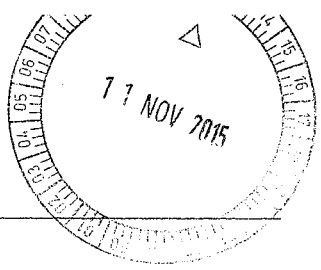

Deputy Premier of Western Australia
Minister for Health; Tourism

Our Ref: 25-49229

Mr Mark Warner
Committee Clerk
Estimates and Financial Operations Committee
Legislative Council
Parliament House
PERTH WA 6000

Dear Mr Warner

QUESTIONS PRIOR TO HEARING 2014-15 ANNUAL REPORT HEARINGS

Please find attached responses to the questions prior to hearing submitted by Legislative Council Member Hon Sue Ellery MLC for the Metropolitan Health Services.

In relation to question 8d, clarification was sought from the Committee and was provided on 3 November 2015. A response will be provided as soon as possible.

Yours sincerely

Dr Kim Hames MLA
DEPUTY PREMIER
MINISTER FOR HEALTH

9 NOV 2015

Level 13, Dumas House, 2 Havelock Street, West Perth, Western Australia, 6005
Telephone +61 8 6552 5300 Facsimile +61 8 6552 5301 Email: Minister.Hames@dpc.wa.gov.au
www.premier.wa.gov.au/Ministers/Kim-Hames

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

2014/15 ANNUAL REPORT HEARINGS
ANSWERS TO QUESTIONS PRIOR TO HEARING

Metropolitan Health Services

Hon Sue Ellery MLC asked:

I refer to the Metropolitan Health Services Annual Report 2014-15 and ask:

1) On Page 30, can you please provide the Average cost per case mix adjusted separation for each tertiary hospital?
Answer: The 2014–15 results for Tertiary hospitals are:

Fiona Stanley Hospital	$13,067
Fremantle Hospital	$9,614
King Edward Memorial Hospital	$7,210
Princess Margaret Hospital	$7,026
Royal Perth Hospital	$7,451
Sir Charles Gairdner Hospital	$7,146

2) On the same page, can you please provide the average cost per case mix adjusted separation for each non tertiary hospital.
Answer: The 2014–15 results for Non-tertiary hospitals are:

Armadale Kelmscott Memorial Hospital	$6,477
Bentley Hospital	$7,960
Kalamunda Hospital	$9,161
Osborne Park Hospital	$7,616
Rockingham General Hospital	$5,373
Swan District Hospital	$5,521

3) On page 30, it refers to a 28% increase in the average cost for a home based hospital patient per day, why has this escalated so much?
Answer: Princess Margaret Hospital had an increase in patients from their oncology department due to a change in treatment protocol. Some children with leukaemia with potential fungal infections need daily infusions administered in the home for many weeks. Other children needed the same infusion but three times per week. This therefore increased the expenditure and activity. This occurred only for 2014-15.

4) On page 30, why has there been a 174% increase in the average cost per non admitted hospital based occasion of service for rural hospitals?
Answer: The year on year change has been a decrease of 33%. The % variation indicated relates to the target. The only Rural setting in the metropolitan health service is within South Metropolitan Health Service - Murray District Hospital. However, unlike small Rural Hospitals within WA Country Health Services, Murray District Hospital is funded on an Activity Based Funding model and as such comparisons to ratios are often unreliable due to the small volume of activity at that site.

5) Also on page 30, in relation to expenditure on the Patient Assisted Travel Scheme, I ask can you please provide a breakdown of expenditure on each aspect of the travel costs covered by the Patient Assisted Travel Scheme (PATS)?
Answer: Peel PATS breakdown of expenditure, 2014/15:
   - Travel expenses - $20,452.
   - Accommodation expenses - $15,755

   Source: PATS Online Database

6) Can you provide a breakdown of the amount spent on interstate PATS including, number of patients receiving interstate PATS and a breakdown of what procedure types (especially surgery type) it entailed?
Answer: 151 applications were approved under the Interstate Patient Travel Scheme (IPTS) during 2014-15 at a total cost of $517,406, comprising of:
   - Airfares - $299,277
   - Accommodation, taxis and living away allowance - $218,129

   Of the 151 approved applicants, 71 were adult and 80 were paediatric.

   The table below provides a breakdown of the specialty surgical areas approved during 2014-15:

Number of approved IPTS applications 2014-15					
SPECIALITY	Q1	Q2	Q3	Q4	**Total**
Adult Cardiology	3	1		2	6
Cochlear implant			1	1	2
Colorectal Surgery	1		1	1	3
Cranio Facial Surgery	2	2	4	3	11
Endocrinology	1				1
ENT surgery		1		2	3
Infant Child and Adolescent Psychiatry	2	1	1		4
Live donor transplant	2	3	1		6
Nephrology/Renal Medicine/ Transplantation	6	3	2	2	13
Neurosurgery		2	2	2	6
Opthalmology Oncology		1		5	6
Paediatric Cardiology	8	9	15	7	39
Paediatric Liver surgery/transplant	9	1	2	4	16
Paediatric Oncology	1				1
Paediatric Orthopaedics	6	2	3	7	18
Pudendal Nerve surgery	2	4	1		7
Radiation Oncology	1	1	4		6
Thoracic Medicine	1		1		2
Transfer from Royal Darwin (trauma)			1		1
Total	45	31	39	36	**151**

7) On page 34, it shows a large increase in the Category 1 overdue waiting times (in days) for WA patients who have waited beyond the clinically recommended timeframes from 12.9 days in December 2013, to 36.3 days in December 2014 – what are the reasons for this blow-out?
Answer: Elective surgery performance has been negatively impacted in 2014-15 due to the significant elective surgery reconfiguration program that occurred during the commissioning of Fiona Stanley Hospital and changes to Royal Perth and Fremantle hospitals. This includes workforce and clinical service changes. This strategy was necessary to ensure the safe commissioning of services, as well as for the safe transfer of patients across the health system. This increased the number of days that some patients waited in this category.

8) On page 42 I refer to the re-alignment of postcodes to ensure maintenance of safe obstetric services with organisational capacity across the metropolitan area and ask;

i) How many patients that would have been treated by postcodes relevant to Fiona Stanley were sent to other hospitals, and how many were sent to each hospital; and
Answer: Nil.

ii) Has the demand on King Edward Memorial Hospital for tertiary level maternity services resulted in low to medium risk pregnancies from women in King Edward catchment area for local intake being referred to other hospitals, if so, how many were sent to other hospitals and to which hospital/s (e.g. numbers to each hospital)?
Answer: No.

b) I refer to the development of the Perth Children's Hospital on page 48 and ask did the Government commit to providing a parent room dedicated for the children's cancer ward; and ask;

i) Is this still being provided, and will it be dedicated for parents of cancer children and include a kitchen meals preparation area?
Answer: Oncology parents will have access to a parent lounge on Level 1 of Perth Children's Hospital, located between Ward 1A (oncology) and Ward 1B (burns, plastics, orthopaedics). The parent lounge will feature a range of amenities, including:

- tea and coffee making facilities
- a microwave
- a refrigerator
- dining table and chairs
- a television
- lounge chairs

A small group of parents of current oncology patients toured the oncology parents lounge at Perth Children's Hospital earlier this year and were satisfied with the suitability of the space.

In addition, there will be an interview and lounge space within the oncology inpatient unit that will offer comfortable seating, a beverage bay and television. In the evenings and on weekends this area will be a dedicated parent lounge space and during weekdays the room will also function as an interview room for staff to meet with families and patients.

All parents of Perth Children's Hospital patients will have access to a comprehensive parent accommodation facilities on Level 5, incorporating:

- a full kitchen
- laundry facilities
- access to the Multi-Faith Centre
- twelve parent accommodation rooms with en suites; and
- two transition suites for two parents and a child who is either deemed well enough to be discharged but could be awaiting transfer; or a palliative care patient whose family prefers to be outside of the oncology inpatient unit environment.

ii) If not, why not?
Answer: Not applicable.

c) I refer to page 53, regarding the Qualified Opinion by the Auditor General in relation to inadequate controls over medical practitioner treatment charges and ask;

i) What is the revenue associated with the medical practitioners treatment of private and overseas patients have been brought to account in 2014/15;
Answer: Total medical practitioner charges raised for categories of billable patients related to Arrangement A and Radiology amounted to $40.6 million.

ii) What is the estimate of revenue not accounted for, and therefore foregone by Government, due to the lack of adequate controls;
Answer: WA Health estimates the revenue foregone to be in the range of $5 million to $8 million.

iii) Given this is the same qualified opinion that has been given every year since at least 2010-11, what measures have been taken to rectify this problem;
Answer: WA Health has implemented new policy and procedures relating to medical practitioner billing arrangements.

WA Health is implementing new IT systems for patient administration (WebPAS), billing (Power Billing and Revenue Collection), that provide a greater degree of control over the revenue process. Implementation of these improved systems is in progress.

WA Health has initiated a Revenue Reform program to improve governance over revenue generation activities, improved business systems/process, private practice arrangements, legislation and learning and development for hospital teams and medical practitioners.

iv) Why has it taken so long to respond; and
Answer: As some of the issues are complex to solve, especially those of a systemic or strategic nature as potential solutions require detailed consideration of many interconnected elements including industrial awards, deployment of new IT systems for billing and development of operational policies and procedures.

v) When will this problem be fixed?

Answer: Improvements have been recognised by the Office of the Auditor General (OAG) and further work is underway in an endeavour to remove the qualification. The OAG noted in their Exit Interview on the 2014-15 Financial Statements that '*We found that although processes and controls have improved at some hospitals, they remain inadequate overall'*. To support strategies to improve revenue performance and compliance, a Revenue Strategy and Support Unit has been established together with the implementation of a comprehensive Revenue Reform Program.

d) On page 113 there has been a steady increase in the percentage of unplanned admissions within 28 days to the same hospital in relation to the provision of mental health services, leading to the percentage of unplanned admissions being 2.7% over target.
Answer: Clarification was sought from the Committee regarding this question. Clarification was provided on 3 November 2015. A response will be provided as soon as possible.

e) I refer to page 119 and ask why there has been such a large drop in the average cost for bed day for admitted patients in small hospitals between 2013-14 and 2014-15?
Answer: There has been a business change between the two financial years to account for the decrease in the average cost for bed day for admitted patients in small hospitals. Expenditure that was originally aligned to this indicator in 2013-14, has now been redistributed and associated with the whole facility (Murray District Hospital) rather than exclusively to this indicator/service output.

f) Why has there been such a large increase in the average cost per (non) admitted occasion of service in the metropolitan health service hospitals between 2013–14 and 2014–15?
Answer: A recent change to data collection for non-admitted occasions of service has resulted in the under-reporting of activity. The total expenditure for this KPI has increased by 21% compared to 2013-14, more than half of which is attributable to the commencement of non-admitted patient services at Fiona Stanley Hospital. The under-reporting of activity coupled with the increase in expenditure has caused the average cost to be overstated.