work to be done as expeditiously as possible. There should be no delays in getting on and doing it. Following the absorption of the Yarloop District Hospital by the Harvey hospital, it is even more important that we waste no time in getting on with the documentation, the contracts and the like. The current plan is that the business case will be completed by September this year, and presented to Treasury for approval. We will then go to construction tender in April 2009, and the intervening time will be spent on making sure that all the documentation is done. Mrs O'Farrell might be able to tell us if there is some way that can be sped up to ensure that we get on with it as quickly as possible.

Mrs C. O'Farrell: I do not think I can add much more to that. We will get onto the business case as quickly as we possibly can. We will make sure that we keep to schedule on that program and commence the work when it is due.

Dr K.D. HAMES: Could I just put in a request before we start, minister? Even though we have five hours for this division, it goes enormously quickly when we are trying to ask questions. Although all the minister's staff feel passionate about issues and want to tell us about them -

Mr J.A. McGINTY: Does the member want us to be more to the point?

Dr K.D. HAMES: We are able to get briefings elsewhere, so I just wonder if they could keep their comments reasonably concise when answering the question.

Mr J.N. HYDE: What about no preambles?

The CHAIRMAN: I am sure the minister will take the information on board. Thank you, member; your question?

Dr K.D. HAMES: I refer to page 633. The director general might be able to give me a better spot, because I want to ask about his office, and the operation of the director general's office in Subiaco. Therefore, I picked page 633 because it talks about financial costs and accommodation and so on. Unless there is a better line item, I will just use that one. I would like to know a number of things about the office in some detail. I do not anticipate that it will need to be provided now, but I would like to know. Why does that office continue to be separated from the health department, and whether there would be savings by having it in the health department building? How many people are working there? What are their salaries? Without necessarily giving me names because that might not be appropriate, I would like the minister to provide details of the position and salary of each person working in that office in Subiaco. How many of the people who are in this room now work in that office?

[3.10 pm]

Mr J.A. McGINTY: Three, counting Dr Fong, is the answer to the member's last question. I suggest that if the member wants that level of information about each employee, that is something that the member should put on notice in order for it to be provided.

Dr K.D. HAMES: Will the minister provide it as supplementary information?

Mr J.A. McGINTY: I think it is the sort of information that really ought to go on notice. However, we can certainly answer the rest of the question. I ask Dr Fong to respond.

Dr N. Fong: When I was appointed to this role in August 2004, the member will recall that there was an existing Director General of Health, Mike Daube. There was no office accommodation for me at that time, as the newly appointed chief executive of the North Metropolitan Area Health Service and the executive chairman of the Health Reform Implementation Taskforce. It was agreed with the minister and the director general at the time that office accommodation would be located. That was all located. It was run through the Government Property Office. It is on record what the fit-out was and what the rental is. In fact, in this house last year in a similar estimates committee, the details of the lease arrangements were provided. I am happy to provide them again. The five-year lease that was entered into for that office accommodation at the time was, and is now, a very good deal in the sense that it was a very low rental per square metre, and it has now escalated significantly, whether it is in West Perth, Subiaco, East Perth or wherever. We have good accommodation. When the director general vacated his position at the time, it was deemed not necessary to uproot all of the Health Reform Implementation Taskforce in the office of the director general. I then just added two people, basically, to manage the office of the director general out of that particular office. We have renegotiated all our office accommodation over the past couple of years. We have rationalised. We have moved out of various places, such as where the Mental Health Review Board was located, to try to consolidate our staff. DonateWest was in Dumas House and other places throughout Perth. Of course, the biggest issue was the leasing of space at 81 St Georges Terrace for the Health Corporate Network. We were able to remove a lot of staff from area health services to take up that central accommodation. If there was any increase in expenditure for the lease rental arrangements, that is where it is reflected. It was $1 million or more to rent that accommodation for the 500 staff who are under that government initiative, the Office of Shared Services.

Dr K.D. HAMES: How many are in Dr Fong's office in Subiaco?

Dr N. Fong: In my office, there are approximately 30 people.

The CHAIRMAN: I ask the member to direct the questions to the minister.

Mr J.A. McGINTY: Dr Fong can respond.

Dr N. Fong: There are approximately 25 to 30 people. That includes the office of the director general. It also includes the staff of the Health Reform Implementation Taskforce. There are also two staff associated with the industrial relations shared services area who assist with the implementation negotiations for industrial arrangements.

Dr K.D. HAMES: I have a further question. I know that the minister said I should put it on notice, but the reality is that the exact details of my question are now recorded in *Hansard*. Can the minister not just answer the question by way of supplementary information? It is not difficult. The chief executive will have all those

details. Can he provide that as supplementary information? I think there are still 14 days for that information to be provided. Otherwise I have to write it all out exactly as I have already asked the minister.

The CHAIRMAN: The best advice I have is that the member put it on notice. It is not the purpose of these estimates committees to provide that sort of information, even as supplementary information.

Dr K.D. HAMES: Am I not allowed to ask the minister whether he can provide it as supplementary information?

The CHAIRMAN: Certainly, the member can ask the question.

Mr J.A. McGINTY: My initial reaction was that if it was something that flowed out of the budget and we were not able to provide the member with that information, that is classically the sort of question that ought be a question on notice. I do not wish to be particularly awkward, and I would happily provide it by way of supplementary information if it were of that character, but I think it is classically something that should be a question on notice.

Dr K.D. HAMES: I have a further question relating to that issue. How many of those 28 or 30 people are on salaries above $100 000 a year?

Mr J.A. McGINTY: Dr Fong?

Dr N. Fong: I would have to take that on notice, because I do not want to make a mistake in this chamber and give the member an inaccurate answer.

Mr J.A. McGINTY: Perhaps again, given that the member is going to put something on notice about the staffing, he could include that as part of that question.

Mr J.E. McGRATH: Mr Chairman, can I ask a further question on the same subject, please?

The CHAIRMAN: The member for Dawesville has finished his questions. The member for South Perth is indeed the next in line.

Mr J.E. McGRATH: But the question is on the same subject. My questions are on another subject. I would like the minister to tell us how many hours a week the director general spends working for the health service.

Mr J.A. McGINTY: I am often on the phone to the director general at 10 o'clock at night and before seven o'clock in the morning, which might give the member some indication of it. My estimation is that, including weekend time, it would be somewhere up towards 80 or 100 hours a week. However, Dr Fong might be able to give a more accurate figure than that.

Dr N. Fong: I do not keep a daily record of my hours. I give the utmost. It is somewhere in that vicinity. It is a huge job. I enjoy it, and I have an excellent team of people who supplement me.

Mr J.A. McGINTY: And an excellent minister to work with.

Dr N. Fong: And an excellent minister.

Mr J.E. McGRATH: My question relates to the eighteenth dot point under "Metropolitan" on page 581; that is, Royal Perth Hospital. What is the status of the title of ownership of the land on which Royal Perth Hospital stands, and are there native title issues that could affect the proposed sale of the land?

Mr J.A. McGINTY: Health has ownership and control of the land. As to the precise nature of the title, I am not sure whether it is vested or freehold. I have never looked at it. It is certainly regarded as health land. I doubt whether any activity on the land would trigger the future act provisions of the Native Title Act, but I do not know. It is most probably asking for a legal opinion, among other things. It is simply not something that we have bothered to look at. If the question is alluding to the future of that land post the relocation of Royal Perth Hospital to the Fiona Stanley site, it is not an issue that we intend to look at until it gets a lot closer. A valuation of the Royal Perth Hospital land has been done, as there has been a valuation of the Princess Margaret Hospital for Children land, and I think the King Edward Memorial Hospital land also, in order to get an indication, and it is hundreds of millions of dollars all up. Again, my recollection is that it is of the order of $300 million or $350 million for the three sites.

Mr J.E. McGRATH: And for Royal Perth Hospital?

Mr J.A. McGINTY: The Royal Perth Hospital site valuation at July 2006 was $124.5 million. However, now that the member has raised the question of the nature of the title, we will need to go back and investigate that because some hospitals are on land that is not freehold but is vested for hospital purposes.

Mr J.E. McGRATH: I have one further question, and this might be something else that needs to be checked: is the minister aware of any legislation passed in this Parliament that would prevent the sale of that land?

Mr J.A. McGINTY: No, I am not. However, again, because the value of the land and the asset sale are not relevant to the future hospital redevelopment issues, it is not an issue that we have particularly turned our minds to. We made sure that we separated the disposal of the asset and the value of the asset from the location of the new hospital to make sure that it was purely a hospital-based decision, and not one related to asset sales. I am not aware that there is any legislation that would prevent the disposal of the Royal Perth Hospital site post 2012. It is one of those issues that we need to turn to. We need to ensure all those issues are covered. However, it simply has not been an issue until now, as it is not part of the equation.

[3.20 pm]

Mr P.B. WATSON: I refer to the fourth dot point on page 595, which has been referred to before. It refers to increased access by country residents to regionally based and visiting specialist services. I compliment Dr Towler's work in bringing overseas specialists to Western Australia. We spend a lot of time waiting to get overseas specialists into the country, as they have to go through a rigorous screening process. I wonder whereabouts the department is with the obstetrician-gynaecologist who is coming to Albany. We have a fly in, fly out service at the moment, but how is the department going with the new residents, and are there any other plans to bring resident specialists into Albany Regional Hospital?

Mr J.A. McGINTY: I will hand over the question to Mrs O'Farrell. However, at the outset I can say that I am acutely aware of the need for a salaried obstetrician at Albany hospital. That has been budgeted for, I think, for two years now.

Mr P.B. WATSON: Two years.

Mr J.A. McGINTY: There has been a very serious difficulty in recruiting, due to the worldwide shortage of specialist obstetricians. An obstetrician has been engaged and is subject to the last few procedures relating to that person relocating to Albany. My understanding is that the specialist will be in Albany within the next two months, but Mrs O'Farrell might be able to provide more detail.

Mrs C. O'Farrell: Yes, the news is getting better. We have had this recruit for several months and we have been held at large through the college and the Australian Medical Council accreditation processes. The doctor is actually in Australia at the moment and is undergoing assessment by the college today for accreditation. In any event, we were able to acquire medical registration for this doctor in the public interest through the WA Medical Board, and he and his wife will be coming over to the west and visiting Albany as a prelude to their relocation. The recruitment is therefore 95 per cent in the bag and looking good.

Mr J.A. McGINTY: What is the date?

Mrs C. O'Farrell: I do not have the date. He has booked airfares and it is not very far away, but I am sorry, I just do not have that particular date in my head.

Mr P.B. WATSON: I have a further question. Is there a minimum time that a doctor secured by the minister must stay in Albany? Is there any other plan to bring any other resident specialist to Albany?

Mr J.A. McGINTY: The answer to the member's first question is no. Dr Fong would like to make a comment generally on overseas-trained doctors.

Dr N. Fong: We get these people to sign contracts with us, so they are contracted. There are conditions in these contracts about relocation expenses and all sorts of things if they move out of their own volition and go home or do something else. There are contractual obligations. Having said that, they are usually restricted by their provider numbers as to where they can practice. They cannot just take off if they get an offer somewhere else.

Following up on the minister's invitation to comment, I would say that we have to be very careful with the calibre of overseas-trained doctors that we let into this country. It is a major issue for us. The member would be aware that it has been a major issue in the Queensland health system in the past few years. The assessment and appraisal of references under the regulations is a very complex process. We would rather take a long time to make sure that the people we are getting have bona fide qualifications and competency than rush them through and have dud people working in the health system. That complex process also puts a huge onus on the health system and private specialists and general practitioners in that they have to supervise these people when they are here, which is usually one of the conditions under which they work here. It therefore does not come without a heap of other associated costs. I just wanted to make the point that it is not simply a matter of attracting people, particularly from what we call the non-competent authority medical training countries. We have a list of countries whose authorities we accept to train without asking many questions. It is therefore an issue that we are careful about.

Mr P.B. WATSON: I have a further question through the Chair. Are there any other plans for any other resident specialist to come to work full time in the hospital at Albany?

Mr J.A. McGINTY: Not that I am aware of.

Mr J.N. HYDE: I have a follow-up question to Dr Towler's comments and perhaps Dr Fong's comments about overseas-trained doctors. One comment I get from competent overseas-trained doctors is that they are considering between going to Canada or the UK, where they may have trained, or coming here. One of the extra burdens in coming to Australia is one of the entrance examinations. These people have told me that the Australian Medical Association has discouraged contracts by imposing on them a competency entrance exam - not so much for specialist requirements - which costs $5 000 or $7 000. That is a deterrent for a well-qualified person from overseas looking at a life change.

Mr J.A. McGINTY: Another thing that Dr Fong does, in addition to his duty as the Director General of Health, is chair the national health workforce committee for the whole of Australia. He could make a better comment than I could in respect of that question.

Dr N. Fong: The commonwealth and the states, after a long time, are nearing completion of rearranging and reorganising the overseas-trained doctor registration process. It is a process of the Australian Medical Council - not the AMA - which is basically contracted to oversee the selection and appraisal of these overseas graduates, particularly from the non-competent authorities.

Mr J.N. HYDE: Is the AMC a business unit of the AMA; or what is it?

Dr N. Fong: No. The Australian Medical Council is the peak body of medical boards that, as far as I am aware, basically answers to the federal Minister for Health and Ageing, if not to the Australian Ministerial Council of Health Ministers. It is the peak body that deals with all issues of registration and competency standards for medical practitioners. There has been a lot of debate over the past 12 months about the conditions being too onerous for overseas-trained graduates to get into this country. The issue of the conditions being too difficult, which the member alluded to, should be of some concern to Western Australia, as we do rely on these people. For example, one condition is that they must sit an examination in an overseas city under the auspices of the Australian Medical Council. The exam is held only a certain number of times a year; the graduates must get to those cities; they have to sit the exam; and there is a fee for the exam. We have to get a fine balance between having a very rigorous process but not one that scares away people from wanting to come and work in Western Australia. The process is being finalised and is supposed to be in place by 1 July this year. We are just about there and we think it will be a well-balanced process.

Mr T.K. WALDRON: I refer to page 605, service 7, patient transport services. The first dot point under major initiatives 2007-08 refers to the patient assisted travel scheme. I greatly support the PAT scheme. It is a very important scheme and I think it has been improved since I have been a member of this place. However, there is always room for improvement. The initiative says that a more flexible and simplified PATS application process will be developed and implemented, and it goes on to refer to the Pilbara. Will the minister enlarge on how he believes this process will be simplified? I follow that question by getting back to specialists and transport. We in the country are getting a lot more elderly people in our population. The issue of getting people to Perth and actually getting vehicles and volunteer drivers is becoming a real issue. Has the minister, through PATS or attempts to improve PATS, investigated the possibility of assisting with purchasing or obtaining appropriate transport for country patients to get to Perth?

[3.30 pm]

Mr J.A. McGINTY: Before I ask Christine O'Farrell to comment on that, I will make two points. First, we are currently developing an Internet base for people to access patient assisted travel information and applications, which should streamline the administration process enormously, because people will not necessarily have to go to a particular hospital to fill out a form. For those who are not computer literate, particularly elderly patients, that will not be all that useful. However, increasingly it will streamline the process. Second, the Australian Senate is conducting an inquiry around Australia into patient assistant transport schemes. It is due to report in September this year. It might provide some valuable information. When petrol prices first went up some time ago, the National Party pleaded with me to increase the subsidy rate. I ended up being roundly criticised for not increasing it enough. I think I would have been better off giving nothing, because I would not have been so criticised. I am always sceptical about questions the member for Wagin asks me about PATS!

Mrs C. O'Farrell: As the minister mentioned, the web-enabled system will make enormous inroads in reducing the administrative cumbersomeness of the scheme. As the member is aware, we have recently increased the fuel subsidy and introduced a safety net so that those who are most disadvantaged by being required to travel frequently can access the scheme within the 70 to 100 kilometre radius, which gives people more access. When one looks at the scheme across the totality of the regions, there are smaller numbers of highly disadvantaged very sick people in the north west of the state, where the cost of transport is huge and the burden of patient liaison social work is massive. Then there are high volumes of patients who live relatively close to Perth who have to

go through administrative hoops of fire to access the scheme when the cost to us for their financial assistance is very low; it is usually between $20 and $40. Processing payments in advance of a person's trip has been a helpful innovation. Patients seem to like that. I think one of our aims is to try to simplify the process so that the large volume of people who use the scheme for relatively short trips at a relatively low cost get very easy access with minimal administrative fuss. A coordinated regional transport service is earmarked as a way to go in the future.

Mr T.K. WALDRON: That is good to hear. I acknowledge that the minister increased those rates. However, we would like them increased even further because of the increase in petrol prices. I am working with service clubs and community groups in my area to find ways of buying cars. I would like to talk to the minister about that at some stage. Perhaps the department can assist those local groups to achieve the desired result.

Dr K.D. HAMES: Before I ask my question, I would like to ask a PATS-related question. I have a copy of an email that was sent to the Minister for Health on 27 March. The author states that he recently learnt that the Department of Veterans' Affairs subsidises pensioners 26.7c a kilometre. He asks why PATS subsidies cannot be increased, particularly given the fact that the cost of fuel is rising. From what the minister said, it was increased last year. However, it was recently predicted that petrol prices will go up to $1.50 a litre, which will make travelling to Perth for a medical appointment hugely expensive. What is the current rate and will it be reviewed?

Mr J.A. McGINTY: The change that was made last year was for people who do multiple trips. The change did not apply to the base rate, which remains the same. I think it went from 15c to 17c a kilometre - Mrs O'Farrell can correct me if I am wrong - for people who make multiple trips. It is not at the DVA rate. The work that has been done historically indicates that it is all about the costs associated with maintaining a vehicle, including petrol. That is some measure of recompense, but it does not fully cover people, in the same way that the public service mileage allowance, the employment mileage allowance and the DVA rate do not provide people with more than what it would cost for petrol and oil.

Dr K.D. HAMES: The author of the email further states that he has to travel a 600-kilometre round trip for a five-minute strip at Sir Charles Gairdner Hospital and a 20-minute appointment with a neurologist. Sometimes people have to travel long distances for relatively simple things. It would be worth looking at not only the subsidies that can be provided to get people to Perth, but also at ways to circumvent the necessity that they must travel that distance for a prescription.

Mr J.A. McGINTY: Or for a routine outpatient appointment. Where there are sufficient numbers, we intend to send specialists to the people rather than vice versa. Again, that depends on which country town we are talking about. I do not recall the details of that particular email.

Dr K.D. HAMES: The Attorney General has his mouth poised to say something.

Dr N. Fong: Attorney General?

Mr J.A. McGINTY: The director general has been promoted!

Dr K.D. HAMES: I am sorry, the director general.

Dr N. Fong: Just another 10 hours!

Dr K.D. HAMES: Dr Fong and Mr McGinty have so many jobs that I lost focus.

Mr J.A. McGINTY: I think that was an invitation to defer to Dr Fong.

Dr N. Fong: I cannot comment on the specific case. However, it underlines one of the major areas that we are trying to turn around in our health system; namely, the outpatient system. Metropolitan patients - country patients are included - are still being brought back to our hospitals' outpatient departments for innocuous follow-ups. We have a very detailed program to revamp the hospital outpatient base service, which is inefficient. We spend hundreds of millions of dollars on outpatients in the metropolitan public hospitals. A lot of that is a waste of resources. We know, for example, that 13 per cent of people do not turn up for their appointments. It is terrific that the department, the hospitals and their staff have been able to turn that around. Any indication from our colleagues in the medical fraternity that they will get behind a review of this area of freeing up appointments and of not having patients return to hospitals to be seen when it is not necessary would be very welcome.

Dr K.D. HAMES: A package has to be put together. It should allow specialists in the private system to see those patients. The commonwealth could pay for it instead of the state. That would be a much more efficient system.

Mr J.A. McGINTY: We want to do more of that. I would like to correct one thing that I said about PATS. The rate went from 13c to 15c, not 15c to 17c.

Mr T.K. WALDRON: When there is more travelling in a community vehicle, the rate is 25c a kilometre.

Dr K.D. HAMES: I refer to service 8 on page 586 of the *Budget Statements* and the issue of parents smoking in cars when children are present. The minister will recall that I introduced legislation into this chamber - it is still on the notice paper - that seeks to ban smoking in cars when children are present. Since that time, the South Australian and Tasmanian governments, both of which are Labor, have introduced similar legislation. A report by Professor Sly from Sir Charles Gairdner Hospital has proved that smoking in cars when children are present can cause serious damage to children. The minister promised during the debate on that bill that Quit WA would spend significant amounts of money educating parents about the dangers of smoking in cars. We are nearly at the end of May and there is still no sign of a public campaign.

Mr J.A. McGINTY: I thought there had been some inclusion -

Dr K.D. HAMES: I have not seen anything on television. I do not know whether anyone in the chamber has seen anything on television. No-one has put his hand up. Where is it?

[3.40 pm]

Mr J.A. McGINTY: I will have discussions with the health department about including that in its advertising. I do not think there was anything on television but I think there was something in print that I recollect concerning educating people about the dangers of passive smoking, particularly in enclosed places when children were involved, including cars. I will need to double-check that because I have not seen it specifically.

Dr K.D. HAMES: Further to that, my impression from our debate was that, in the same way that there has been a major Quit campaign on smoking, it would be the next major issue. The minister was talking about something in the order of $1 million for the campaign, and that it would be a major feature campaign to educate parents about the risk. If that is not what is happening, it is certainly the impression I got. In fact, the suggestion was that the campaign would be in March-April of this year. If is not the case, I will bring back the legislation to the house to debate again.

Mr J.A. McGINTY: The government has a program that it intends to roll out about bans on smoking in different places. In July last year it was for pubs and clubs. We then had the Tobacco Products Control Act. The thirty-first of this month is World No Tobacco Day. There will be significant new legislative arrangements coming into force under which it will be illegal to sell cigarettes unless the person has a licence to sell them. There will also be very severe restrictions on tobacco displays at the point of sale. The area will be restricted to one square metre.

Dr K.D. HAMES: That was to be the first campaign; this was going to follow.

Mr J.A. McGINTY: Yes. When the smoking in cars issue arose - I am very much aware of the importance of this and I have no argument with the fact that it is dangerous - the decision was whether it was best to make it a criminal offence or best to seek to educate people to change their behaviour. The argument was not about whether people should smoke in cars. We all agree that people should not, particularly when children are in the car. The question is whether we should make that a criminal offence. That is the nature of the argument.

Dr K.D. HAMES: I do not agree with the minister about what should be done. However, I was comfortable with the fact that there was to be some education. To educate people to change that sort of behaviour we need a major television campaign, not just a few advertisements in the paper.

The CHAIRMAN: Before the minister proceeds, can I get an understanding from him and the member for Dawesville that if supplementary information is to be provided about smoking in cars with children present in the cars, what the nature of that supplementary information might be?

Mr J.A. McGINTY: It will not be supplementary information; it is more in the nature of a debate between us.

I am not opposed to the idea of making it an offence to smoke in a car when there are children or other people involved, but particularly children. The issue for me is where it fits in the priority of things and what do we do about the enforcement. Public health-wise, I agree completely with the point the member is making.

Dr K.D. HAMES: The minister needs to read Professor Sly's report.

Mr J.A. McGINTY: I accept what the member has said about his conclusions; it is fairly evident that is the case. From 1 July there will be a complete ban on smoking in the forensic mental health unit at the Frankland Centre. That is difficult, as the member would appreciate, because we are putting together mental health and criminality. The three groups in the community that smoke the most are Aboriginal people, people with mental health issues and people in prisons. There are two of those issues there. It will be hard, but we are doing it. Every hospital campus in the state will be completely smoke-free by the end of this year. It will not be enough for a person just to go outside the building; he will have to get off the premises completely. It will be very much

the same as schools. I am very inclined to look at alfresco dining as something else where an initiative should be taken. I am still not convinced that making it an offence required to be enforced by the police is a good use of police time or an appropriate use of enforcement methodology.

Dr K.D. HAMES: It is no different from mobile phones. It is against the law but it is not policed properly. However, once it is against the law, it is against the law. Most people have stopped. It is like mobile phones because it is a major health issue.

Mr J.A. McGINTY: Every day, as I drive through Perth's western suburbs on my way from Fremantle, I see a lot of criminal behaviour taking place as people talk on their phones. I have an aversion against laws that are not enforced as a matter of principle. That is where the argument rests.

Dr K.D. HAMES: Run the campaign then.

Mr J.A. McGINTY: We certainly need to do more to clamp down.

Dr K.D. HAMES: The minister said he would.

Mr J.A. McGINTY: I will undertake to find out whether the department has followed through on the undertakings it has given me, including that in the advertising.

Mrs C.A. MARTIN: I refer to page 581 of the *Budget Statements*. There is reference to stage 1 of the redevelopment of the Broome Regional Resource Centre, which is seen as a work in progress. There is also reference to various Kimberley projects, which is the last line item. Page 582 refers to the Kununurra Integrated District Health Service and the Wyndham Multi Purpose Centre. I could not find anything about Derby, Fitzroy Crossing, Kalumburu and Oombulgurri concerning health services for the Kimberley. I understand that hospitals throughout the region have either been completely replaced or refurbished. I am not having a go; I am just wondering where they are in the budget papers.

Mr J.A. McGINTY: Derby is either finished or is just about finished. That is my understanding.

Mrs C.A. MARTIN: I looked in completed works but I could not find it there. It has disappeared and I want to brag about it.

Mr J.A. McGINTY: It might well be that the intended completion date of construction was June 2007, which means that it comes into the current financial year, whereas the budget makes provision for the next financial year. That might well be a project that is completed by the start of the next financial year. The total cost of the Derby acute inpatient ward and ambulatory centre was $14.465 million. My understanding is that it will be completed by the end of this financial year - unless the member knows something different.

The member also referred to page 581. A number of smaller projects are rolled into the last line item, which refers to "Kimberley - Various Health Project Developments". The $42 million upgrade to make Broome the regional resource centre will enable a lot more people to be treated locally. I know that the new CT scanner at Broome has increased the capacity of the hospital to do a lot more diagnoses and therefore be able to treat people locally with better outcomes. The major issue in Broome at the moment is mental health. It is interesting that, so far in these estimates, mental health has not rated a mention, but I think it should. We are looking at the ability of including a secure inpatient mental health facility at the Broome District Hospital to deal with mental health issues for the whole of the Kimberley. Therefore, instead of being required to be sedated, put on an aeroplane and sent down to Perth when a person is in the acute stage of his mental illness, that person can be treated locally. That will mean there will be a greater level of psychiatric and mental health nursing expertise in the Kimberley, which I think will be well received. The total capital expenditure in 2007-08, which is the year that lies ahead for projects in the Kimberley, is $38.13 million.

As the member knows, Derby Regional Hospital has now been substantially upgraded through the projects just finished. An amount of $42 million is for Broome, with the possibility of a mental health facility. There is a new hospital that is significantly under construction at Fitzroy Crossing. In addition, I opened the new hospital at Halls Creek last year. Work is taking place on upgrading Kununurra, and there is also some work in Wyndham. As a regional area, the Kimberley has, for very good reason, done very well out of capital works on hospital and health care facilities in recent times.

Mrs C.A. MARTIN: As I said, I could not see anything for Kalumburu.

Mr J.A. McGINTY: That would be picked up under the last point at page 581, which deals with various projects in the Kimberley. The smaller projects are rolled in together rather than listed. I suspect there are probably 100 capital works projects throughout the state. We most probably should better delineate in the budget papers the exact nature of the works being done, but I understand that the Kalumburu works are much needed.

[3.50 pm]

Mrs C.A. MARTIN: With the added mental health services, will we still be able to maintain our community mental health facility? We have a facility in which families can go in with a person who is suffering from mental illness and stay to help bring that person through. Will the government maintain that?

Mr J.A. McGINTY: A good balanced mental health service places primary emphasis on community mental health - treating people and keeping them well within the community through a variety of programs. It is not that inpatient facilities are an admission of failure, but good community health facilities will reduce the demand for inpatient facilities. Nonetheless, there are people with acute mental illnesses, and if we are able to develop a mental health ward at the hospital at Broome, that would be for people during the acute stages of their illness. Hopefully, as they step down from that, the community mental health services will take over so that there can be one continuum of mental health care, with a need to use the acute facilities for only a short time.

Mrs C.A. MARTIN: I understand that various health projects are planned for the coming year. Have the birthing suites throughout the regions been fitted with bath facilities? A lot of women are in them for a while, and I note that a number of places did not have those facilities.

Mr J.A. McGINTY: Most of the maternity facilities in Western Australia are, to say the least, old-fashioned. We have put the draft maternity services plan out for public discussion with a view to providing greater choice for women in how they give birth to their babies, whether that be in a family birthing centre, a midwife-led or obstetrician-led delivery, higher intervention services, and even homebirths. Currently we fund 150 homebirths a year, which is a drop in the ocean of the 27 000 babies born in Western Australia last year. All of that is out for public discussion. There has been a significant public debate in the media, which I am delighted with. In terms of the facilities available, for instance, Swan District Hospital does not have ensuites, and did not have a bath; not that a woman would want to give birth in a bath, but perhaps it can be used to ease the pain. Just recently, one has been installed at Swan District Hospital. We are looking at upgrading maternity facilities throughout the state. When a major upgrade is done, we would be looking at providing ensuites and baths in the birthing suite. Most probably the biggest single change resulting from the maternity services review will be the provision of family birthing suites such as the one at King Edward Memorial Hospital. They will be far more widely spread, at least in the major cities and towns of country Western Australia where appropriate backup exists.

Mrs C.A. MARTIN: I refer again to page 581. I note that the process of building the Fiona Stanley Hospital will take up to 2011.

Mr J.A. McGINTY: It will be finished in 2012.

Mrs C.A. MARTIN: I would just like to say that it is great to see that the metropolitan area will finally get the same standard of hospital care that we have in the Kimberley!

Meeting suspended from 3.55 to 4.10 pm

Dr K.D. HAMES: I have a question to which I am sure the answer will be brief, but I want to get it on the record. I refer to the first dot point under "Healthy Leadership" on page 585. I think the minister would agree that healthy leadership does not go hand in hand with Mr Brian Burke. Can the minister advise whether there has been any email correspondence between Brian Burke and any health department employee since 2003; and, if so, will the minister table the relevant correspondence?

The CHAIRMAN: That was a rather long bow, member, but we will see what the minister wants to do with that question.

Dr K.D. HAMES: It was not a long bow, Madam Chair; it was a simple question that has a simple answer.

The CHAIRMAN: I do not think it relates to a specific budget line, but we will see.

Dr K.D. HAMES: It is healthy leadership.

Mr J.A. McGINTY: I have just asked the director general and he said that there has been no email communication between him and Brian Burke between 2003, which I think was the date the member gave -

Dr K.D. HAMES: Yes, since 2003.

Mr J.A. McGINTY: Dr Fong became director general in 2004 and the answer in respect of him is no. There are 35 000 or 37 000 employees in the health sector. I cannot vouch for every one of those employees.

Dr K.D. HAMES: That is not necessary, minister. I am satisfied.

Mr J.A. McGINTY: No, I did not think it was. That is the answer from Dr Fong. However, can I say that I spoke with Brian Burke once and it was very brief! However, there was no email. I think he told me where to go, from memory.

Mr J.N. HYDE: Later I want to raise some more issues about the emergency sections of hospitals, but now I refer to the key efficiency indicators listed on page 591. The third line item is for the average cost of PathWest services. The actual cost and the budgeted cost of a service is $22. Why are the costs for pathology services in public hospitals not being bulk-billed through Medicare? Is this top-up on top of the Medicare rebate, or is the commonwealth expecting us to fund pathology in public hospitals?

Mr J.A. McGINTY: I ask Dr Peter Flett to respond to that question.

Dr P. Flett: All pathology services that we do in public hospitals are state funded. The only commonwealth funding that we get is for work we do outside hospitals that are requested by private clinicians. We do about $26 million worth of that work, which is commonwealth funding that comes into the state. The rest of it is state funded; that is, out of hospitals and out of outpatients.

Mr J.N. HYDE: I can go into Clinipath on Murray Street and swipe my Medicare card, but if I go to an emergency section of a hospital, Medicare will not pay for the service; the state of Western Australia has to pay for it.

Dr P. Flett: That is correct.

Mr J.A. McGINTY: Dr Fong might be able to add a little more to that.

Dr N. Fong: Under the Australian Health Care Agreement, we are responsible for funding all hospital-based services. Emergency departments are classified as a hospital-based service, notwithstanding that probably 40 or 50 per cent of the people who attend those departments probably do so for primary care reasons and should be seen in the primary care sector; therefore, those services should be paid for under the Medicare system, but that is another story. We are engaged in a privately referred non-inpatient strategy, which is a bone fide strategy that the commonwealth agreed to whereby we can have outpatient pavilions or outpatient services set up. The commonwealth Medicare benefits schedule can be accessed for the doctor's consultation and for radiology and pathology services, and that is an opportunity that we are exploring and will more fully explore under legal arrangements.

Mr J.N. HYDE: An outpatient services section has been set up next to Royal Perth Hospital in my electorate. Is that considered to be a hospital? We are trying to divert people who come through the door at Royal Perth across the road if they present with something that should not really be dealt with in an emergency room. If those people go to the outpatient section, are they bulk-billed? Some people in my electorate are saying that they cannot get bulk-billed there, so they go to the emergency section. If they have been sent to pathology, is that treated as a Medicare service or does the state have to fund that through our outpatient clinics?

Dr N. Fong: To continue my previous answer, it depends on whether the doctor sees the patient as a privately referred non-inpatient. The doctor has to be part of the arrangement in that outpatient setting and the doctor has to agree to see the patient as a "private" patient, even though the patient does not pay anything and can access the CMBS. This is a legal thing to do. We are encouraging doctors to sign up to that. They can make revenue out of that arrangement, as well as legally shift some of the cost to the commonwealth Medicare benefits schedule for doctor consultation and for pathology and radiology services. Yes, the member is quite right; because the outpatient service at Royal Perth Hospital in Goderich Street is a stand-alone building, it fits the criteria excellently for accessing the PRNI scheme.

Mr T.K. WALDRON: I refer to the last dot point under "Workforce" on page 595, which states -

> The WA Country Health Service will establish a workforce unit to develop consistent and innovative approaches to workforce strategy, clinical employment and new clinical roles including extending the use of therapy assistants, clinical support workers and patient care assistants.

When it refers to "extending the use", what types of additional duties will these assistants and support workers have in the extension of their roles, and will the clinical workforce in the Country Health Service also be extended?

[4.20 pm]

Mrs C. O'Farrell: Yes, the unit has just commenced its work. Its initial task is to establish what I call a sophisticated workforce planning and recruitment function for the medical workforce. We have a lot of people in each of our seven regions engaged, on a fairly continuous basis, on the thankless task of trying to fill medical vacancies, both substantive vacancies and locum positions, and organising specialist visiting services, with

contracts and the like. These are very highly paid clinical administration people. I think that a more efficient way to look after a lot of that work - at least a lot of the legwork - would be to centralise it, set up some good systems and do it really well, and support the regions quite actively in that. That is their first role. They will also take a lead role in expanding the nurse practitioner roles throughout country regions, in emergency departments, in mental health care settings and in primary care settings.

We have a very well-established therapy assistant program, and they will be responsible for continuing that program. We already have well-established use of patient care assistants. I guess the thing that we would like to look at, in conjunction with other area health services, of course, as part of our healthy workforce strategic plan, and in response to what we are now facing with ongoing shortages in our nursing and medical workforce, is alternative types of workers to take on as much as possible of the support work, which will extend the capacity for our highly skilled nursing and medical clinicians to provide patient care.

Mr T.K. WALDRON: So it is a means of covering a shortfall in health workers in some of our country centres?

Mr J.A. McGINTY: Mrs O'Farrell?

Mrs C. O'Farrell: Yes, it is, especially in the areas where it can extend the impact of a clinician; that is, with a small number of expert clinicians training some people. I think the therapy assistant model is an excellent example of where we have been able to extend the impact of therapy services by training those people. We do a lot of care in the environment of aged care, as the member would know, as well as in our emergency and acute care programs. Therefore, there is tremendous scope to bring in alternative workers to work in those non-admitted-patient and non-acute-care environments, and particularly to try to do that in a way that builds some community capacity by creating more employment opportunities and training opportunities for local people.

Mr T.K. WALDRON: Mrs O'Farrell is happy that the training is there and that the people can handle the roles that they are going into?

Mrs C. O'Farrell: We have not encountered any difficulties to date, because our allied health professionals have got completely engaged in the process of designing training programs and guidelines and supervisory frameworks for our therapy assistants. We have a well-established certification training program for our patient care assistants. Most of these types of roles would be a combination of learn on the job with a preceptor, and under a supervisory framework, and some TAFE-based education.

Mr J.E. McGRATH: My question relates to service 10, "Dental Health Services", on page 615. I refer to a budget allocation in 2007-08 of approximately $60 million, which is $2.5 million more than last year. As at December 2006, the dental waitlist was 12 209. Can the minister inform the committee what the current state of the waitlist is, and how the extra funding that has been allocated for the next financial year will make some inroads into that waitlist?

Mr J.A. McGINTY: I will get Mr Peter Jarman, the head of Dental Health Services, to comment on that. However, before I do, I say that about four years ago we had about 25 000 or 26 000 people on the dental waiting list, which was still far better than the national average. Australia-wide, 650 000 people are now waiting for dental care. Western Australia's per capita share of that should give us a waiting list of about 65 000 people. The fact that there were 12 000 people as at December is attributable to the fact that dental care is not expensive. Therefore, with a relatively modest budget investment, we can do very significant things in giving people easier access to dental care. Some other states have given up even trying, as the member can appreciate, with such long lists. I think in Tasmania people talk about a 25-year wait for dental care. It is very fortunate that we do not have that as an issue. However, Mr Jarman might be able to give the member more up-to-date figures. As a result of an election commitment at the last election, we have put in an additional $1 million a year to keep the waitlist down. I do not know that it is thought that the waitlist will go down any lower than that, but Mr Jarman might be able to give us the picture.

Mr P.V. Jarman: At 30 April, the waitlist was 13 845 people at the close of business on that working day. I might comment that the feature of it is that the average wait time was down to 8.6 months from about 10 months earlier in the year. Although the number is higher, the waitlist time is shorter, and that reflects a change in the distribution of the types of patients who are waiting.

Mr J.A. McGINTY: Just by way of elaboration on that, I ask Mr Jarman whether he sees any trends emerging and in what direction he expects the list to go during the next 12 months.

Mr P.V. Jarman: I would expect it to stay fairly constant over the next 12 months. The cost of provision of dental care has increased by 33 per cent in the past couple of years. Because we rely on the public sector to support the state programs, I would expect it to stay constant.

Mr J.E. McGRATH: I have a further question of the minister. It is mentioned in the budget papers under major initiatives for 2007-08 that approximately 250 000 schoolchildren are targeted to be enrolled and under care in the school dental program.

Mr J.A. McGINTY: Did the member say "caries in the schools"?

Mr J.E. McGRATH: No; 250 000 schoolchildren are targeted to be enrolled and under care in the school dental program.

Mr J.A. McGINTY: Yes.

Mr J.E. McGRATH: Are there any children who we understand are not having proper dental care? How well covered are our children by dental care, whether it be through the school program or through their own family dental service?

Mr J.A. McGINTY: Mr Jarman?

Mr P.V. Jarman: The figure from the Australian Research Centre for Population Oral Health indicates that 97.3 or 97.4 per cent of Western Australian children receive dental coverage, about 84 per cent of them through the school dental program. Therefore, from the research, a very small percentage appears to be missing out.

Mr J.A. McGINTY: Does Mr Jarman have any idea who they are? I do not mean names and addresses.

Mr P.V. Jarman: No, I do not.

Mr J.E. McGRATH: I would like to raise a further point. I went to school in Hamilton Hill, which was a pretty tough area, and I remember that we had kids at school who did not own a toothbrush. That is something that has always been of concern to me. At every possible opportunity, we should make sure that our children have proper dental care. From those figures, I would think that the situation is pretty good.

Mr J.A. McGINTY: Yes. Can I say that kids from Hilton Park were tougher than kids from Hamilton Hill!

Mr P.B. WATSON: I refer to the third dot point on page 579, which states -

> The focus in hospital service delivery remains on ensuring that the resources and capacity of the health system are applied to meet both demands for emergency services and access to elective surgery.

My main point is about emergency services. What is the government doing to maintain the high standards that we have in our emergency service departments?

[4.30 pm]

Mr J.A. McGINTY: I mentioned earlier that the one area that has been presenting the greatest difficulties in the entire public health system, with an expenditure this year of $4 billion, is the emergency departments. In the first few months of this year there have been incredible peaks in the number of people presenting to emergency departments. That has resulted in an unacceptably high number of people in the emergency departments and a very high proportion of those people being admitted to a hospital bed. I was on the radio in the past couple of days and heard one of the nurses from the emergency department of Sir Charles Gairdner Hospital speak about the number of nurses resigning purely because they could not provide good patient care as the emergency departments were overcrowded. It is for that reason that, in discussion with the doctors and nurses working in the emergency departments, we intend to limit the number of people in the emergency departments so that nurses in particular, but also doctors, can provide safe clinical care, which I am increasingly being advised with the chronic overcrowding is being jeopardised. For that reason, there will now be a limit placed on the number of patients at any one time being treated in cubicles or occupying a bed in the emergency departments. It was not an easy decision to make, but was one that was forced upon us as a result of the very high level of presentations to emergency departments.

One advantage of taking this new approach is a certain improvement in the nurse-patient ratio for patients in assessment and treatment areas. That is regarded as necessary, particularly for patients in triage 1 or 2 categories. There will be improved patient privacy, which is often interfered with or violated when there is chronic overcrowding in emergency departments. There will be also an increase in the pace of delivery of medical care by not having people there in such high numbers. There will also be reduced pressure on staff. One problem in the health service is attracting staff. How do we go about attracting them? It is very hard to attract staff to work in emergency departments at the moment because it is very hard to get job satisfaction when people believe that they are not providing an adequate standard of safety or care for their patients. The downside to making this decision is that lower category triage patients will have to wait longer for assessment and treatment. That is necessary as a safety measure. The way in which this can be alleviated is by hospital administrators in particular, and also clinicians, driving efficiency within their own hospitals to ensure that

patients are discharged. They need to look at nurse-led discharges of patients. They need to make sure that they are far more efficient when patients are ready to leave, and not leave patients in a bed for any longer than they absolutely must be there, so that beds can be freed up for patients from the emergency department to come through. However, for triage 3 and 4 categories - category 5 does not require admission in the general course of events - there might well be longer waiting times. However, I believe it is better to have lower priority cases waiting longer than jeopardise the seriously ill in emergency departments. Hopefully, the consequence of opening up all the beds that I spoke about starting next month, but with major impact on 1 July, coupled with greater discharge efficiency in the back of the hospitals will be a greater flowthrough of patients. We will then be able to attract staff to work in the emergency departments and not jeopardise patient safety. I therefore see this as a major problem but one that we are confronting.

Mr P.B. WATSON: I have a further question through the Chair. Who can release people in triage 1 and 2 categories now; is it a nurse or does it have to be a doctor?

Mr J.A. McGINTY: No, it is doctors who discharge patients at the moment. I think in many cases people have received their treatment and it is a question of whether they ought to be discharged. We are all aware that Monday is classically a high-demand time in emergency departments. That is because not enough patients have been discharged over the weekend. If nurses, according to well-established protocols, are given the power to discharge patients who are ready to go home and who are simply sitting in a bed waiting for the specialist to come and see them, I think we can get a far better flow through of patients in the hospital system. My call, therefore, is really for hospital administrators to do everything they can to maximise bed occupation, which will then relieve pressure on emergency departments. There is no problem in emergency departments other than that they cannot get their patients out of there. That is called access block. If there can be, at least at the major tertiary hospitals, far more efficient patient discharge from the wards, that will free up the beds to take patients through the emergency departments and into the wards far more efficiently. That is the real challenge that we have in front of us now.

Dr K.D. HAMES: I refer to page 580, and the section "Achieving key service and care targets". I want to talk about categories 1, 2 and 3 for waiting list patients. There are two issues I want to address: one is the waiting times for those categories and the other is a particular type of patient. I will deal with the latter first, as it is an issue that has come to me two or three times, and particularly today, and is about patients with a nerve compression injury. That condition can be acute or chronic. Those patients are not category 1 and are almost inevitably not urgent. They are not category 2, which would lead them to becoming urgent. They are generally and almost inevitably category 3. Yet what happens to them? The condition might be a lower lumber disc prolapse, for example, causing nerve pressure, sciatica and so on. Those patients are then disrupted from their activities or work. It is an extremely painful experience. They then have to go onto opiates or derivatives; in other words, addictive painkillers. They are category 3 because they are not urgent, as the condition is not life-threatening. They then must wait to be seen by a specialist. Often, they will front up first to a GP. The GP sends them to a specialist and they then have to wait for an appointment at a pain clinic. They must go through that process and if the option for a disc prolapse is surgery, there is an 18-month waiting list. Surgery is not always successful and the problem is that delay makes it even less likely to be successful. I wonder whether there needs to be, not necessarily an alternative category to deal with those people who have the potential to become addicted to their medication and, in effect, become drug addicts, but perhaps a redefinition of categories 1 and 2 to take into account the potential severe disability that those patients will suffer by delay. Secondly, delay results in an increased cost. Inevitably, those people go onto a disability services pension or unemployment benefits and are often disabled after a delay in surgery because it is less likely to be successful. I am fairly certain there is nothing in the budget for this, and we will probably read some stories in tomorrow's newspapers about some current cases. Is there an option for some alternative?

Mr J.A. McGINTY: Yes. There are two issues here. One is the waitlist for surgery and the other is outpatient treatment. We have discussed this internally trying to find a solution. The issue raised by the member for Dawesville is a very real one. Ultimately, surgery will be found not to be the best option for a number of people with chronic pain conditions, but they do have to wait an inordinately long time for an outpatient appointment to determine whether they require surgery. We are looking at the moment at other ways to fast-track those people into a proper pain management regime, which might well be their long-term treatment. I will get Dr Lawrence to comment on the issue in more detail, but we are looking at a way to fast-track the determination of whether surgery is necessary. Another point I would make is that we are now getting very close to the point at which nobody in this state will wait longer than 12 months for surgery. A key performance indicator is the complete removal from the waiting list of all those people who have been waiting for a long time. As the member for Dawesville knows, a category 3 patient should be operated on in the clinically desirable time of 12 months. As at now there are 552 patients in category 3 who have waited longer than 12 months for surgery. That is down by

many thousands on what it was a few years ago. The waiting time for surgery is being addressed. People are not waiting the three or four years that they had to wait years ago. However, there are still some pressure points. I will ask Dr Lawrence to comment on the issue raised by the member for Dawesville, the initiatives that have been taken and how she views that particular problem - it is a problem - being addressed in the immediate future.

[4.40 pm]

Dr R.A. Lawrence: The issue of the categorisation of patients has been left to clinicians. The categorisation of a patient is a clinical decision that relates to how the condition is affecting the patient. If we were to consider changing the categorisation, we would certainly need to take advice from the clinicians. The networks could facilitate that if the clinicians think that would be a valuable task. At the end of the day, we will always have a categorisation and it will be based on clinical need. The positive is that 92 per cent of the cases that fall into category 3 are waiting within boundary, which is a hugely positive step. We have made significant progress.

Dr K.D. HAMES: Waiting in boundary is not good enough for patients who are on high doses of morphine and who risk becoming addicts. That is the key. A clinician cannot in good faith put such a patient in category 1 or category 2, because the patient does not fit the definition of those categories. If a clinician did that, he would have to put every patient with a prolapsed disc in category 1 or 2, because it is a severe and acute problem that requires special attention to stop a potential addiction. That is what I am worried about. Many patients have to be put on morphine. The difficulty is getting them off it. The minister is correct when he said that many of these patients do not need surgery. However, if surgery is done, it probably should be done fairly early in cases of an acute and severe prolapsed disc. I am suggesting that the definition be changed to allow a surgeon to put a patient who has an acute prolapsed disc and who needs surgery into a different category so that the patient can be operated on quickly.

Mr J.A. McGINTY: I agree with the member for Dawesville about the identification of the problem. Dr Fong wants to make a quick point. Perhaps Dr Lawrence can develop that issue further.

Dr R.A. Lawrence: The answer is yes, we could look at changing the categorisation. The second component is looking at methods to reduce the impact and burden of the disease in the lead-up to being seen and having surgery, if that is appropriate. That is certainly being worked up in orthopaedics. We are working on and implementing models with multidisciplinary teams, pain management, physio and all those things that help with symptom control, which would help alleviate the potential for opiate addiction. Those initiatives will help this group of patients. The initial targets for orthopaedics and chronic back pain is one of the others.

Dr N. Fong: Dr Hames, the re-engineering of the outpatient service that I talked about before is happening. There were a couple of thousand patients on the neurosurgery outpatient list. Most of those had low back pain and did not require surgery. They needed some other intervention or assessment. We have now successfully put in place at Sir Charles Gairdner Hospital - I am not sure about Royal Perth Hospital - an assessment process that involves people other than neurosurgical registrars and neurosurgeons. It is another way of involving other skilled workers. That is one of the reasons that our outpatient waiting lists are coming down. We hope to see that happen a bit more. Not everyone has to be seen by a specialist. We want to tighten the system. We want to work with general practitioners in determining how they refer patients on. We want more work done in the community, which could be charged to the commonwealth Medicare benefits schedule, rather than putting people on a list and having them picked up in a hospital budget.

Dr K.D. HAMES: When I was a general practitioner, we used to do those work-ups, but we gave up because some hospitals and specialists - even in the private sector - would do them all over again. The repetitive process must be changed. I notice that the department is trying to cut down the category 3 waitlist to 180 days and the category 2 waitlist to 90 days. I have a warning for the department that relates to what doctors said about overcrowding in the emergency department at Sir Charles Gairdner Hospital the other day when it went on code yellow. The opposition has hassled the government about waiting lists and in turn the government has asked hospitals to focus on their waiting lists. As a result, that number of theatres available for emergency department surgery has been reduced. Tackling one area crowds another. The government promised that by the end of June, no category 2 patients would be outside the waiting time. Last month that figure was 3 500. The government has reduced that figure this month. In doing so, however, category 1 has increased marginally and category 3 has gone up a bit more. As soon as the government attacks the area that the opposition says it should attack, that area goes up and when that area is attacked, it too goes up. Rather than tinkering with the issue of the day, the system needs an overall change.

The CHAIRMAN: Does the member have a question?

Dr K.D. HAMES: Yes! Does the minister think it needs an overall change?

The CHAIRMAN: I thought the member would get to it eventually! His preamble was a tad long.

Dr K.D. HAMES: I had to explain the question carefully.

Mr J.A. McGINTY: I understood the member's question perfectly. We have targeted elective surgery because for too long too many people waited far longer than they should and far longer than what they do in comparable countries, such as Britain. In that country's much maligned National Health Service, nobody waits longer than six months for surgery. We should be able to deliver that in Western Australia. If we could ensure that everyone was dealt with within the clinically appropriate time for their condition, whether that be a category 1, 2 or 3 condition, that would be a remarkable achievement, because it has never been done before. Most other states are nowhere near that. One of the things that I am very pleased about is that elective surgery waitlists have again fallen quite significantly during the course of this month. As at 20 May, the waitlist has fallen to 13 493. That compares with the approximately 20 000 when we came to government and the 22 000 at the waitlist peak in 1999. Importantly, during April this year, there was more surgery than there was in April last year. The indications are that the amount of surgery undertaken this May will be more than that undertaken in May last year. I accept the member's general criticism. During the recent months the amount of surgery has not been greater than it was previously; in fact, it was less than what it has been during the past couple of years. The most interesting thing about the elective surgery waitlist is that in the first 20 days of May, the waitlist has been reduced by 443. That means that there are 3 296 fewer people on the waitlist than there were at the end of May last year. The waitlist is being reduced dramatically. We targeted the very long-wait people - that is, people waiting more than 500 days for their surgery. As at 20 May, we managed to reduce the number to a very easily targeted figure. In that way, we can deal with the people who had been waiting for an excessively long time. As at 20 May, 285 people had been waiting for more than 500 days. That was one of the key performance indicators we set out to achieve by 30 June this year. We will come close to that. Some of those waiting for a long time have difficult conditions, which is the reason they have been waiting for a long time.

[4.50 pm]

Dr K.D. HAMES: Category 2 was part of that.

Mr J.A. McGINTY: Yes. The category of "longer than 500 days" is across all categories, particularly categories 2 and 4. In May last year 1 182 patients were in that category and we are now down to 285. That is very significant progress. Category 2 is coming down as well. I am pleased about that.

Dr K.D. HAMES: Only this month. It has gone up in other months.

Mr J.A. McGINTY: Yes, but we have deliberately focused initially on category 1 to make sure that the hundreds of people who have been waiting too long are brought down to manageable proportions. We have substantially achieved that. Category 3 includes people who have been waiting an excessively long time - up to a year and a half, or 500 days. We have almost broken the back of that and got on top of that. We saw that category 2 was not drifting out all that much but it was not improving. Relatively, it was therefore getting worse. Now that the attention is coming off the two ends, we are able to focus on the category 2 and category 3 patients. Hopefully, we are making significant headway there. We should be able to do better, but I take the member's point that if we focus exclusively on elective surgery, that will generate pressures elsewhere in the system, and that is why we want a system-wide health reform program. The other very important thing is that the median waiting time for admission to elective surgery has, for the first time ever, come down beneath 100 days. We are now down to 96 days, which is 3.2 months. It is the lowest median waiting time, on average, it has ever been. I am very pleased about that. In terms of elective surgery generally, we are making very good progress. I still want to see it driven even further.

Dr K.D. HAMES: I concede the minister's statement for this month.

Mr J.N. HYDE: I refer to service 5, "Emergency Department Services", at page 600. My reading of the figures is that for 2005-06 over $111 million was spent, increasing to over $121 million this year. The money has been increased. We have touched on the issue of skills shortages, throughputs and looking at hospitals as a macrocosm rather than a microcosm of what amazing things people are doing in emergency departments and what the people in this room are doing administratively to make a difference. My reading is that it is not a money issue; the money is going in. Is there something else that can be done apart from the skills issue and the management of patients?

Mr J.A. McGINTY: I think that there is a very significant amount more that can be done in the emergency departments. I alluded to that before in discussion with the staff of the emergency departments. It is time to put a stop to the chronic overcrowding. I have indicated the nature of the solution I want to see our hospital administrators drive with even greater enthusiasm. I will ask Dr Russell-Weisz, who is responsible overall for the emergency departments, to respond with what he sees as the appropriate solution to that problem.

Dr D.J. Russell-Weisz: The solution is multifactorial; it is from the front door - people coming through the emergency departments, as we have heard - right through to the back door, as well as patient flows through hospitals. Over the past two years we have focused on ambulatory care initiatives such as hospital in the home, rehabilitation in the home, and hospital and nursing home initiatives, which are trying to keep patients out of hospitals and prevent them from coming to hospitals. We also have strategies within the emergency departments to assist with patient flow from those departments. Work has been done on reducing the length of stay in hospitals, as well as establishing teams such as float teams and winter allied health teams so that we can get patients quickly into hospital if they need to be in hospital and also move out patients who can be looked after at home. We have had a major focus on discharge teams and on trying to get more patients out of hospitals who were admitted by 10 or 11 o'clock in the morning. Extended across the system are admission and discharge transit lounges, which all aid discharge so that we free up beds. There have been a number of initiatives in emergency departments and also in the hospitals. Probably the most successful in the hospitals is reducing the length of stay. Length of stay has been reduced significantly, especially at Royal Perth Hospital and Sir Charles Gairdner Hospital. By patients staying less time in hospitals, we can release more beds. All those initiatives need to continue and be enhanced further. Coupled with the initiatives mentioned by the minister today and previously is the freeing up of care awaiting placement beds and more subacute beds. By creating more subacute beds and care awaiting placement beds we create more capacity for the rehabilitation of patients in the community who require it. There are really three things: front door, back door and patient flow through the hospital. It is also recognising that emergency departments are always busy; they are high-stress environments and our staff are doing an excellent job.

Mr T.K. WALDRON: I refer to the ninth dot point under "Major Initiatives For 2007-08" at page 604, which refers to the recruitment of nurse practitioners. We have been very supportive of nurse practitioners The dot point states -

> Recruitment of nurse practitioners to designated nurse practitioner sites in country Western Australia that provide emergency care will take place.

Is the department on target for the 12 nurse practitioners it hopes to appoint in 2007? How many additional nurse practitioners will be recruited?

Mr J.A. McGINTY: Bear in mind that nurse practitioners work in a variety of settings. I will look just at the country, which is the member's area of interest. We are working towards the introduction of 25 nurse practitioners during the course of this coming year. Designation has been gained for 72 WA Country Health Service sites to become emergency care nurse practitioner sites. Nurse practitioners will appear across the countryside. That is where they excel, particularly in smaller country towns where there may not be ready access to a general practitioner. A very experienced nurse with the skills of a nurse practitioner is, arguably, the best form of care that a person can get.

Mr T.K. WALDRON: Would it be possible to get a list from the minister of where the nurse practitioners are in country Western Australia?

Mr J.A. McGINTY: Certainly. I will undertake to provide that by way of supplementary information; that is, the location of the employment of nurse practitioners and intended future sites.

[*Supplementary Information No A33.*]

Mr J.E. McGRATH: I refer to mental health services at page 629. Given the minister's comments earlier about his concerns regarding mental health and the way it is affecting the community, does the minister believe that new hostel places or community supported residential places are a priority? If the answer is yes, how much has the government spent in the past 12 months on these services?

Mr J.A. McGINTY: Members will recall that two or three years ago mental health was in the headlines seemingly on a weekly basis with criticism being made about either the lack of inpatient beds or the lack of community facilities. People who fell through the cracks were frequently featured very prominently in the media. In 2004 we committed $173 million to a mental health strategy that was really designed to address five areas and, in my view, to do not much more than simply expand what was already there because what was already there was cracking at the seams. I accept the criticisms that were made at the time about the inadequacy of mental health services. The five areas included, firstly, emergency departments. When people's acute mental health conditions made them front in emergency departments, they required far more resources to be able to be dealt with but there was no dedicated mental health team. We now have that as well as dedicated mental health beds in emergency departments at all of our major hospitals with the exception of Sir Charles Gairdner Hospital, although there is a dedicated team at that hospital's emergency department.

[5.00 pm]

Secondly, we did not have enough in-patient beds for acutely ill people. We undertook to provide an extra 108 acute in-patient beds and they are progressively coming on stream. We opened the Ellis ward at Graylands Hospital. An extra 18 beds are being constructed at Bunbury and eight extra beds have opened at Armadale. Eighteen beds are under construction at Bentley Hospital. We have just recently agreed, but construction has not started yet, on doubling the size of the mental health unit at Joondalup hospital. Again, that is a very dramatic expansion of the in-patient mental health beds.

The third area that the member referred to was community-supported accommodation. I regard that as an absolute priority. Keeping people well in the community, by which I mean putting roofs over their heads and providing them with support to enable them to lead a useful life in the community, is arguably one of the most fundamental things we should do. I am very supportive of that. We have a current program to provide 200 community-supported residential units, and an additional 50 units for homeless people in East Perth and Fremantle. Therefore, a lot of effort is being put into that.

The fourth area is to generally upgrade the community-based mental health services, and finally, upgrading the staffing, safety, and attraction of staff to work in mental health services. We have substantially implemented that. Construction of the first of the community residential units is now complete. The rest will be completed in the next 12 months at, I think, about 10 different sites throughout Western Australia, including major country areas. I want to see that expanded and continued, and I will talk with the Minister for Housing and Works about that. However, I also think that the emphasis now needs to shift to more community-based care, to keep people well in the community and to enable them to lead useful and satisfactory lives. I know that I have been going on a little bit, and I am aware of the member for Dawesville's request not to, but this is really the first time mental health has been raised today.

Unfortunately, I have been in the position in which we have had to disagree with some local communities who have said, "We don't want this facility in our backyard, thankyou." The most notorious of those was at Mt Hawthorn -

Mr J.E. McGRATH: The Hawthorn centre.

Mr J.A. McGINTY: Yes, the Town of Vincent. I was very pleased that a line was drawn saying that we need this facility and we are going ahead. The Town of Vincent backed off and we went ahead with it. Much to my embarrassment, I have now got my own council in the City of Fremantle saying that it does not want a homeless youth mental health hostel in Alma Street, over the road from the hospital. Western Australian Planning Commission approval has been gained. We intend to get on and build it, notwithstanding the opposition of some people in the local area. Overwhelmingly, I now get the sense that the community appreciates the need for these facilities, even if there is some local resistance to it. It is my determination to press ahead with that.

[Mr A.P. O'Gorman took the chair.]

Mr J.E. McGRATH: Can the minister tell me whether the number of hostels has increased or decreased in the past 12 months?

Mr J.A. McGINTY: Many of the patients who will be accommodated in the community are currently residing in private psychiatric hostels. Many of the private psychiatric hostels are located in inner urban parts of the state. Generally speaking, they are very large old houses on very valuable real estate. What we are seeing is a number of those hostels shutting down for economic reasons; the value of the land is something that the owner wishes to realise rather than continue to run the service. In many senses, the extra purpose-built accommodation in community-supported residential units will simply be a replacement for private psychiatric hostels that are disappearing. Hopefully, we will be doing it so that we can expand the range of accommodation. This is purpose-built new accommodation, which will be better for people, particularly with the supported accommodation from organisations such as St Vincent de Paul and others that we hope to have run these services for us. Hopefully, that will expand the number of beds that are available. Therefore, if private psychiatric hostels do not shut down at a faster rate than we are building them, then we will see a significant expansion of services available.

Mr J.E. McGRATH: We talk about the response times in emergency departments in our hospitals. Regarding response times in mental health for community emergencies, can the minister give some indication of what percentage of the most urgent cases have been attended to in the required time?

Mr J.A. McGINTY: I will ask Dr Steven Patchett, who is the head of mental health services, to comment on that issue and anything that I missed in answer to the member's earlier questions about mental health.

Dr S.J.R. Patchett: To endorse some of the earlier remarks that the minister made about hostels and community residential services, I think it is important for us all to note that mental health services these days are not just about treating symptoms. The importance of embedding inter-treatment systems and services that will address

disability in relation to learning, education, employment and certainly accommodation, has long been recognised. Accommodation is now seen to be an integral part of the delivery of mental health care: the community-supported residential units and hostels are an important part of that. To give some further information surrounding hostels, a new three-year service agreement has been developed with private licensed psychiatric hostels. That is a purchasing framework that links funding to the level of disability, using an instrument called the personal care support assessment questionnaire. Therefore, it is a much more precise linking of funding to the actual disability experienced by the resident.

A number of initiatives have been developed comparatively recently to address the greater number of psychiatric patients who are attending emergency departments. Mental health emergency liaison nurses have been embedded into eight metropolitan sites and one rural site. There are acute mental health observation beds in Royal Perth Hospital, Sir Charles Gairdner Hospital, and Fremantle Hospital. There are on-duty psychiatric registrars, and more of a psychiatric presence in emergency departments. Reiterating the earlier words of Dr Russell-Weisz, there are new emergency services at the front end in the community, attempting to prevent psychiatric patients coming to emergency departments in the first place; that is, the mental health emergency response line and seven community emergency response teams that are able to see patients urgently in the community. A further comparatively recent initiative, which is still in its early days, is an integrated bed management system backed up by patient flow coordinators in each of the units to streamline and see the total number of beds in the metropolitan region as a resource for the whole of mental health services to utilise.

The final point is the time in the emergency department. The target for those initiatives has been a 12-hour KPI. It is still early days, and I am unable to give the member the figures on how often that is being exceeded.

Dr K.D. HAMES: I refer to page 586, under aged care services, to talk about Parkinson's disease. I am particularly concerned that the minister has not given sufficient focus to the issue of Parkinson's disease management in the community. I know a lot of the focus for everyone in this room now is to try to keep patients out of hospital. For example, I thought the department's advertising program on falls was excellent; showing that ceramic figure. There are 200 new referrals every year to the Parkinson's nurse specialist service. They have two people running that service; one north of the river and one south of the river. They have written to the minister asking for increased services, and there is nothing in the budget to say that there will be anything. I put it to the minister that it is essential, particularly for patients with Parkinson's disease, that they get strong community support from specialists who are expert in the management of Parkinson's disease. I ask the minister if he will look through his very large budget to find a way of funding increased numbers; even just to double the number of Parkinson's nurse specialists to four.

[5.10 pm]

Mr J.A. McGINTY: Parkinson's Western Australia is very adept at lobbying on this issue, and I receive a significant number of representations on the Parkinson's nurse specialist positions. Parkinson's Western Australia is requesting an additional $192 000 per annum to employ two additional nurse specialists, which would double the number of these specialists and increase client care by 60 per cent, which is 2 037 hours; education and training by 24 per cent, which is an extra 830 hours; and coordination and planning by 16 per cent, which is 550 hours. This would be an increase over the current level of activities for which they are funded. We need to look at whether the association can demonstrate any significant savings or returns on investment, given other initiatives that can produce reductions in emergency department presentations, hospital admission or length of stay. In the absence of the demonstration of tangible benefits, it is not possible to commit to extra funding for Parkinson's Western Australia when it is competing with applications for funding for activities that will achieve those objectives. In conjunction with Parkinson's Western Australia, we need to look at other avenues for meeting the needs of this group, and I acknowledge those needs. The expansion of the Neurological Council of Western Australia funding under the commonwealth-state post acute care program is being investigated to determine whether it can cater for the demand for support of all people with degenerative neurological conditions. I acknowledge the importance and the fact that the association wants to double the funding it currently receives so that it can double the number of nurse specialists employed, but we are looking at other ways in which we might be able to address those concerns.

Dr K.D. HAMES: Lobbying hard does not have to be bad.

Mr J.A. McGINTY: I am not suggesting it was.

Dr K.D. HAMES: It could mean that people are greedy, but it could also mean that they are desperate. The minister would know the importance of prevention. I have talked to people who have received that nursing care or have participated in similar programs for people with stability problems. There is a physiotherapy program using fit balls and swimming pools that is also extremely successful. Something that works in that way for Parkinson's disease in particular will significantly reduce medical costs through falls and fractures. It is money

well spent on prevention. The government is spending huge amounts of money on programs such as hospital in the home and the frequent flyers program to prevent these people ending up in hospital, yet when there is a very good centre, it seems that because the association is lobbying hard and has expressed its concerns to the opposition, the minister is not giving it sufficient credibility. I do not know what the association has done, but it is receiving 200 referrals a year, and it seems a reasonable request to want to increase the number of nurses for the whole metropolitan area to four.

Mr J.A. McGINTY: I will make two quick comments. The first is that my reference to lobbying was a reference to my knowing and understanding the issues, because they had been presented to me on very many occasions. It was not meant in any way to be a comment deprecating the efforts of the association. The second comment is that I demand of the people sitting around me that they deliver me a balanced budget. By that, I mean a budget that comes in under the approved expenditure limits. This year is particularly tight, but nonetheless people have been told not to spend between now and the end of the year if it means that we will go one cent over the approved expenditure limit. That is an absolute requirement, and since I have been the minister, health finance has behaved impeccably. We are under pressure on every front to fund the equivalent of Parkinson's nurse specialists in a thousand other community-based organisations. We cannot fund all those if we are to deliver on the very important financial imperative of coming in within the approved expenditure limit. My credibility, to get the billions of dollars for building new hospitals and the like, is dependent on me running a tight ship financially when it comes to the operation of the entire budget. This year, I expect that we will come in under the approved expenditure limit yet again, as we have done every year.

Dr K.D. HAMES: This is for next year.

Mr J.A. McGINTY: Sure, but there are pressures from the nurses' enterprise bargaining agreement that we are in the middle of negotiating; the doctors' enterprise bargaining agreement that we are in the middle of negotiating; the expansion of services; the number of people presenting to emergency departments; the need to drive down elective surgery waitlists; and the desire to increase community mental health services. The pressures are unbelievably massive, and it takes discipline to say that we will not breach our approved expenditure limit. Having made those two points, I know Dr Simon Towler wants to comment specifically on the Parkinson's issue.

Dr S.C.B. Towler: I want to say two things. The report on government services just released for 2007 demonstrates that, in Western Australia, the per capita expenditure on non-inpatient episodes of care is almost twice the rate of a number of other states of Australia. There is a substantial challenge for us in alignment with the new program that seeks to provide more effective care in the community, of which the Parkinson's disease care model is a very good one. Under the health networks, we have been working with the Neurological Council and through the Neurosciences and the Senses Health Network in establishing the basis for a conversation about improving overall models of care. The Parkinson's disease issue and some of the other chronic neurological diseases are being considered in a framework. We are also looking for the opportunity to review our expenditure through non-government service providers in each of our health care priorities. That work will be developed over the next few months. I have been a strong supporter of the Parkinson's disease model. It has been very effective in north metropolitan Perth.

Mr P.B. WATSON: I refer the minister to the second point on page 585, about delivering effective screening programs. I will use this point to talk about something I raised last year and, I think, the year before about prostate cancer. It is tremendous that there is screening for breast cancer and a lot of other things. I remember when I first went to my doctor about prostate cancer, probably 10 years ago, he told me that more men die with prostate cancer than die from it. I think the doctors have changed their minds over the past 10 years, and I have had personal experience of this happening. Is there any provision in the budget for prostate cancer screening or any other activity dealing with it? I cannot find anything.

Mr J.A. McGINTY: I will firstly indicate an answer to the question that the member posed earlier. The specialist obstetrician-gynaecologist for Albany will be visiting Albany on Thursday, 24 and Friday, 25 May - that is, this weekend - to begin his orientation prior to commencing employment at Albany in early July 2007. The delay has been because of the assessments that have been undertaken, but it is very good to bring a conclusion to that. Dr Fong may be able to answer the member's question about men's health, since he is reaching the age at which that becomes an issue.

Dr N. Fong: We have a strong commitment to cancer services. Part of the election commitment of the government was to increase cancer-specific services, particularly in country areas, where we know that the outcomes of cancer are worse, as was indicated by last year's Senate inquiry into cancer treatment and services. We have appointed a total of 16 cancer nurse coordinators - eight in the metropolitan area and eight in the

country - whose jobs are to both be service oriented - assisting in clinical service, diagnosis and treatment - and assist in education.

Mr P.B. WATSON: Is that money not mainly for women's health issues?

Dr N. Fong: No, this is cancer in general. The member may not be aware, but under our cancer strategic plan we have what are called tumour collaboratives, which are groups of clinicians, nurses, doctors and researchers grouped into different areas of cancer, and one of them deals with urological cancers. The idea of the tumour collaboratives is to develop protocols and plans to specifically deal with those cancers. Dr Towler has been appointed solely to deal with this issue of developing these networks, which will make a difference to service delivery across our system. He may want to make a particular comment on the tumour collaborative relating to prostate cancer.

[5.20 pm]

Mr P.B. WATSON: Before he does that, we have a prostate cancer support group in Albany run by Karen Rendell at her own expense, although the government helps. She has a big bus and goes around to all the regional areas off her own bat. She has been to Collie and has spoken to all the mine workers. She has been to Esperance. She is going right throughout the state, including the mid-west. She is doing this off her own bat, because there is no service or facility in those areas. What Karen is doing is tremendous, but we should be providing more help. She has set up centres in Albany, Esperance and Busselton, but she is a volunteer. When we have meetings in Albany, 30 or 40 prostate cancer sufferers are there. The issue is getting under the radar and it really concerns me.

Mr J.A. McGINTY: I think that was more of a statement.

Mr P.B. WATSON: I was just following on because Dr Towler was going to make a comment.

Mr J.A. McGINTY: Perhaps Dr Towler might be able to answer that question.

Dr S.C.B. Towler: I would like to say a couple of very important things. The member probably needs to know that I am currently chairing the national committee recommending to the Australian Health Ministers Advisory Council, and therefore ministers, on cancer-screening programs, so this is an area of some particular interest. There is at this stage no recognised or appropriate overall screening program for prostate cancer.

Mr P.B. WATSON: I think what we are looking for is education, not so much screening.

Dr S.C.B. Towler: Putting the screening issues aside, there is not a recognised program that we could adopt directly to address the prostate cancer issue. The member is probably well aware that this year we have worked with the commonwealth to introduce the new national bowel cancer screening program, which is a very important initiative. Through the cancer network, we have established tumour collaboratives. Sadly, the urological tumour collaborative has probably been one of the last collaboratives to be established, but I met with the new clinical leads of that group just 14 days ago. We are very committed to creating for the whole of Western Australia, and in keeping with the model that I outlined earlier, a cancer network with nodes of influence to improve the information available to the community, to work with people seeking information - the cancer network will become an important source of information on the disease management services that are available - and to encourage people to take responsibility for their own care. At the moment general practitioners are key players in prostate cancer management. We have engaged general practitioners in all the networks to work with them on providing better information. At the moment I am reviewing an information DVD, which has been prepared by people with an interest in the area who are looking to provide additional information. We are very conscious of this issue. There is no recognised screening program per se for prostate cancer. The member also needs to be aware that Cancer Australia, which has been given substantial resources by the commonwealth government, has aligned its structure around tumour collaborative groups, and we look for its lead in setting up a national framework to work with primary care to improve the overall care of people with this cancer. It is, unfortunately, one of the cancers for which the rates are increasing in this state.

Mr P.B. WATSON: I think this issue relates to education. Women will go to a breast-screening unit, but men will not go to a similar unit. We have to get the message out to them, especially the guys in the bush. They do not want to go to a doctor. We are battling to get them to go a doctor if they are just about dead, but they could have something that is killing them and not know about it. We are not getting the message out to them.

Mr J.A. McGINTY: That is why we are getting John Todd involved, along with the member, in promoting these sorts of issues. We need to get the message out there. I agree with that statement, yes.

Mr T.K. WALDRON: I refer again to mental health and to the third dot point under "Major Initiatives For 2007-08" on page 597. The dot point refers to 18 additional beds for the acute psychiatric unit in the south west. First, is the minister looking at plans for additional beds in other regional centres? There may be some that I am

not aware of. Secondly, there are problems in country hospitals with patients who may be violent and the police have to take them to Perth because they cannot be handled at the hospital, and that takes the police out of the country towns. Has any thought been given to having a secure room in the major inland regional hospitals in which those people could perhaps be held overnight?

Mr J.A. McGINTY: I think the member has referred to the construction of the additional 18 beds for the acute psychiatric unit in Bunbury, which will be completed in the coming year. We are looking at Broome. Again, it is a question of population size in establishing secure facilities for acutely unwell people.

Mr T.K. WALDRON: Is there any likelihood that one will be constructed in Albany?

Mr J.A. McGINTY: Albany has a mental health unit. Mental health must feature prominently as part of the upgrade of facilities to regional resource centre status. I think that is the more likely facility to provide those services. I have been inside the mental health unit at Kalgoorlie, and there is pressure for that unit to be expanded. I have been inside the mental health unit at the recently completed Geraldton hospital. The answer to the member's question is that I see the acute facilities being associated with the regional resource centres. Secondly, I am hopeful that there will be an expansion of community-supported residential units into more country towns than is currently the case. Construction will be completed in Geraldton, Bunbury, Albany and Busselton. I would like other country towns to have that community-supported accommodation, not accommodation for the acutely unwell.

Mr T.K. WALDRON: There is a real issue with police in the country towns that do not have those types of facilities.

Mr J.A. McGINTY: The biggest problem we have is staffing and attracting psychiatrists to work in some of these regional facilities. We will confront that problem when the Bunbury unit opens and we need to get more staff. We are also looking at Broome as we expand the services. Generally speaking, as the services expand, there will be acute facilities in the regional resource centres and community-supported accommodation facilities in more centres than is currently the case, because there is a need across the board.

Mr J.E. McGRATH: I refer to the eighth line item for new works listed in the table on page 583. This question has been left for me by the member for Roe, and I think he has written it in Latin! He is a typical doctor!

Mr J.A. McGINTY: Does it look like a prescription?

Mr J.E. McGRATH: Yes, it looks like a prescription! The member for Roe is unable to be here today. However, he would like to ask the minister why has the $100 000 for the Esperance integrated district health service redevelopment that was itemised for 2008-09 in last year's budget been put back a year and added to the figure of $800 000 that was in last year's budget, so that we now have a figure of $900 000 for 2009-10? Does this confirm the fact that the project in Esperance has been put back a year?

Mr J.A. McGINTY: I assure the member that the answer to that question is no; it is purely a cash-flow issue. It would have been paid at the end of the financial year as the works began, and it will now be paid as a result of the way in which the invoices will be submitted next year. There has been no delay in the Esperance proposal, and we intend to deliver that on time in accordance with the program that has been outlined. It was just an item that was there for payment at the end of the financial year that will now been paid, and it will not interfere in any way with the time frame for the Esperance hospital.

Mr J.E. McGRATH: The member for Roe is a little concerned about the minister's previous comment about Kalgoorlie Regional Hospital. He said that due to the boom in this state, it would be difficult to get the construction work done. The member for Roe hopes that that will not apply in Esperance, and he wants the minister to give an assurance to the people of Esperance that the $900 000 will not be put into the 2010-11 column.

Mr J.A. McGINTY: I am happy to give that assurance. Generally speaking, the south west and the great southern, and I have no reason to think that Esperance would be any different, are a somewhat different market from the booming conditions in the goldfields and in the metropolitan area and, for that matter, in the north of the state. Work has started on the Denmark hospital in recent weeks. We had a good tender arrangement, and work has now started on building an $18 million hospital in Denmark. We have not deferred the Busselton hospital, because we expect it to go ahead. We have not deferred Albany. The advice we got from people associated with the construction industry was that we needed to take a bit of pressure off in Perth; therefore, at Sir Charles Gairdner Hospital, half a billion dollars was deferred for six months. Midland was deferred for 12 months, and Kalgoorlie was deferred, again because of its location. However, through the member for South Perth, I can assure the member for Roe that we have every intention of proceeding fully on the long-established time frame for the construction of the new facilities at Esperance.

[5.30 pm]

Dr K.D. HAMES: I refer to the home and community care services that appear on page 617. Again, I express some concern about the commitment to keep people out of hospitals, which is, in effect, what this is about, and what the other programs are about. I am very pleased that there has been an increase in the budget for these services. I see that the allocation has gone from $153 million to $166 million. Of course, the minister will be aware that for every 66c that the state government provides, the commonwealth provides $1. The problem is that the population growth and the ageing of the population are chewing up every extra dollar that the state government puts in, and then some. Therefore, although the HACC services are able to expand marginally, the demand on these services is increasing enormously. I would like to know whether the minister can do anything further, given that a limited increase in state money results in a greater commensurate increase in commonwealth money - so it is a good way to get commonwealth money - to address issues that keep people out of hospital. Then I want to talk specifically about Mandurah. Therefore, if the minister can answer the general question first, I will come back to Mandurah in particular.

Mr J.A. McGINTY: I am very pleased with the way in which the HACC services are run in Western Australia and with the increase in the budgetary allocation to those services. HACC services are absolutely critical in keeping people well in the community. I agree completely with those sentiments that the member has expressed. Dr Fong might be able to add something to that also.

Dr N. Fong: I echo the minister's point. We have 70 000 clients in the HACC program currently, and it is growing at about 10 per cent a year. Thankfully, it is one of the areas in which Treasury is always happy to match the funding from the commonwealth. We expect to always have that matching funding. It is a matter of whether the commonwealth will continue to put its outlays into this area. In aged care, we have other areas that are obviously supplementing the HACC services. It must be remembered that they are home and community care services in the sense that they are not about just prevention of ill health; they are about wellbeing and all sorts of things. We have a residential care line that helps people in nursing homes. We have chronic disease management teams that, frankly, focus on the aged predominantly. They are all over and above the HACC designated services, which, as the member knows, are quite well defined. We have increased the HACC range of services, because in the past there was a grey area of post-acute care for which HACC moneys were being used. Those moneys have now been put back into true HACC services, and post-acute care is now being picked up by the department in the hospital and nursing home services. Therefore, we agree that there are a range of things that need to be done for the aged population.

Dr K.D. HAMES: Before I ask the Mandurah question, can I clarify something that was said? What comes first? Does the commonwealth tell the state what its funding will be and then the state matches that as per the agreement, or does the state tell the commonwealth what the state's increase will be and then the commonwealth matches that?

Mr J.A. McGINTY: I think Dr Towler knows the answer to that question.

Dr S.C.B. Towler: I inform the member that the commonwealth makes the first offer on the amount to be uplifted, and the state is invited to match it.

Dr K.D. HAMES: The second question relates particularly to Mandurah. As the minister knows, I have written to him on a few occasions about Mandurah. I remain either dissatisfied or unclear. My understanding is that the Mandurah HACC program has a historic debt problem. I think there was overexpenditure. In any event, there was a problem with funding. I have been told that until that amount is paid back, the funding to Mandurah will not increase. Therefore, its budget has remained static for a couple of years, despite the fact, as the minister knows, that Mandurah is, arguably, after Wanneroo, the first or second fastest growing community in Australia. My electorate has one of the highest levels of aged people in Western Australia, and we desperately need services in that area. I would be very concerned if that is still happening to the HACC budget for Mandurah because of past mistakes, or whatever it was, by the management. The management is now doing an excellent job, and I think it should be given the funds it needs to properly look after that community.

Mr J.A. McGINTY: I thought that historic issue had been resolved. That was my understanding of it. If that is not the case -

Dr K.D. HAMES: Did its budget go up this year? Does anybody know that?

Mr J.A. McGINTY: I would not know that. However, if that information I have just given the member about the historic position is not accurate, I would certainly appreciate the chance to have further discussions with the member about what we can do to resolve the situation. However, that is my understanding.

Dr K.D. HAMES: At these estimates committee hearings, we do all the budget stuff, and these matters tend to be forgotten by everyone, including me. Can the minister provide that by way of supplementary information, because we have not asked for any supplementary information yet? Can the minister provide the details of the Mandurah HACC funding over the past couple of years to show that the budget has increased? If it has not increased, the minister can provide an explanation.

Mr J.A. McGINTY: As a favour to the National Party, we agreed to give it supplementary information on an earlier issue.

Dr K.D. HAMES: Is that right? I missed that.

Mr T.K. WALDRON: It was very well received too.

Dr K.D. HAMES: Can this be a second lot of supplementary information?

Mr J.A. McGINTY: I indicate that we will provide that by way of supplementary information.

The CHAIRMAN: Will the minister detail what he will provide, please, by way of supplementary information?

Mr J.A. McGINTY: We undertake to provide, by way of supplementary information, the HACC funding for the Mandurah area, including whether the historical issues associated with the funding for HACC services in Mandurah have been resolved.

[*Supplementary Information No A34.*]

Mr T.K. WALDRON: I refer to page 616, and the dental health entries. Under "Major Achievements For 2006-07", the third dot point refers to the new Joondalup Dental Clinic and construction of the new Kununurra clinic, which is great. Under "Major Initiatives For 2007-08", the third dot point states that the new Bunbury dental clinic will open in 2007, and that there are new dental clinics planned for Broome and Fitzroy Crossing. That is good. It is a very positive move. Last year, I raised with the minister the vacuum in inland areas. People who are on benefit cards, in particular, cannot access those services readily. They must go to Pinjarra. They will now be able to go to Bunbury, and I think the member for Albany said that there is a clinic in Albany. Is there any possibility that in the future the government will consider opening a government dental clinic in a centre such as Narrogin to serve that vast area?

Mr J.A. McGINTY: I guess the answer to that is that it would be highly desirable to do it. The big problem that we are facing is the shortage of dentists. It is an international shortage. A number of years ago, at the instigation of the member for Albany, we put extra money in, and then embarked upon an international campaign to recruit overseas-trained dentists. I remember in Albany, for instance, meeting up with a young husband and wife who had come from South Africa. Unfortunately, they are no longer in Albany; I think they have gone to the Kimberley now. I think they might even be working in one of our -

Mr T.K. WALDRON: I think they moved to Narrogin.

Mr J.E. McGRATH: A better electorate, with a better local member!

Mr J.A. McGINTY: That is the problem with getting dentists. While I am reasonably content with our overall dental waiting lists, compared with those elsewhere in Australia, our biggest problem is attracting dentists to come and work in this state. We have tried things like offering a 10 per cent attraction and retention scheme to offer something to young dental graduates that is moderately competitive with private practice, and to retain those that we currently have. That is constantly the issue. Often, when the waiting list blows out somewhere, it is because we simply cannot recruit a dentist. We do not want to spread the resources that we have too thinly, and we want to have the resources in the major population centres, so people will need to travel there. Of course, in electorates such as the member for Dawesville's there is the potential for a travelling dental scheme to visit. That applies from time to time in some but not all areas.

[5.40 pm]

Mr T.K. WALDRON: Just on that, if I could go through the Chair, is it a major cost to set up a government dental clinic?

Mr J.A. McGINTY: Yes.

Mr T.K. WALDRON: I have no idea.

Mr J.A. McGINTY: Perhaps Mr Jarman can comment. He is shaking his head sideways. I am not sure whether that means yes or no.

Mr T.K. WALDRON: My question is whether it is a major cost to set up a government dental clinic. Does the minister have any idea what the cost would be approximately?

Mr P.V. Jarman: Yes, it is a major cost to set them up. We would look at a two-chair clinic as the minimum, and that would cost somewhere in the vicinity of $600 000.

Mr T.K. WALDRON: Through the Chair: was that for two?

Mr P.V. Jarman: For a two-chair clinic, which would be operated by one dentist.

Mr J.A. McGINTY: The real issue is the recruitment of dentists to work in those areas. There is no point putting up a building if we do not have staff for it.

Mr T.K. WALDRON: I understand that.

Mr J.E. McGRATH: My question relates to the sixth dot point on page 592. I ask the minister to tell me whether this question was raised while I was out of the chamber. Recognising the minister's plan to create a regional resource centre at Merredin, what is the WA Country Health Service specialist service plan for recruiting specialists to create the regional resource centre; in other words, what is the plan to get specialists to work there?

Mr J.A. McGINTY: Merredin is not one of the six designated regional resource centres. The six are Broome, Port Hedland, Geraldton, Kalgoorlie, Bunbury and Albany. However, we do have plans to upgrade the specialist and surgical services provided to the wheatbelt through Merredin District Hospital. Christine O'Farrell might well be able to offer further comments on the plans for upgrading the services at Merredin.

Mrs C. O'Farrell: Yes, Merredin is one of our hospitals that is designated as an integrated district health centre, which means that it should be providing a range of general practitioner-based procedural medical services. It has been some time since Merredin has been able to fulfil that role, which is the result of a declining number of doctors and of doctors who have procedural skills in anaesthetics and obstetrics. Our first commitment, therefore, in trying to resurrect that function in Merredin hospital has been to increase the capacity of medical staffing. We have had to go to a partially salaried model to supplement the medical staff, and we are making some progress with that. Our primary concern in the short to medium term is to establish it as the centre for emergency medical services after hours for the hub and spoke system within the district, of which it is the centre, and we are bolstering the surgical services through an outreach visiting program. We do not generally have resident specialists in our district centres, although if we are lucky and we have them there, we certainly welcome them. We do have a general surgeon, for example, in Narrogin who also provides some visiting services to Merredin. The centre will therefore be on a visiting outreach basis. Our main emphasis is on rebuilding a capable in-house team of procedural medical doctors to provide district support after hours for emergency services, to cover the emergency department services and the wards, and back up an obstetric and surgical service for us.

Dr K.D. HAMES: I will need a hand from the minister because I cannot find a dot point to ask a question about motor neurone disease funding. Where do I look for an item in the budget?

Mr P.B. WATSON: The Chair should rule that out of order!

Dr K.D. HAMES: I thought it would be under the service and appropriation summary, but looking through each of those items, including chronic illness and continuing care support, I cannot see it there.

Mr J.A. McGINTY: Page 602, under non-admitted patient services.

Dr K.D. HAMES: Page 602; which dot point?

Mr P.B. WATSON: Do you want the minister to ask the question?

Dr K.D. HAMES: Under page 602, minister.

The CHAIRMAN: Service 6.

Dr K.D. HAMES: I want to talk about funding for motor neurone disease. I attended a dinner recently held by the Motor Neurone Disease Association of WA. It was very well attended by both sides of Parliament, so that organisation has strong bipartisan support.

Mr J.A. McGINTY: Yes.

Dr K.D. HAMES: I have to say that the president was fairly scathing in his comments and was particularly disappointed about funding to support organisations such as the Motor Neurone Disease Association. I have to say that similar feelings about government funding and support have been expressed to me from Cystic Fibrosis Western Australia and Multiple Sclerosis Western Australia; I think they said their funding has hardly changed over the past six years. What is worse is that there used to be about 20 beds available for respite care at the old hospice unit at Shenton Park for people with motor neurone disease. Since that unit was closed by the

government, only one respite care bed has been available, and that has been provided by Brightwater. In any one year, about 140 people have motor neurone disease, 40 of whom die each year. They are therefore replaced by another 40 the following year. Support for people with motor neurone disease places a huge burden on carers, who are normally family members. They desperately need support for respite care and they are just not getting it. They are becoming disillusioned and depressed by that difficulty and the lack of that respite support. Is the minister aware of the difficulty they have in getting respite care; is he aware of the lack of funding for beds; and is there something he can do about that?

Mr J.A. McGINTY: The issue has been brought to my attention and I am aware of it. I have spoken with some people about this issue. Again, the government provides funding to the organisation of a little less than $200 000. My recollection is that it is around $180 000. Again, the issue fits in with what we can do to offer assistance. There are about 1 000 groups of this nature in the health system. I do not mean that in any derogatory sense to the Motor Neurone Disease Association; it does a fantastic job.

Dr K.D. HAMES: With respect to the minister, I do not think there is any other organisation that has a third of its membership die each year.

Mr J.A. McGINTY: No. Nonetheless, we are funding the association. It wants more. I understand that point of view. We have a budget within which we must operate to meet the various needs, and I am not prepared to blow the budget in health. That is the difficulty.

Dr K.D. HAMES: I have a further question. I understand that issue. I do not agree with the minister's answer, but I understand the reasons for it. However, the minister has significantly reduced the standard of care for those patients by shutting the hospice that provided them with a significant number of respite beds. That is a matter that the minister must address. Carers of people with this condition need relief because of the huge demand on them.

Mr J.A. McGINTY: Yes.

Dr K.D. HAMES: Otherwise the minister will end up with them in hospitals clogging up beds.

Mr J.A. McGINTY: I will correct one matter; that is, the Cancer Council WA ran the cottage hospice and it made the decision that it no longer wished to provide that service as a stand-alone facility. That was not a decision that I made. As those beds at the cottage hospice were funded by the government, we needed to step in and divert the funding that was previously made available to the Cancer Council to fund beds in other facilities for palliative care. The member's criticisms need to be directed to the Cancer Council because it shut the facility for the purpose for which it was used; it was not a decision that I made.

Dr K.D. HAMES: Further to that, I am fairly certain that the member for Nedlands would strongly disagree with the minister on that if she were present in the chamber.

Mr J.A. McGINTY: That does not mean that she is right, though.

Dr K.D. HAMES: That is an issue between the two of you. The reality is that even though a significant number of people with motor neurone disease die each year, it is not appropriate to give them respite by putting them into palliative care beds. These people do not have cancer; 60 per cent of them will not die for a while. They do not need palliative care.

[5.50 pm]

Mr J.A. McGINTY: The member is talking about respite care, not palliative care.

Dr K.D. HAMES: They need respite beds. Whatever their background and history, can the minister find respite beds for people with motor neurone disease who are in desperate need of support?

Mr J.A. McGINTY: I take on board the member's request. I will ensure that the matter is reviewed by the Department of Health to determine whether anything more can be done. I appreciate the point the member for Dawesville is making.

Dr K.D. HAMES: If the minister attends the cystic fibrosis dinner in the next few weeks, he will probably hear the same sort of complaint.

Mrs J. HUGHES: I refer to the training that is required to care for people who suffer from motor neurone disease. Sometimes motor neurone sufferers are put into our hospitals because there is nowhere else for them to go. The training that nurses must undergo to care for these patients appears to be an issue, because it is a specialised form of nursing. How is the nursing fraternity kept up-to-date with the nursing procedures for these types of admissions?

Dr N. Fong: We have a neurosciences health network that is chaired by Professor Bryant Stokes. His task is to lead a network of people from non-government, government, consumer and private health provider organisations to develop a comprehensive plan to deal with neurological and neurosurgical issues, which includes motor neurone disease, Huntington's disease and other similar diseases that afflict people in our community. We also fund to the tune of $1.2 million the Neurological Council of Western Australia, which comprises a collective group of organisations. It is housed at Niche at the Sir Charles Gairdner Hospital campus. That council helps to work-up plans and education support for community groups. In terms of how we better skill our nurses or community-based nurses, we provide postgraduate training for specific specialty areas. In terms of motor neurone disease, we have clinical nurse specialists trained in neurological disorders. Training is available; it is a matter of whether the community-based organisations allow their people to access those courses. We provide scholarships for various clinical nurse specialties. We have tried to address that issue. If there is something we are not specifically doing, we are open to suggestions.

Mr T.K. WALDRON: I refer to the seventh dot point on page 592 of the *Budget Statements*, which states that the deployment of information technology based clinical systems to country regions commenced in 2006-07, including the implementation of computer radiography at Geraldton Regional Resource Centre and pathology systems at Northam Regional Hospital. I do not know a lot about those systems; however, I want to know whether they will be extended. While we are talking about collecting blood, I ask the minister whether there is any chance of getting back a mobile blood bank collection service.

Mr J.A. McGINTY: That question should be directed to the Australian Red Cross, because it makes that decision. I would have thought that, given the shortage of blood products, asking healthy country people to attend a mobile unit to donate blood would be a good proposition. It is up to the Australian Red Cross to make that call. It has said that it is not cost effective and that is where its call rests.

In terms of the expansion of the picture archive and communication system, it is operational in Geraldton. We intend to implement it throughout the rest of the country areas. I also refer to the patient archive information system, which relates to x-rays and other imaging being recorded electronically rather than in the old negative form. My understanding is that we propose to run that out to other hospitals. I expect that that has occurred in some country hospitals. I ask Dr Flett to talk about pathology at Northam and what has happened there.

Dr P. Flett: PathWest was formulated about two years ago. From that, a number of different databases were merged into one single pathology information technology system. We are in the process of rolling out that central system across the whole of Western Australia. The first rollout was at Northam Regional Hospital. The system will be installed everywhere so that we will have one single system as opposed to multiple systems throughout the state.

Mr J.E. McGRATH: I refer to the second dot point under "Healthy Resources" on page 585 of the *Budget Statements*. I am happy to take this information by way of supplementary information. Can the minister report on the attainment or otherwise of each key result area of the Western Australian operational plan for 2006-07? Can the minister provide the answer as a breakdown of each key result area and each subset of the KRAs and indicate whether the targets were met?

Mr J.A. McGINTY: The information the member seeks is provided in the Department of Health's annual report. That is the best place to access it. It is made available as soon as the annual report is released. It is also audited in that way. There are an enormous number of key performance indicators in the operational plan that go to every aspect of health care delivery. It would be an enormous task to answer the question outside of the annual report.

Dr K.D. HAMES: I refer to "Major Policy Decisions" on page 586 of the *Budget Statements*. In last year's budget, the major policy decisions were mental health initiatives and state-matched funding for joint state-commonwealth programs. Last year's budget included an item that related to continence management, for which $1.758 million was allocated in 2006-07, with forward estimates of $1.8 million for 2007-08, $1.8 million for 2008-09 and $1.9 million for 2009-10. I cannot find a reference to that major initiative in this year's budget. A press release that the minister gave at the time referred to providing people with continence aides. I understand that after that announcement and the 2006 budget, there was no action until February this year, when people were told to apply. Seven months after the start of the financial year, people who need support for incontinence were told to apply. I have been told by people in my electorate who have applied that they are still waiting for assistance nearly 12 months later. Will the minister advise whether that has been included in the budget? If it has, what is the government doing to provide assistance to people who have incontinence problems?

Mr J.A. McGINTY: Last year we committed to establish an incontinence support scheme, which involved two parts. The first was advice and support for people with continence issues. The second was to provide a subsidy for continence products. The 2006-07 budget provides $1.8 million to ensure that the scheme is up and running.

Dr K.D. HAMES: I have done a search of the *Budget Statements* and I cannot find it. It is part of service 16. However, under that service there is no mention of it, even though last year it was a major policy initiative.

Mr J.A. McGINTY: There was some delay getting it up and running because we needed to develop appropriate protocols and we had to seek advice about how it should operate in conjunction with a non-government provider. A number of government agencies were involved, including the Disability Services Commission and the Department of Health. It was a matter of resolving those issues. We are keen to spend the money. The scheme will provide not only continence support, but also continence management advice. The member for Alfred Cove asked a question about this matter about two or three months ago. I was advised then that several hundred people had applied and that no-one had been rejected. It was expected that payments would be forthcoming within weeks of people applying.

Meeting suspended from 6.00 to 7.00 pm

The CHAIRMAN: Member for Dawesville.

Dr K.D. HAMES: I was hoping that during the break someone would have found an answer to my question about incontinence funding, unless everyone was just eating.

Mr J.A. McGINTY: It is item 16, as we referred to earlier.

Dr K.D. HAMES: Although all those protocols to which the minister referred had to be put in place, one of the key components of this issue is not only providing advice, but also incontinence pads, as the minister said. People need those incontinence pads now and yet nearly a year after the announcement was made, they cannot get the money to fund the incontinence pads. The $1.8 million is in the budget. How much of that $1.8 million was spent this year? Can the minister get that figure from his advisers?

Mr J.A. McGINTY: There is a division of responsibility between the Department of Health and the Disability Services Commission. The role of the Disability Services Commission is to fund the subsidy for the incontinence pads. The $2 million that has been set aside for each of the four years under the Disability Services Commission's budget - not here - is to subsidise the products. The role of the Department of Health, for which $1.6 million has been allocated for four years, is a contract with the Silver Chain advisory service to provide the advisory support rather than the direct provision of the products, which is done through the Disability Services Commission.

Dr K.D. HAMES: Is the minister saying that during all this time when we have been chasing funds for people who desperately want subsidies for their incontinence pads, including the question asked by the member for Alfred Cove, we have been chasing the wrong people?

Mr J.A. McGINTY: The member should chase the Disability Services Commission for the incontinence pads.

Dr K.D. HAMES: Does the minister have any idea why it has not been providing the support funding for that?

Mr J.A. McGINTY: As I understand the situation, as a precondition for providing the pads, the support service, which offers counselling and advice, precedes the granting of the subsidy. This relates back to when the member for Alfred Cove asked the question and when I got this information. The provision of those services has begun and will lead to the granting of the subsidy for the incontinence products.

Dr K.D. HAMES: Have those people been waiting for the minister?

Mr J.A. McGINTY: I am not sure because I have not had an update on that for two months. However, it certainly was being implemented during the first half of this year.

Dr K.D. HAMES: That sounds like a pretty ordinary arrangement. People are desperate to get a subsidy for the pads and the money is in the budget for the pads yet they cannot get it until the minister has organised services to provide advice and counselling to them, presumably about other issues not relating to their desperate need for pads.

Mr J.A. McGINTY: It is related to their incontinence and the way it can best be managed.

Dr K.D. HAMES: They would still need pads while they are being counselled.

Mr J.A. McGINTY: I agree. Something was agreed to be done and a greater degree of expedition is appropriate.

Dr K.D. HAMES: The minister made a major announcement about this.

Mr J.A. McGINTY: Yes.

Dr K.D. HAMES: Yet nearly a year later people are still complaining. I ask the minister, or whoever in his department is responsible, to take a lead role in making sure that that money is provided as quickly as it possibly can be to the people who need it.

Mr J.A. McGINTY: In the light of the way in which the matter has been raised today, I will make sure that the department liaises with the Disability Services Commission. If there is any remaining impediment, I will ask for it to be removed to ensure that the money flows. It was a new service and therefore it was necessary to develop the appropriate protocols. Arguably that should have been done more quickly but I think everything is now in place.

Dr K.D. HAMES: That leaves the government with a spare $1.6 million to support motor neurone disease.

Mr J.A. McGINTY: It might be that the payment is retrospective. I do not know. I will ascertain that and I take the member's point.

Mr T.K. WALDRON: The last dot point before specialist services on page 592 of the *Budget Statements* refers to a detoxification service that has been established at the Halls Creek District Hospital. Having been involved in Halls Creek, I am interested to know whether that service is operating well. Are the local people utilising that service, and are we seeing positive results from it?

Mr J.A. McGINTY: I ask Christine O'Farrell to respond to that.

Mrs C. O'Farrell: Local people are using the service. We have built a new hospital in Halls Creek and now have the room and capacity that we did not have in the old hospital. Our team said that the provision of that service would make a contribution to the alcohol problem. I do not have any numbers for the member, but I think they are quite low. However, it is being utilised and it is appreciated. It is making an impact, along with the other initiatives that have been implemented at the community level.

Mr T.K. WALDRON: Is the minister confident that as the locals become aware of the benefits of it, they will utilise it more, or is there some resistance to it?

Mrs C. O'Farrell: The local people and their families have wanted this type of facility because otherwise they would have to leave town to receive treatment. They have been asking us to do this for some time. The new facility has enabled us to offer this service to the community.

Mr C.J. BARNETT: I have a very detailed question for the minister. I would like to know the year-to-date expenditure for the North Metropolitan Health Service, the South Metropolitan Health Service, Princess Margaret Hospital for Children, King Edward Memorial Hospital for Women, and the dental facilities, PathWest, the Royal Street facility and the Drug and Alcohol Office. What is the overspend or underspend for each of those services for this year, or what is it estimated to be?

[7.10 pm]

Mr J.A. McGINTY: We will need to provide that by way of supplementary information. I will comment about the aggregates. We have our approved expense limit. The last I heard, which was some few weeks ago, was that that was under pressure, but we still expect to come in very marginally under the approved expense limit. That is for the Department of Health as a whole. There will obviously be some underspending and overspending in that, but I am pleased that in the aggregate sense, subject to the chief finance officer delivering on 30 June, we will deliver a balanced budget.

Mr C.J. BARNETT: Are there any areas of significant underspending? We always hear the reasons for the health sector overspending, but are there any areas in which factors have moved to require less expenditure than anticipated?

Mr J.A. McGINTY: I ask John Leaf to respond.

Mr J.W. Leaf: Perhaps rather than focusing on significant areas of underspending, I will focus on an area in which we are achieving better than budget, which is in our revenue generation. Some of that is actually helping to offset expenditure. Obviously, there is a connection between the two - by providing more services that we can bill, we spend more. The answer to the member's question is really that it is a net-cost-of-service balance. When we come to the question, we will address both the revenue side of the equation and the expenditure side in the north, the south, the country, PathWest etc.

Mr C.J. BARNETT: Can I have some explanation of why the revenue is better? Is the department collecting what it could not collect before? Are there other factors?

Mr J.A. McGINTY: While that is being answered, I ask Mr Leaf to also identify those areas in which significantly more has been spent than originally planned. We will come back with the precise figures.

Mr J.W. Leaf: There are a number of pressures on this year's budget. Some of those were spoken about during the course of this afternoon and evening. Those pressures relate to dealing with problems in our emergency departments that have required us to seek additional beds from the private sector to cope with care-awaiting-placement patients. That is a pressure on this year's budget from both the north and the south. Elective surgery has cost us a substantial amount of extra funds in again seeking private sector ways in which to deal with our incapacity to find beds and places to deal with categories in which we are trying to meet performance targets. That is the hospital side of our business. I have to say that we are experiencing the most pressure in the area that we addressed earlier. If we try to solve one part of the equation of emergency departments and elective surgery to get the balance right, they both tend to cost money and one creates a problem in another area. They are our key pressure points.

Mr C.J. BARNETT: Mr Leaf mentioned revenue.

Mr J.W. Leaf: We have a process with outpatients by which, if a patient is referred privately by a general practitioner, we are able to recover those funds from the commonwealth government. That is proving to be successful. We are achieving more revenue there. I might ask Mr Toutountzis whether he can help me with some more specific issues.

Mr J.A. McGINTY: Neale Fong can add to that.

Dr N. Fong: The other positive revenue story for health is that we have been able to get more revenue from the health insurers. Patients who come into our hospitals who have private health insurance can elect to be privately treated; we avail them of that opportunity. We by know means go after those patients. In fact, we want them to use the private hospitals. However, if they have to come to a public hospital because they cannot be treated at a private hospital, they can choose to be private patients; we give them that option and collect the revenue. Designated officers have been employed. It has been a very successful program. The patients are there anyway. The other successful area of our budget management is in achieving efficiencies. Members may remember that the Health Reform Committee report called for more efficiencies in health. We had targeted $24.166 million in procurement reform for 2006-07. We expect to have an extra $2.5 million in savings by the end of this financial year, so we will have achieved a total of $26.61 million. Some areas in which we have been able to identify efficiencies include the management of contracts for fluids, linen and some pharmacy lines. We won three Treasurer's awards for procurement reform this financial year, which we are very proud of. We will be targeting savings of $6.2 million in 2007-08. When that is added to the $26 million, it will make $32.667 million in savings from procurement efficiencies. Power and telecommunication contracts are examples of procurement efficiencies. We have been able to put those savings towards the revenue side to deal with some of the budget pressures that we are under.

Mr C.J. BARNETT: The department may not always be able to control all factors, such as ageing, but is the minister confident that it is in control of the finances of the health system; that is, does the department know where the money is going, what is happening and what are the trends? I am not asking whether the endemic problems in the health system have been solved, but whether the department understands and is across the financial side of the system. That is not easy to do.

Mr J.A. McGINTY: A few years ago, the public health system was regularly criticised for its lack of financial stringency and management. I would like to think that this is one of the success stories. It is not something that is heralded. There is discipline now in people at all levels of the system appreciating that things must be done within a tight financial context, notwithstanding the desire of clinicians in particular to spend whatever it takes to treat a patient or group of patients. This will be the fourth year in which we will have delivered within the approved expenditure limit. We now have a far better understanding of the key drivers and pressure points and how to control them within reasonable limits.

The CHAIRMAN: Before I go on, I want to clarify with the member for Cottesloe and the minister the specific information to be provided by way of supplementary information. I ask the member for Cottesloe to read out his question and I ask the minister to confirm whether there is anything that he is not prepared to give by way of supplementary information. I will then allocate a number.

Mr C.J. BARNETT: I am seeking the expected overspend or underspend for a number of areas of health expenditure, including the North Metropolitan Area Health Service, the South Metropolitan Area Health Service, Princess Margaret Hospital for Children, King Edward Memorial Hospital and other specific facilities, such as dental, PathWest, the Royal Street facility and the Drug and Alcohol Office.

Mr J.A. McGINTY: We will undertake to provide that information. It may be convenient to provide annual figures rather than year-to-date figures given that we are so close to the end of the financial year.

[*Supplementary Information No A35.*]

Dr K.D. HAMES: I have a supplementary question. I noticed that the minister said that expenditure was not within budget but within expenditure limits. I note that health has gone over budget. The budget was $2.472 billion and the estimated spend is $2.511 billion. How much over budget is within expenditure limits?

Mr J.A. McGINTY: The budget is the funding within which we operate. During the course of the year, decisions are made to provide additional services. For instance, decisions were made to expand mental health services during the course of this year. That was then added to the base budget allocation. The yardstick that I use as to whether there has been a balanced budget is whether the additional services that have been approved and the additional budget that was approved after the issuing of the original budget come in within what is approved through the expenditure review and cabinet processes. That is the yardstick that is used. It is not related to the original budget. I expect that we will do the same thing during the course of this year.

[7.20 pm]

I expect there will be other initiatives post budget, some of which might come out of the Council of Australian Governments, for instance. We might decide during the course of the year that it is appropriate to undertake a particular new service where that is funded in addition to the base budget. Sometimes we are expected to absorb new services within the budget that was handed down. I instance COAG and mental health as two examples where the base budget allocation was adjusted during the year. Another one during the course of this year was a cabinet decision to fund Beyond Blue and to provide the funding to be able to do that. It is things of that nature.

Dr K.D. HAMES: As I worked it out, $39.052 million is the amount the department has gone over budget. Is that right? It is $2 472.302 million compared with $2 551.354 million.

Mr J.A. McGINTY: The capital user charge needs to be taken out as well, so that further complicates the matter.

Dr K.D. HAMES: It says the capital user charge has been extracted.

Mr J.A. McGINTY: I think the figure is greater than that because of the additional commitments made during the course of the year. Perhaps I can run through them. There was $32 million for recognition of increased revenue, which was added to the expense limit. There were wage cost pressures, in particular the Health Services Union enterprise bargaining agreement, which was an additional $31 million. There was also an HSU work value claim which was back payment to the specified callings, the allied health professionals; that was $10 million. There were a number of carryovers from 2005-06, which totalled $14 million. I can detail those if the member wishes me to. There was a notional accounting change in respect of superannuation liability, which was $7 million. There was also a transfer of 2006-07 allocations to 2007-08 totalling $8 million. This is in fact a reduction rather than an increase in the expense limit for the Derby Nursing Home and for cancer services. A sum of $2.2 million was allocated to Alzheimer's Australia for a land transaction grant. There were depreciation adjustments of $9 million; funding to create the office of Nobel Laureates, $900 000; and additional commonwealth special purpose payments of $12.7 million.

Dr K.D. HAMES: That is a receipt.

Mr J.A. McGINTY: Yes, but it increased the expense limit because it then gave us the capacity to provide more services. Lotteries Commission additional revenue amounted to $2.5 million; there was a reduction in the expense limit in respect of the mental health strategy because some services we were proposing could not come on at the time we originally anticipated, so there was a reduction of $6 million; and there was a further miscellaneous adjustment of $1.5 million, all of which add up to $106 million during the course of the year. That gives the member an idea of the flavour of the adjustments.

Dr K.D. HAMES: Ups and downs.

Mr J.A. McGINTY: Yes, predominantly additional pressure for services with some reductions where services were not delivered.

Dr K.D. HAMES: I refer to "Aboriginal health" on page 610 of the *Budget Statements*. I would like to spend a bit of time on Aboriginal health. We are into our last 35 minutes and I welcome other members to ask questions on Aboriginal health so that we can spend a bit of time on it, although members are obviously free to ask their own questions. The issue I am concerned about is that the Health Department has a $4 billion budget and Aboriginal health is one of the shames of Australian society, not just in Western Australia but throughout Australia. We are one of the worst countries in the world for managing Indigenous populations. The health of

our Aboriginal people is deteriorating and there is at least a 20-year gap in life expectancy for all Aboriginal people compared with other Australians. In spite of that there are only three dot points in this list of major initiatives for 2007-08 that relate to Aboriginal health. I find that fairly disturbing. In preparation for my speech on the budget in the house last week I got the 2000-01 budget from the last year of our government and as I was looking for capital expenditure I saw the section on Aboriginal health. It comprised six pages of plans for Aboriginal health. This worries me enormously. I would have thought the government needed a major focus, not just in its attitude towards Aboriginal health but in its plans for next year to address the serious issues of cardiac disease, alcoholism and diabetes especially in Aboriginal communities. Why has the department not focused far greater attention on what it provides to the public by way of information about what will be done for Aboriginal health?

Mr J.A. McGINTY: The member is quite correct and I agree with his analysis about health outcomes for Aboriginal people. They are a scandal by any world or international standards. The absence of dot points does not indicate any lack of commitment or desire to do a lot more to redress the inequities in health outcomes for Aboriginal people. I guess we could have put in six pages of words -

Dr K.D. HAMES: Where are the plans? Where is something to suggest that the government will give Aboriginal health a serious focus?

Mr J.A. McGINTY: I would like to get Dr Simon Towler to talk about what has been happening in that area and the focus we have given to Aboriginal health.

Dr S.C.B. Towler: I thank members for the opportunity. I appreciate this opportunity to focus on issues for Aboriginal Western Australians. I would like to remind members that the government made a commitment under the national strategic framework for Aboriginal and Torres Strait Islander health in about 2005, which outlined a series of priority areas. It is our approach, and what is I think fundamentally different about WA Health in 2007 is that we do not seek to separate out from the activity of the health system a specific focus on just Aboriginal health services because we believe it is fundamentally intrinsic to WA's responsibilities to its population. In Western Australia, Aboriginal people make up some 3.5 per cent of the population but are overrepresented in health services threefold to fourfold. The recent report on government services and the national health performance framework report on Aboriginal services draw some very interesting and salient points in relation to the investment by the state in services to its most disadvantaged people. Other than in the Northern Territory, Aboriginal people use hospital services in Western Australia more than in any other jurisdiction in the nation. The state has an unrelinquishable responsibility to ensure that hospital services are available to all its people and in fact when one analyses the total investment in health services provided to the Indigenous population of the state, it averages nearly $3 840 per capita versus an expenditure on the rest of the population of some $1 250. Compared to the national average expenditure on Indigenous health, which averages only $3 900 across the nation, it indicates a very profound commitment by the Western Australian government to investment in services to meet the needs of its Indigenous people. People in this chamber know even better than I that in a state of 2.5 million square kilometres and with a distribution of health services that is particularly challenging, these are particularly difficult issues. I draw members' attention to some specific matters.

The first thing that members need to note is that yes, I agree that life expectancy for Aboriginal people remains many years less than that of the rest of the population. In fact, it has narrowed in the last triennium and consistent with the rest of the population has improved, as has the life expectancy of all people in the state. More needs to be done. The focus that has been taken by WA Health in considering Aboriginal health matters has been to embed it in planning for every single area health service.

[7.30 pm]

We believe that an approach that addresses the needs of Indigenous people needs to be respectful, but needs to be a strong partnership between mainstream health services and community service provision. A national strategic framework for Aboriginal and Torres Strait Islander document focuses very strongly on the need to address the health needs of Aboriginal people in the primary care sector and community sector. It is an important recognition that that responsibility also very strongly lies with the commonwealth government. The investment figures for WA Health show that certainly at the monetary level it is making a very serious contribution.

Also, in the recent health performance framework report there was some very good news in terms of those initiatives that have been put in place. There have been substantial reductions in WA in advance of the Northern Territory and Queensland, which are the only other states to report specific outcomes for Aboriginal people, with a reduction in neonatal mortality and overall perinatal mortality. The SIDS rate in this state is well below that of other states. The focus of recent initiatives, particularly around young Aboriginals and their families, is beginning to bear some fruit.

Furthermore, there has been much acknowledgement that poor Aboriginal outcomes are the consequences of years of particular forms of risky health behaviour that results in poor long-term health. The current program to invest in health promotion that has been led with the development of the health promotions strategic framework has had a particular focus on addressing health promotion activities that are more effective for our Indigenous community members and the rest of the community. Western Australia has a very strong history in successful health promotion campaigns, with dramatic reductions in smoking, from 35 per cent to 15 per cent, with consequent health benefits. We have been involved in an experiment that demonstrates that standard social marketing approaches are profoundly inefficient in meeting the needs of disadvantaged groups, particularly Aboriginal health groups, where smoking remains very high.

In health promotion contracting, which we have been undertaking, I am pleased to announce that 16 per cent of the activity under those health promotion strategies will specifically target improved health outcomes for Aboriginal people. WA Health, through its planning processes, is now moving to a structure that recognises within each area health service that we have a commitment to population-based services rather than specifically just hospitals. If one attends to the recently released South Metropolitan Area Health Service's clinical plan, one will see that there is a focus in what is being planned for the metropolitan area for Aboriginal services.

The challenges in the state are very broad. With 65 per cent of the people living outside Perth, we recognise that most of the services provided by WA Health to Aboriginal people flow through Western Australian country health services. In the new foundations documents, addressing Aboriginal health services is one of the major pillars. The work that we have been doing with the Office of Aboriginal Health, and looking to opportunities in a greater partnership with the commonwealth, will create a reasonable focus around the needs of regional Aboriginal groups that seeks to improve overall primary health care.

WA Health Services is a major provider of primary care, particularly after hours. In a number of locations it runs major Aboriginal health services. An outstanding example is the Great Southern Aboriginal Health Service, based in Albany, which is run through WACs and is very strongly supported by the local Aboriginal council and managed through the country health services system. I believe that the work we are doing in Aboriginal health is particularly comprehensive. There is evidence of a strong investment in meeting the needs of Aboriginal people. We do not deny the need for greater cooperation and more work. The striking issue for us at the moment is to address the issues of primary care, which we need to do with the commonwealth.

Western Australia is under duress from having fewer general practitioners per capita than any other state and their being inappropriately distributed within Western Australia to provide substantial primary care services to Aboriginal populations that are remote from major centres. It is critical that a primary care program worked with the commonwealth enables us to improve primary care services away from Perth. It does not deny the need to address them more strongly. Our approach is to take this approach forward and to look for opportunities, particularly through three new initiatives, identified by the commonwealth in its recent budget - addressing increases in child health checks, building greater strength in the Aboriginal workforce and looking for opportunities to work with the primary care sector to embed Aboriginal services right across the state as a key priority. It is clear that Western Australia invests a lot of money in this area. We have a very clear approach to how we want to move forward. We look forward to the opportunity to do so.

Dr K.D. HAMES: Does Dr Towler have a photographic memory? If he had not been looking at me, I would have sworn he was reading that.

The CHAIRMAN: He was impressive.

Dr K.D. HAMES: I do not believe that the increased expenditure by this state on Aboriginal health is a reflection of this state doing better work than the other states. It is a reflection of the increased need on this state because of serious problems in the Aboriginal community, particularly those caused by the remoteness of this state. A lot of that expenditure is going on after the event and not on preventing the event. It is spent on treating and managing the serious medical problems in remote Aboriginal communities.'

I have worked as a doctor in remote communities. One occasion was by design, when I was a doctor at Beagle Bay, and another was by accident, when I was the Minister for Health at Kiwirrkurra and the health worker had disappeared on a sexual liaison with the community manager to Alice Springs. Stanley Ngala and I managed patients there. The reality is that those communities are not getting sufficient attention to treat the illnesses that lead to the end-stage problems that WA Health treats. I refer in particular to diabetes, heart disease and alcoholism. They are not just health issues, nor were they when I was the minister. The problem we had at that time was trying to get the health department to come on board and not run off and do its own stuff in isolation.

The Minister for Housing and Works and Minister for Indigenous Affairs spoke in the estimates committee about what the respective departments are doing to improve health; that is, normalisation, water supply and

housing issues. There was no suggestion in any of her responses about what is being done in conjunction with the health department.

Mr J.N. HYDE: That is not correct. Her comments were about Indigenous services throughout all departments, including health. The member should not twist her comments.

The CHAIRMAN: I know how passionate the member for Dawesville is about this subject, but I am sure he is getting to a question.

Dr K.D. HAMES: I am getting to a question. I am happy to go through *Hansard* and prove it to the member for Perth. Nevertheless, it is not a criticism of the minister. There are serious issues to do with preventive health. I support the view that that is part of general health.

The CHAIRMAN: Is there a question here?

Dr K.D. HAMES: Yes, I come back to the original question. Sure, it is only something that is in a budget paper. Is it not up to the government to detail the more specific requirements of Aboriginal health, particularly the management of the prevention of diabetes, which is one of the health scourges of Aboriginal communities?

Mr J.A. McGINTY: I accept the criticism about the treatment of the end product through acute services; however, it is essential that we spend money on making sure that acute hospital services are available to people in Aboriginal communities. That is the reason that we are currently spending more than $100 million rebuilding every hospital in the Kimberley. We have opened the hospital at Halls Creek.

Dr K.D. HAMES: I know; this was in the 2001-02 budget as I recall.

Mr J.A. McGINTY: Broome is about to become the regional resource centre. This month we are completing the significant rebuilding of the Derby Regional Hospital and there are changes to the hospitals in Wyndham and Kununurra. It is massive capital expenditure to treat the acute problems, which is necessary. I hope that a lot more Aboriginal people from the Kimberley will be treated in the Kimberley as a result of that significant investment. I agree that the emphasis on lifestyle issues and, for that matter, a whole-of-government approach to those lifestyle issues is essential, and that is what Dr Towler was saying about the range of initiatives that have been taken.

[7.40 pm]

In the justice portfolio, the extent of disadvantage is dramatically greater, at 3.5 per cent of the population, or 43 per cent of the prison population, and it is getting worse, because it is about 80 per cent of the juvenile prison population. That is the extent of the disadvantage there. In many of the other health indicators, although there has been some improvement, the measure of disadvantage is still totally disproportionate. We are certainly keen to put a big effort into addressing those lifestyle issues. That must, of necessity, be addressed by a combination of every area of government undertaking; that is, economic activity, education, and law and justice issues. One of the things that I believe will indirectly contribute towards a more wholesome Aboriginal community will be the implementation of the recommendations of the Law Reform Commission on Aboriginal customary law. What we are doing in respect of land issues is also very much a part of that totality of approach. We could write a book on it. There is certainly no intention, by reducing it down to dot points, of being anything other than economical.

Mr T.K. WALDRON: I refer to the "Major Initiatives For 2007-08" on page 614, and the heading "Immunisation". It states in part that the focus on immunisation will continue, including the roll-out of a new vaccination program for human papilloma virus to prevent cervical cancer. I support that program. I am interested to know how it is progressing, particularly in schools. Has there been much resistance from parents to that program?

Mr J.A. McGINTY: I am aware of some resistance from parents. I expect that some parents will say no. There was some coverage in the past few days of a Catholic girls school, from memory in Melbourne, at which a number of girls received the vaccination and ended up in hospital. There seemed to be some difference of opinion, led by the federal health minister, and the President of the Australian Medical Association, and others, about whether that was indicative of some broader concerns. I have asked about this matter, and I have been told that there has been no significant resistance from parents. I expect that in some religious-based schools, a number of parents would say no. It is, of course, their prerogative to do that. The roll-out commenced at the beginning of the current school term, which began several weeks ago. From the information I have received, most parents are making the decision that they would rather protect their daughter from cervical cancer than introduce the question of whether it will encourage promiscuity - which seems to be the main argument against that type of vaccination.

Mr T.K. WALDRON: A couple of people did come to see me about it. I was just wondering whether it was a general concern. I have not heard much about that vaccination program since it began, and I wanted to know what was happening.

Mr J.A. McGINTY: That is all we can add to that.

Mr C.J. BARNETT: I refer to page 578, "Grand Total". This is a fairly general question. Has the department been required to pay any compensation to any patient, staff member or nurse as a result of legal proceedings, or out-of-court settlements, for malpractice?

Mr J.A. McGINTY: I am certain there have been such payments. I am certain the answer is yes.

Mr C.J. BARNETT: I seek supplementary information on the number of cases in which compensation has either been awarded or agreed to.

Mr J.A. McGINTY: Yes. I undertake to provide by way of supplementary information details of any payments of compensation for medical malpractice, for the last year for which information is available.

[*Supplementary Information No A36.*]

Dr K.D. HAMES: I refer again to that same dot point on Aboriginal health. Recommendation 15 of the Reid report states that a primary health care strategy for Aboriginal people should be developed and implemented. Has that been done; and, if so, can we have a copy of it?

Mr J.A. McGINTY: Yes, it has been done, and it has been released. I do not think we have a copy with us today. I undertake to provide the member with a copy of the Aboriginal primary health care plan.

The CHAIRMAN: Will that be done outside of the supplementary information process?

Mr J.A. McGINTY: Yes.

The CHAIRMAN: Good. The member for Wagin.

Mr T.K. WALDRON: I refer again to Aboriginal health. The last dot point on page 607 states that primary medical care services for Aboriginal people are being enhanced in seven wheatbelt towns, and other sites are recruiting staff. It continues on page 608 and states that Aboriginal health workers are collocated with general practitioners wherever possible, and negotiations with all general practitioners within the wheatbelt region will be completed in 2006-07. Are Aboriginal health workers taking up these positions? What negotiations are taking place with general practitioners in the wheatbelt region?

Mr J.A. McGINTY: I will ask Christine O'Farrell to comment. However, before I do that, I would like to answer a question that was asked by the member for Dawesville about smoking in cars and homes. My answer to the member was correct. That matter has been factored into advertisements that are being run by the Cancer Council of Western Australia to try to educate people about the dangers of smoking in cars and at home when children are present. That advertising program will, coincidentally, be launched this Sunday. I am told the budget for that campaign is $400 000.

Dr K.D. HAMES: Will that include television advertising?

Mr J.A. McGINTY: I do not think so. The launch will be on Sunday. I think it is print and electronic media, not television. I may be wrong. Having said that, I will ask Christine O'Farrell to answer the question asked by the member for Wagin.

Mrs C. O'Farrell: WACHS provides the only dedicated Aboriginal health service in the wheatbelt. It does so in a funding partnership with the Australian government. It provides a similar service in the great southern region. Those two services are very successful. They are starting to bed down and mature. Yes, we are able to employ Aboriginal health workers. The idea is to work in a very integrated way with various service providers, including hospitals and private general practitioners. It is intended that the health workers in the Aboriginal service, and the other staff, will facilitate and broker access for Aboriginal people, assist with discharge planning, and try to ensure that people do not disappear and fall through the cracks in the navigation process between service providers. It is beginning to become a very notably successful service.

Mr T.K. WALDRON: Although the well men's clinics have been established, is there any focus on the health of Aboriginal men? As the member for Albany has mentioned, sometimes blokes are not keen to come forward when it comes to health issues. That problem is often exacerbated for Aboriginal men. Has there been any focus on that as part of that program?

Mrs C. O'Farrell: Yes, there has. In not only the wheatbelt but also the great southern region, it is very important to provide both male and female Aboriginal health workers, as the member would be aware. The role of the male health workers is to try to broker access for Aboriginal men. The most important thing is to

encourage and educate Aboriginal men to become interested in their health. The next most important thing is to try to overcome some of the real or perceived barriers that Aboriginal men face in accessing a health service. That may initially be through a male Aboriginal health worker, or through facilitated access to a general practitioner. The process may also start because the person has had occasion to be treated in an emergency department, or be admitted to a hospital.

Mr T.K. WALDRON: Are the GPs in that area cooperating with this program and helping to take it up generally?

[7.50 pm]

Mrs C. O'Farrell: Yes, they are.

Dr N. Fong: I have an additional point to make about the Aboriginal health workforce. Western Australia has made some significant inroads in relation to Aboriginal nursing and medical students. Currently, 18 Aboriginal medical students are training in our medical schools, which I think is a record for the country. The very first Aboriginal doctor to graduate was in my cohort year in 1982, Dr Helen Milroy. She is now the head of the Centre for Aboriginal Medical and Dental Health at the University of Western Australia, encouraging and fostering this whole issue. We assist in the funding of that centre. Also, four Aboriginal students are enrolled in the registered nurses training program at Murdoch. There are currently 18 nurses training for an enrolled nurse program. We are a little restricted in knowing the full extent of our health workforce because of the privacy issues with Aboriginal and Torres Strait Islander identification. That is all good news. I believe we have 17 Aboriginal people doing a bridging course, getting ready to get into enrolled nursing. Along with that and the Marr Mooditj Foundation, which has been longstanding in WA, I think we are starting to get some momentum in the Aboriginal health workforce. If we can get the medical students right through to the end, it will be a terrific outcome.

Dr K.D. HAMES: Aboriginals make up three per cent of the population. Presumably, they are a significantly high percentage of your customers. What percentage of the workforce in total is Aboriginal?

Dr N. Fong: As I said, it is very difficult for us to identify that.

Dr K.D. HAMES: Dr Fong should know that because a certain committee has just asked him that question. I do not remember the answer so I thought he might tell us.

Dr N. Fong: If the member knows the answer, he might frame it in the question.

Dr K.D. HAMES: I am not allowed to say because it is a committee issue. The current chair is also a member of that committee.

The CHAIRMAN: I think that is called checkmate!

Dr K.D. HAMES: I have a couple of final questions that have been given to me. Has the department established any new offices in the past year? Are there any plans for any new offices in the coming year? In asking that, I recall that during the last budget the department was looking at establishing a new south metropolitan office. If the department does have such plans, we would like to know the establishment, staffing and operating costs.

Dr N. Fong: No offices have been established this year. Those offices were established in 2005-06. They were to house the South Metropolitan Area Health Service and the project team for the Fiona Stanley complex, which will be substantial. They are situated in Mt Pleasant. The approximate square metreage is about 650.

Dr K.D. HAMES: Which office was this?

Dr N. Fong: In Mt Pleasant. It was established in 2005-06.

Dr K.D. HAMES: I am not interested in 2005-06 but this current financial year.

Dr N. Fong: No new offices have been established this year.

Dr K.D. HAMES: Are any planned for next year?

Dr N. Fong: There are none planned. There is the obvious expansion of the team. The architects team for Fiona Stanley Hospital was announced today. It will contribute towards that. We want to have that team together beavering away on the planning and design of the Fiona Stanley complex. It makes sense to have it at Mt Pleasant when we have clinicians coming in for meetings from Royal Perth Hospital and Fremantle Hospital. It is a central point at the end of the freeway. That was the thinking.

Dr K.D. HAMES: I have one final question. This question is not my question. It is on an issue with which the minister and I agree, hence my hesitation in asking it. What advice did the director general provide to the minister on surrogacy? Did the director general advise the minister that it is appropriate that the Surrogacy Bill

enable single parents and same-sex couples to be given children as arranged parents? Did the director general advise the minister that it is inappropriate that the Surrogacy Bill enable single parents and same-sex couples to be given children as arranged parents? I do not even know what that question is getting at.

Mr J.A. McGINTY: The director general provided me with no advice on this issue. In fact, I think he was remarkably disinterested in the issue, much to my chagrin. I discussed the issue with a range of health department officers, particularly from the legal section, and people from the Reproductive Technology Council but I do not remember discussing it with the director general.

Mr C.J. BARNETT: I wish to add to that. The minister made a point about surrogacy. If the legislation passes, I thought an issue such as surrogacy would have some implications for an operation such as King Edward Memorial Hospital for Women. There would be some ethical issues and clinical issues, perhaps conflict between two women. If that law goes through, I cannot believe that a maternity hospital would not consider the implications, if there are any.

Mr J.A. McGINTY: That is most probably right. The people that I sought advice from included, firstly, the Reproductive Technology Council and its officers. Con Michael provided me with some written advice after the bill was introduced, where he disagreed with a particular provision.

Dr K.D. HAMES: An excellent specialist. He delivered three of my children.

Mr J.A. McGINTY: I agree with the member. He is currently an excellent head of the Medical Board of Western Australia. I had a clear view of what I wanted to do. It was something I discussed with the legal people in the health department. I am not sure of the basis on which their advice came forward. The most useful advice was from the Reproductive Technology Council, where the major implications come. They will be drawing up the ethical guidelines, dealing with the issues that the member for Cottesloe referred to.

Mr T.K. WALDRON: I refer to the heading "Workforce" on page 595, under which it says that nursing graduate placements will be increased across all country health regions. Could the minister give me some details of how many graduate nurse placements will be made in each health region? Is the minister having any issues getting graduates to go to country WA?

Mrs C. O'Farrell: No, we are not. In the last 12 months of the program 52 graduates went through all our regions, which was a good result. That number was a factor in the extent to which the various regional hospitals felt that they could take on graduates. For the next 12 months we will set our sights higher. We are aiming to guarantee a place to every graduate who wants to come to us. We would anticipate a much higher number.

Mr T.K. WALDRON: Are they heading to any particular region in country WA? Is it south west coastal, Bunbury, etc?

Mrs C. O'Farrell: They love the north west and they love Kalgoorlie. In particular, they love Katanning and Albany. They really enjoy their time in the country. Some of them obviously come from the country. The young people in particular seem to get into these quite tricky and seemingly less popular places and have a really great time because the work is great, the experience they get is great, they have a lot of fun and they often stay with us.

Mr T.K. WALDRON: It is a wonderful place to be out there.

Mr J.A. McGINTY: I thank all members who have participated and all of the staff who are here today for what has been a very informative session.

The appropriation was recommended.

[8.00 pm]